May 5, 2026

[redacted]

RE: [redacted] v. WV DoHS BFA
ACTION NO.: 26-BOR-1637

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 people 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,

Amy Hayes
State Hearing Officer
Member, State Board of Review

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

cc: Kristyne Hoskins, Department Representative
Steven Murphy, Department Representative

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted]

Appellant,

v. **Action Number: 26-BOR-1637**

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 28, 2026.

The matter before the Hearing Officer arises from the January 4, 2026 decision by the Respondent that the Appellant was eligible for the Specified Low-Income Medicare Beneficiary program, and not eligible for other levels of Medicare Premium Assistance.

At the hearing, the Respondent appeared by Kristyne Hoskins, Economic Service Worker Senior, and Steven Murphy, Economic Service Worker, West Virginia Department of Human Services (DoHS). The Appellant appeared and was self-represented. All witnesses were placed under oath and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Case comments screen prints for comments dated February 13 through March 5, 2025
D-2 RSDI Information Response screen print
D-3 SSI-Related Medicaid Income Budget screen print for determination date January 24, 2026, and payment begin date March 1, 2026
D-4 Notification from DoHS to Steven Rowe dated January 4, 2026
D-5 West Virginia Income Maintenance Manual Section 3.7
D-6 West Virginia Income Maintenance Manual Section 4.12.1
D-7 West Virginia Income Maintenance Manual Chapter 4, Appendix A: Income Limits

Appellant's Exhibits:

A-1 Screen print of Patient Information, Guarantor Information, and Insurance Information for [redacted] from medical records

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 a recipient of Social Security Retirement, Survivors, and Disability Insurance (RSDI) benefits and began receiving the benefits in March 2023. (Exhibit D-2)

2) The Appellant's gross unearned income from RSDI is $1,457 per month. (Exhibit D-3)

3) The Appellant is enrolled in Medicare Part A and Medicare Part B. (Exhibit D-4)

4) The Appellant was enrolled in Medicare automatically in March 2025 after receiving RSDI benefits for 24 months.

5) The Appellant's MAGI Medicaid was closed when the Appellant began receiving Medicare. (Exhibit D-1)

6) In March 2025, the Appellant requested to reopen MAGI Medicaid coverage and the Respondent's worker advised him that he had Specified Low-Income Medicare Beneficiary (SLIMB) coverage. (Exhibit D-1)

7) On January 2, 2026, the Respondent notified the Appellant that his Medicaid and/or Medicare Premium Assistance (MPA) had been reviewed and that his SLIMB benefits would continue with no changes in coverage. (Exhibit D-4)

8) The Appellant requested a fair hearing on March 13, 2026, because his medical needs exceed the coverage provided by the programs of assistance he qualifies for. (Fair hearing request submitted to the Board of Review and part of the Administrative record)

APPLICABLE POLICY

Title 42 of the U.S. Code, Section 426 - Entitlement to hospital insurance benefits, describes enrollment in Medicare, and provides, in pertinent part:

(b) Individuals under 65 years

Every individual who—

(1) has not attained age 65, and

(2)

(A) is entitled to, and has for 24 calendar months been entitled to, (i) disability insurance benefits under section 423 of this title or (ii) child's insurance benefits under

section 402(d) of this title by reason of a disability (as defined in section 423(d) of this title) or (iii) widow's insurance benefits under section 402(e) of this title or widower's insurance benefits under section 402(f) of this title by reason of a disability (as defined in section 423(d) of this title), or

(B) is, and has been for not less than 24 months, a disabled qualified railroad retirement beneficiary, within the meaning of section 231f(d) of title 45, or

(C)

(i) has filed an application, in conformity with regulations of the Secretary, for hospital insurance benefits under part A of subchapter XVIII pursuant to this subparagraph, and

(ii) would meet the requirements of subparagraph (A) (as determined under the disability criteria, including reviews, applied under this subchapter), including the requirement that he has been entitled to the specified benefits for 24 months, if—

(I) medicare qualified government employment (as defined in section 410(p) of this title) were treated as employment (as defined in section 410(a) of this title) for purposes of this subchapter, and

(II) the filing of the application under clause (i) of this subparagraph were deemed to be the filing of an application for the disability-related benefits referred to in clause (i), (ii), or (iii) of subparagraph (A),

shall be entitled to hospital insurance benefits under part A of subchapter XVIII for each month beginning with the later of (I) July 1973 or (II) the twenty-fifth month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and ending (subject to the last sentence of this subsection) with the month following the month in which notice of termination of such entitlement to benefits or status as a qualified railroad retirement beneficiary described in paragraph (2) is mailed to him, or if earlier, with the month before the month in which he attains age 65.

