August 01, 2024

[redacted]

Re: [redacted] v WV DoHS
ACTION NO.: 24-BOR-2151

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 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,

Angela D. Signore
State Hearing Officer
Member, State Board of Review

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

cc: Rebecca Skeens, WV DoHS, [redacted]

BEFORE THE WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

IN THE MATTER OF:

[redacted],

Appellant,

v. ACTION NO.: 24-BOR-2151

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 26, 2024, on an appeal filed May 06, 2024.

The matter before the Hearing Officer arises from the February 06, 2024 determination by the Respondent to terminate the Appellant's Adult Medicaid eligibility due to household income exceeding the eligibility limits.

At the hearing, the Respondent appeared by Rebecca Skeens, Department of Human Services (DoHS). Appearing as a witness for the Respondent was Lavetta Casto, Economic Service Supervisor. The Appellant appeared *pro se*. Appearing as witnesses for the Appellant were [redacted] Appellant Landlord and [redacted] Insurance Producer. All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

D-1 COVID-19 Continuous Coverage pamphlet

D-2 WV DoHS Notice of Medicaid Review, dated December 11, 2023; Medicaid Review Form, dated December 29, 2023
D-3 WV PATH eligibility system printout of Case Comments, dated February 05 through February 09, 2024
D-4 WV DoHS Notice of Decision, dated February 06, 2024
D-5 WV PATH eligibility system printout of RSDI Information Response
D-6 West Virginia Income Maintenance Manual (WVIMM) §§ 3.7 through 3.7.1.B

Appellant's Exhibits:

A-1 Social Security Administration (SSA) Notice of Decision, dated June 17, 2022
A-2 WV DoHS Notice, dated June 02, 2023
A-3 WV DoHS Notice of Decision, dated July 28, 2023
A-4 WV DoHS Notice, dated December 11, 2023; [redacted] Bank Statement; SSA Benefit Verification Letter, dated July 24, 2023; Department of Veterans Affairs Notice, dated July 24, 2023; and WVIMM § 4 excerpts
A-5 WV DoHS Notice, dated January 19, 2024; and WV DoHS Notice and Application, dated December 11, 2023
A-6 WV DoHS Notice, dated February 06, 2024
A-7 West Virginia Code § 9-4D-2
A-8 2023 Federal Poverty Level (FPL) Table
A-9 Medicare.org printout
A-10 WV DoHS Medicaid Eligibility and Requirements excerpt
A-11 WVIMM § 4 excerpt
A-12 WVIMM § 4.3.2
A-13 WVIMM § 4.7 through 4.7.5.L
A-14 WVIMM § 4.14 through 4.14.4.N
A-15 ****
A-16 WVIMM § 8.1 through 8.3.2
A-17 WVIMM § 13.1 through 13.10.4; and Appendix A.1 through A.9

**** A-15 was absent from the Appellant's packet of evidence

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 Modified Adjusted Gross Income (MAGI) Adult Medicaid benefits for an assistance group (AG) of one (1).

2) The Appellant began receiving service-connected disability compensation in the amount of $1,108.82 per month from the Department of Veterans Affairs (VA benefits) on December 01, 2022. (Exhibits D-2, A-1, and A-4)

3) The Appellant began receiving Social Security Disability Insurance (SSDI) benefits in the amount of $1,008.00 per month from the Social Security Administration (SSA) on December 01, 2022. (Exhibits D-2, A-1, and A-4)

4) During the COVID-19 Public Health Emergency (PHE) continuous coverage was provided to all Medicaid recipients, regardless of income. (Exhibit D-1)

5) Beginning April 1, 2023, eligibility reviews for Medicaid which had been suspended during the COVID-19 PHE. (Exhibit D-1)

6) The Appellant began receiving Medicare Part A and B in June 2023. (Exhibits D-3 and A-5)

