July 9, 2024

[redacted]

RE: [redacted] v. WV DoHS/BFA
ACTION NO.: 24-BOR-2292

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,

Tara B. Thompson, MLS
State Hearing Officer
Member, State Board of Review

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

cc: [redacted] DoHS

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 24-BOR-2292**

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 June 18, 2024.

The matter before the Hearing Officer arises from the Respondent's March 25, 2024 decision to terminate the Appellant's Adult Medicaid benefits.

At the hearing, the Respondent appeared by Kelly O'Bright, DoHS. The Appellant appeared and represented herself. Both parties were placed under oath. No documents were submitted as 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.

2) On March 25, 2024, the Respondent issued a notice advising the Appellant her Adult Medicaid benefits would be terminated after March 31, 2024, because she was being evaluated for another type of assistance.

3) On March 7, 2024, the Appellant submitted her Medicaid eligibility review.

4) During the Appellant's March 2024 eligibility review, the Respondent verified the Appellant's Medicare eligibility status through the Respondent's data exchanges.

5) The Appellant became eligible to enroll in Medicare on April 1, 2024.

APPLICABLE POLICY

West Virginia Income Maintenance Manual (WVIMM) § 1.2.2.B *Redetermination Process* provides that periodic reviews of total eligibility for recipients are mandated by federal law.

WVIMM § 1.8.6/A *MAGI Adult Group* provides that the redetermination process is completed using electronic data matches without requiring information from the client. The redetermination process is initiated which matches current information with the hub.

WVIMM § 10.6.5.A *AG Closures* provides that when a client's circumstances change to the point that she becomes ineligible, the AG is closed.

WVIMM § 23.10.4 *Adult Group* provides that Medicaid coverage in the Adult Group is provided to individuals who 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 or enrolled in Medicare Part A or B; and
    - The income eligibility requirements described in Chapter 4 are met

DISCUSSION

The Respondent terminated the Appellant's Adult Medicaid benefits because her Medicare enrollment eligibility had changed. The Appellant contested the Appellant's termination of her Adult Medicaid benefits after March 31, 2024. The Appellant argued that she requires medical treatment she cannot afford without Adult Medicaid coverage. The Appellant argued that her Medicare coverage is insufficient to meet her medical needs.

The Respondent's representative testified that after her Adult Medicaid termination, the Appellant was evaluated for Medicare Premium Assistance and was determined to be ineligible due to income. At the onset of the hearing, the parties clarified that the hearing issue was the termination of the Appellant's Adult Medicaid, not subsequent eligibility determinations for different programs.

The Appellant argued that her husband should have been included in her AG when her eligibility was determined. As the Respondent's decision to terminate the Appellant's Adult Medicaid eligibility was based on her Medicare enrollment eligibility and was not based on issues related to her household composition and income, arguments related to the AG size and household income were given no weight in this decision.

During the hearing, the Appellant testified that she didn't understand the inconsistency of eligibility guidelines between programs. The Appellant argued that the policy should be revised and contended that her income and household composition should be considered consistently between programs.

The Board of Review lacks the authority to change the policy or award Adult Medicaid through circumstances beyond what is written in the policy. Therefore, this Hearing Officer's decision is policy-based. As the policy does not provide any Adult Medicaid eligibility exceptions based on the Appellant's ability to afford healthcare absent Adult Medicaid coverage, this Hearing Officer is unable to award any eligibility exceptions and can only determine if the Respondent terminated the Appellant's Adult Medicaid benefit eligibility according to the policy.

The Respondent's representative testified that the Appellant was not eligible for Adult Medicaid because she is Medicare eligible. The Respondent's representative testified that the Appellant completed her Medicaid eligibility review on March 7, 2024. During the eligibility review, the Respondent verified that the Appellant was Medicare-eligible, effective April 1, 2024. The Appellant did not contest her Medicare eligibility and testified that she accepted Medicare coverage for three months before terminating the coverage because she could not afford it.

As the Appellant is Medicare-eligible and the policy excludes Medicare-eligible individuals from participating in Adult Group Medicaid benefits, the Respondent correctly terminated the Appellant's Adult Medicaid benefits after March 31, 2023.

CONCLUSIONS OF LAW

1) Individuals entitled to enroll in Medicare Part A or B cannot be included in the Adult Group.

2) The preponderance of evidence revealed that the Appellant was eligible to enroll in Medicare.

3) The Respondent correctly terminated the Appellant's Adult Medicaid eligibility after March 31, 2024.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to terminate the Appellant's Adult Medicaid benefits.

ENTERED this 9th day of July 2024.

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Tara B. Thompson, MLS
State Hearing Officer