Title 42 of the U.S. Code Section 1396a - State plans for medical assistance, states that that the State or local agency administering a Medicaid plan will take all reasonable measures to ascertain the legal liability of third parties (including Medicare, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan…

West Virginia Income Maintenance Manual, Section 3.7 describes the Eligibility for Medicaid as an Adult, in pertinent part (emphasis added):

3.7 Adult Group

The Patient Protection and Affordable Care Act, amended by the Health Care and Education Reconciliation Act of 2010, enacted March 30, 2010, are together referred to as the Affordable Care Act (ACA). The ACA established the categorically mandatory coverage group known as the Adult Group. Effective January 1, 2014, Medicaid coverage is provided to individuals age 19 or older and under age 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 Part A or B**. Eligibility for this group is determined using Modified Adjusted Gross Income (MAGI) methodologies established in Section 4.7.

West Virginia Income Maintenance Manual Chapter 4 Definitions defines Spenddown as: The amount by which income exceeds the Medically Needy Income Level (MNIL) for the Period of Consideration (POC). Further, Spenddown procedures for SSI-Related Medicaid are described in Section 4.14.4.J Spenddown:

4.14.4.J Spenddown

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.

4.14.4.J.1 Procedures

The Worker must determine the amount of the client's spenddown at the time of application based on information provided by the client. The spenddown amount may have to be revised if the verified income amount differs from the client's statement. The Worker must also explain the spenddown process to the client.

The following procedures are required for the spenddown process.

• The Worker prepares the DFA-6, attaches a DFA-6A and gives them to the client or mails them. The DFA-6A notifies the client that an eligibility decision cannot be made until he meets his spenddown by providing proof of medical expenses.

The DFA-6 must also contain any other information the client must supply in order to determine eligibility.

If the client indicates he needs help to understand the procedure for meeting his spenddown, the Worker provides all help needed. In no instance is the client to be denied Medicaid because he is physically, mentally, or emotionally unable to verify his medical expenses.

• The client is requested to provide proof of his medical expenses, date incurred, type of expense and amount, and to submit them to the Worker by the application processing deadline.

• Medical bills are entered and tracked in the eligibility system as they are received. When the bills or verification are received, the Worker reviews the information to determine:

o The expenses were incurred, they are not payable by a third party, and the client will not be reimbursed by a third party.

o The individual(s) who received the medical service is one of the persons described in Section 4.14.4.J.2 below.

o The expenses are for medical services and are appropriate to use to meet a spenddown. See Section 4.14.4.J.3 below.

• The Worker must enter the pertinent information about expenses received from the client in the eligibility system. This information includes:
    - o The date of service
    - o The provider of the service
    - o The total amount of the bill
    - o The third-party liability amount

West Virginia Income Maintenance Manual, Section 4.12 describes the Income Eligibility for QMB, SLIMB, QI-1 (Categorically Needy, Mandatory), in pertinent part:

4.12.1 Determining Eligibility
Countable income is determined by subtracting any allowable disregards and deductions from the total countable gross income. Deemed income is addressed in Section 4.12.2 below.

Countable income is determined as follows:

Step 1: Determine the total countable gross unearned income and subtract the appropriate disregards and deductions. See Section 4.14.2.

Step 2: Determine the total countable gross earned income and subtract the appropriate disregards and deductions. See Section 4.14.2.

Step 3: Add the results from Step 1 and Step 2 to achieve the total monthly countable income.

Step 4: Compare the amount in Step 3 to the QMB, SLIMB, or QI-1 income levels for the appropriate number of persons. See Section 4.14 for SSI-Related deeming procedures.

If the amount is less than or equal to the QMB, SLIMB, or QI-1 income levels, the client(s) is eligible.

Eligibility for these coverage groups is determined as follows:

- QMB – Income is less than or equal to 100% FPL.
- SLIMB – Income is greater than 100% FPL, but less than or equal to 120% FPL.

West Virginia Income Maintenance Manual Chapter 4 Appendix A program income limits:

100% of the Federal Poverty Level (FPL) for a one-person assistance group: $1,330
120% of the FPL for one-person assistance group: $1,596

West Virginia Income Maintenance Manual, Section 5.3.1.B describes the Supplemental Security Income Medicaid Groups, in pertinent part:

5.3.1.B Supplemental Security Income (SSI) Medicaid Groups
The SSI Medicaid Groups include: SSI-Related Medicaid, CDCSP, PAC, QDWI, QMB, SLIMB, and QI1.

