WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted]

Appellant,

v. **Action Number: 26-BOR-2628**

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 September 22, 2026.

The matter before the Hearing Officer arises from the Respondent's July 28, 2026 decision to terminate the Appellant's eligibility for Adult Medicaid.

At the hearing, the Respondent appeared by Erin Nelson, DoHS. The Appellant appeared and was self-represented. Appearing as a witness for the Appellant was [redacted] the Appellant's son. All witnesses were placed under oath, and the following documents were admitted into evidence.

Department's Exhibits:
NONE

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, beginning in May 2024.

2) The Appellant is an ongoing recipient of Long-Term Care Medicaid.

3) The Appellant does not receive any income, including income from the Social Security Administration.

4) On July 27, 2026, the Respondent received an alert that the Appellant was turning 65-years-old and would become eligible for Medicare.

5) On July 28, 2026, the Respondent issued a written notice (Form EDC1) advising the Appellant his Adult Medicaid eligibility would end, beginning on September 1, 2026.

6) The Appellant's written request for a fair hearing was received by the Board of Review on August 28, 2026.

7) The Respondent terminated the Appellant's Adult Medicaid coverage after August 31, 2026.

8) At the time of the hearing, the Appellant was age-eligible but not yet enrolled in Medicare.

APPLICABLE POLICY

Code of Federal Regulations 42 CFR § 431.230(a) ***Maintaining Services*** provides that if the agency sends notice as required and the beneficiary requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless:
(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and
(2) The agency promptly informs the beneficiary in writing that services are to be terminated or reduced pending the hearing decision.

West Virginia Income Maintenance Manual (WVIMM) § 9.3 ***Notice of Action Resulting in a Change in Benefits*** provides that the DFA-NL-C *Notification Letter: Pending Change in the Benefits You Receive* is used to notify the client of case closure or a decrease in benefits when advanced notice is required. Advance Notice is required for most adverse actions as defined below.

WVIMM § 9.3.1 through § 9.3.1.B ***Advance Notice Requirements*** provides that a client must receive advance notice in all situations involving adverse actions except those described in the Adverse Actions Not Requiring Advance Notice section. A Medicaid Assistance Group (AG) closure or client removal from the AG requires advanced notice.

WVIMM § 9.3.1.D.3 ***Date Adverse Action May Be Taken — Fair Hearing Requested after Receipt of DFA-NL-C: Requesting within Advance Notice Period*** provides that when a client

requests a fair hearing before the date of the proposed closure, benefits are restored or reinstated immediately, whether or not the client requests reinstatement.

If the Department is upheld in the Hearing, the previously proposed action is taken without further notice to the client …

WVIMM § 23.10.4 ***Adult Group*** provides that, to be eligible for Adult Group Medicaid, an individual must meet the following requirements:
They are age 19 or older and under age 65;
They are not eligible for another categorically mandatory Medicaid coverage group:

- SSI
- Deemed SSI
- Parents/Caretaker Relatives
- Pregnant Women
- Children Under Age 19
- Former Foster Children
- They are not entitled to enroll in Medicare Part A or B; and
- The income eligibility requirements described in Chapter 4 are met.

DISCUSSION

The Appellant disagreed with the Respondent's termination of his eligibility for Adult Medicaid benefits. During the hearing, the Appellant requested his Medicaid eligibility be extended until he resolves the delay in onset of his Medicare coverage. To be eligible for Adult Medicaid, the Appellant must be below age 65 and not entitled to Medicare Part A or B.

During the hearing, the Appellant did not dispute turning 65-years-old, or contest any information supplied by the Respondent. The Appellant testified that the Social Security Administration determined there was a discrepancy with the information he supplied to verify his identity, therefore, the onset of his Medicare benefits is delayed until he meets with SSA to affirm his identity.

While no exceptions exist to permit the Appellant's eligibility to be extended for programs which he does not qualify for, the submitted testimony revealed that the Respondent incorrectly terminated the Appellant's Medicaid benefits during the pendency of the hearing.

The Respondent's policy requires the Respondent to issue a DFA-NL-C *Notification Letter, Pending Change in the Benefits You Receive* to notify the client of case closure or a decrease in benefits when advanced notice is required. According to the presented information, the Respondent issued a different form, EDC1, to notify the Appellant of his pending Adult Medicaid closure.

According to the Respondent's policy and federal regulations, when a client requests a fair hearing before the date of the proposed closure, benefits are restored immediately, whether or not the client requests reinstatement. On July 28, 2026, the Respondent notified the Appellant in writing that his

Adult Medicaid eligibility would end, beginning on September 1, 2026. On August 28, 2026, the Board of Review received the Appellant's written hearing request form. However, the Respondent terminated the Appellant's Medicaid, beginning on September 1, 2026, instead of continuing his coverage through the pendency of the hearing. Pursuant to the federal regulations, the Respondent may not terminate or reduce services until a decision is rendered after the hearing. Because the Respondent failed to continue the Appellant's Adult Medicaid benefits through the pendency of the hearing, the Respondent must retroactively restore his Adult Medicaid through the date of the hearing decision. According to the Respondent's policy, if the Respondent's proposed adverse action is upheld in the hearing decision, the proposed action is taken without further notice to the client.

As the issue of Medicare benefit eligibility is administered by the Social Security Administration, not the state agency, no relief can be granted by the Board of Review regarding the delay in the onset of the Appellant's Medicare benefits. Because the Appellant does not meet the age criteria and is age-eligible to enroll in the Medicare program, the Appellant is ineligible for Adult Medicaid benefit.

CONCLUSIONS OF LAW

1) To be eligible for Adult Medicaid, the Appellant must be below age 65 and not entitled to Medicare Part A or B.

2) The preponderance of evidence revealed that the Appellant turned 65-years-old.

3) Although the Appellant's Medicare benefit eligibility is pending verification of his identity, the Appellant is age-eligible for Medicare benefits.

4) The Respondent proved by a preponderance of evidence that the Appellant's eligibility for continued Adult Medicaid was correctly denied.

5) According to the Respondent's policy and federal regulations, when a client requests a fair hearing before the date of the proposed closure, benefits are restored immediately, whether or not the client requests reinstatement.

6) The preponderance of evidence proved that the Appellant requested a fair hearing before the date of adverse action.

7) Because the Appellant requested a fair hearing before the date of adverse action, the Respondent incorrectly terminated his Adult Medicaid benefits during the pendency of the hearing decision.

8) Because the Appellant's Adult Medicaid benefits were not continued during the pendency of the hearing decision, the Respondent must retroactively restore his benefits to the date of termination through the date of the decision by the Hearing Officer.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to deny the Appellant continued eligibility for the Adult Medicaid program. Because the Respondent failed to continue the Appellant's Adult Medicaid benefits through the pendency of the hearing, the matter is **REMANDED** for retroactive restoration of the Appellant's Adult Medicaid through the date of the hearing decision.

ENTERED this 30th day of September 2026.

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Tara B. Thompson, MLS
Certified State Hearing Officer