West Virginia Income Maintenance Manual Section 8.2.2 describes Enrollment in Medicare, in pertinent part (emphasis added):

> **8.2.2 Enrollment In Medicare, Part A And Part B (Medicaid Only)**
> All applicants for and clients of Medicaid, who qualify for Medicare Buy-In, must enroll in Medicare, Parts A and B, unless an exemption to enrollment is met. Exemptions include, but are not limited to:
>
> • No established record of birth, or
> • The individual has other creditable health insurance and will be disadvantaged by Medicare enrollment.
>
> See Section 8.6.2 for Medicare eligibility requirements and Section 25.2 for Medicaid coverage groups subject to Department of Human Services (DOHS) buy-in.
>
> **Failure, without an exemption, to enroll in Medicare for the Medicaid applicants or clients who qualify for Medicare Buy-In results in denial of Medicaid** or exclusion from the Medicaid assistance group (AG). When the individual is the only Medicaid AG member, Medicaid is closed. The individual remains ineligible until he enrolls.

West Virginia Income Maintenance Manual, Section 23.8 describes Medicaid Eligibility Between Coverage Groups, in pertinent part:

> The Worker must consider all the following information in determining eligibility and in establishing eligible cases.
>
> **23.8.1 Consideration of All Medicaid Coverage Groups**
> 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.

West Virginia Income Maintenance Manual Section 23.12.1 describes Medicare Premium Subsidies, in pertinent part:

> **23.12.1 Qualified Medicare Beneficiaries (QMB)**

Income	Assets
100% FPL	$9,660 – Individual $14,470 – Couple

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 Medicare Part A and/or enrolled in Medicare Part B. He must be entitled to Medicare in any of the following three ways:
  - By being age 64 years and 9 months old or older;
  - By having been totally and continuously disabled and receiving RSDI or Railroad Retirement benefits for 24 months or longer; or,
  - 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.

23.12.2 Specified Low-Income Medicare Beneficiaries (SLIMB)

Income	Assets
101 – 120% FPL	$9,660 – Individual $14,470 – Couple

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:
  - By being age 64 years and 9 months old or older;
  - By having been totally and continuously disabled and receiving RSDI or Railroad Retirement benefits for 24 months or longer; or,
  - 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 contests the determination by the West Virginia Department of Human Services (DoHS) that he is only eligible for Specified Low-Income Medicare Beneficiary (SLIMB) Medicare Premium Assistance, instead of other types of Medicaid. SLIMB is a program of Medicaid assistance that pays the Medicare Part B premium. The Respondent bears the burden of proof to demonstrate by a preponderance of evidence that it correctly determined that SLIMB was the appropriate program for the Appellant.

The DoHS administers Medicaid, which provides comprehensive health insurance for eligible low-

income adults and children and the aged, blind, or disabled. Medicaid also provides assistance with Medicare cost-sharing for certain low-income individuals through Medicare Premium Subsidies. Although these programs fall under the category of Medicaid, the eligibility factors and the types of benefits provided are different.

Eligibility for the different types of Medicaid programs depends on many factors outlined in federal and state law, state regulations, and agency policy. In administering Medicaid programs, the DoHS receives federal funding and thus must comply with federal law. The DoHS policy that describes the way the state administers Medicaid programs is the West Virginia Income Maintenance Manual (IMM). The IMM is available to the public and can be referenced at any time to learn about the eligibility requirements for all programs.

The IMM states: "When the client expresses an interest in applying for Medicaid, the Worker must explore eligibility for all Medicaid coverage groups." The Appellant previously received a type of Medicaid assistance which provides health insurance called Modified Adjusted Gross Income (MAGI), as part of an Adult Group. One of the factors for eligibility for MAGI Medicaid is income. However, policy requires that MAGI Medicaid only be issued to individuals who are not entitled to enroll in Medicare. This is because federal law provides that health insurance provided through Medicaid is the payor of last resort. As such, federal law requires that the DoHS ascertain the liability of third parties, including Medicare.

The Appellant testified that he is currently 57 years of age and started receiving Social Security Retirement, Survivors, and Disability Insurance (RSDI) benefits in March 2023. Federal law provides that a person younger than age 65 who has been entitled to disability insurance benefits for 24 months is entitled to Medicare. In March 2025, after receiving RSDI benefits for a period of 24 months, the Appellant was automatically enrolled in Medicare Parts A and B. The evidence showed that, after March 2025, the Respondent closed the Appellant's MAGI Medicaid because he was enrolled in Medicare. The Respondent correctly determined that, because the Appellant was enrolled in Medicare, he was no longer eligible for MAGI Medicaid.

The Appellant requested to be enrolled in both Medicare and the MAGI Medicaid, or alternatively, to be enrolled only in MAGI Medicaid. However, policy, in adherence with federal law, states that all applicants for and clients of Medicaid, who qualify for Medicare, must enroll in Medicare, Parts A and B, unless an exemption to enrollment is met. Exemptions include, but are not limited to, clients who have no established record of birth, or the individual has other creditable health insurance and will be disadvantaged by Medicare enrollment. Other creditable health insurance does not include MAGI Medicaid itself. A person is disadvantaged by Medicare enrollment when the other health insurance they qualify for covers less than Medicare. The Appellant did not show that he met an exemption to this policy because MAGI Medicaid is not other creditable health insurance.

The evidence showed that in March 2025, the Respondent reviewed the Appellant's eligibility for other Medicaid programs called Medicare Premium Assistance (MPA). MPA programs provide assistance with Medicare cost-sharing. There are four levels of MPA administered by the state to individuals who are enrolled in Medicare: Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLIMB), Qualified Individual (QI), and Qualified Disabled

Working Individuals (QDWI).

Eligibility for MPA programs is based, in part, on income. To be eligible for QMB, an applicant's income must be less than 100% of the Federal Poverty Level, which is $1,330. To be eligible for SLIMB, an applicant's income must be between $1,330 and $1,596. The Respondent's representative, Steven Murphy, testified that the Appellant was evaluated again for all MPA programs in January 2026. Mr. Murphy testified that the Respondent determined that the Appellant was eligible for the SLIMB program because his income from RSDI was $1,457, which is more than $1,330 and less than $1,596. The Respondent determined that the Appellant was not eligible for QMB because his income was more than the limit for that program. The Appellant did not refute the amount of income attributed to him.

The Appellant contended that he knows someone who he believes receives both Medicare and Medicaid and requested that he be enrolled in both programs of assistance. The Respondent's representative testified that people are often confused because the MPA programs, which are cost-sharing programs that help with Medicare premiums, are also referred to as "Medicaid." The Respondent's witness also testified that the QMB level of MPA is often referred to as just "Medicaid," which causes confusion about what coverage is provided. QMB offers the most coverage of the four types of MPA, and coverage includes payment of Medicare Part A and Part B premium amounts and payment of all Medicare co-insurance and deductibles, including those related to nursing facility services. SLIMB coverage, on the other hand, is limited to payment of the Medicare Part B premium.

The Appellant contended that his medical needs and the cost of his care are not being met by the SLIMB benefits. The eligibility requirements and income limits for Medicaid programs are set by federal and state law. The Board of Review cannot pass judgment on policy itself. The Hearing Officer can only determine if the agency acted correctly and followed the policy based on the facts presented. The preponderance of evidence showed that the Respondent correctly determined that the Appellant was not eligible for MAGI Medicaid because he was enrolled in Medicare, and that the Appellant was eligible for SLIMB, and not QMB, because his income exceeds the limit for enrollment in QMB.

The Appellant testified that he had applied for a Medicaid program with a spenddown provision. The Supplemental Security Income (SSI)-Related Medicaid Spenddown program helps aged, blind, or disabled individuals with incomes too high to qualify for income-based Medicaid programs. Eligibility for the program depends on many factors, including the amount of medical bills the applicant has. At the time of the hearing, the Respondent had not yet processed the Appellant's application for the SSI-Related Medicaid Spenddown program. The Respondent's witness testified that the Appellant needed to submit medical bills so the Respondent could determine his eligibility.

CONCLUSIONS OF LAW

1) Pursuant to policy, Medicaid clients who qualify for Medicare must enroll in Medicare Parts A and B unless an exemption is met, and the Appellant did not show that he met an exemption.

2) Federal law requires that Medicaid be the payor of last resort, and policy states that a person who is entitled to Medicare is not eligible for MAGI Medicaid.

3) The Appellant's gross unearned income of $1,457 per month exceeded 100% of the Federal Poverty Level (FPL) of $1,330, but was below 120% of the FPL of $1,596, at the time of his redetermination review, so the Respondent correctly determined that the Appellant is eligible for Medicare Premium Assistance at the Specified Low-Income Medicare Beneficiaries (SLIMB) level but remains ineligible for the Qualified Medicare Beneficiaries (QMB) level.

4) The Appellant's application for the SSI-Related Medicaid Spenddown program had not yet been processed at the time of the hearing.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the action of the Respondent to approve Specified Low-Income Medicare Beneficiary (SLIMB) Medicare Premium Assistance (MPA) to the Appellant. A determination by the Respondent as to the Appellant's eligibility for the SSI-Related Medicaid spenddown program of assistance is subject to all fair hearing rights.

ENTERED this 5th day of May 2026.

_____

Amy Hayes
State Hearing Officer