7) On December 11, 2023, the Respondent issued a notice informing the Appellant that in order to determine continued MAGI Medicaid eligibility, the Appellant was required to complete a review form and return it to the Respondent no later than January 01, 2024. (Exhibits D-2 and A-5)

8) The Respondent received the Appellant's completed redetermination for continued Medicaid eligibility review form on January 05, 2024. (Exhibit D-2)

9) Subsequent to the January 05, 2024 Medicaid eligibility review form, the Respondent issued a notice of decision to the Appellant informing him that, effective January 01, 2024, his Medicaid benefits would end, due to the Appellant's failure to complete an eligibility review. (Exhibit A-5)

10) The Appellant's eligibility review was processed by the Respondent on February 05, 2024. (Exhibit D-3)

11) On February 06, 2024, the Respondent issued a notice of decision to the Appellant informing him that, effective February 01, 2024, his MAGI Medicaid benefits would end,

due to the Appellant's enrollment in Medicare Part A. (Exhibits D-2 and A-6)

12) The Appellant contested the Respondent's decision and requested a Fair Hearing on May 06, 2024.

APPLICABLE POLICY

West Virginia Income Maintenance Manual (WVIMM) § 3.7

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 [emphasis added]**. Eligibility for this group is determined using Modified Adjusted Gross Income (MAGI) methodologies.

WVIMM § 3.7.1.B provides, in part:

These individuals cannot be included MAGI Medicaid:

- Individuals eligible for these categorically mandatory coverage groups:
  - Supplemental Security Income (SSI)
  - Deemed SSI
  - Parents/Caretakers
  - Pregnant Women
  - Children Under Age 19
  - Former West Virginia Foster Children
- **Individuals entitled to or enrolled in Medicare Part A or B [emphasis added]**
- Parents or other caretaker relatives living with a dependent child under the age of 19, unless the child is also receiving benefits under Medicaid, WVCHIP, or other minimum essential coverage (MEC).

WVIMM § 3.7.2 provides, in part:

The income of each member of the individual's MAGI household is counted. The income group is determined using the MAGI methodology established in 3.7.3.

WVIMM § 4 Appendix A provides, in part:

> For a one (1) person Assistance Group (AG), 100% of the FPL = $1,255
> For a one (1) person Assistance Group (AG), the income limit is $1,670 = 133% FPL

WVIMM § 9.3.1 provides, in part:

> A client must receive advance notice in all situations involving adverse actions except those described in the Adverse Actions Not Requiring Advance Notice section. The advance notice requirement is that notification be mailed to the client at least 13 days prior to the first day of
> the month in which the benefits are affected.

WVIMM § 9.3.1.A provides, in part:

> A Medicaid AG closure client must receive advance notice of Adverse Action.

WVIMM § 9.3.1.C provides, in part:

> The 13-day advance notice period begins with the date shown on the notification letter. It ends after the 13th calendar day has elapsed. If the 13-day notice period ends on a weekend or holiday, the action is taken on the first subsequent workday.

WVIMM § 9.3.1.D.1 provides, in part:

> Usually the Worker will take the action in the eligibility system before the 13-day advance notice begins, in order to be effective, the first day of the following month.

WVIMM § 10.8.3 provides, in part:

> The AG must be closed when the individual(s):
>
> - Turns age 65;
> - **Begins receiving Medicare Part A or B; or [emphasis added]**
> - 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.

WVIMM § 23.10.4 provides, in part:

As a result of the ACA, the Adult Group was created effective January 1, 2014. Eligibility for this group is determined using Modified Adjusted Gross Income (MAGI) methodologies established in Section 4.7.

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.

Parents or other caretaker relatives living with a dependent child under the age of 19 are not eligible for Medicaid in the Adult Group unless the child is receiving benefits under Medicaid, WVCHIP, or otherwise enrolled in minimum essential health coverage (MEC).

DISCUSSION

The Appellant was a recipient of MAGI Medicaid benefits during the COVID-19 PHE. During the PHE, safeguards were implemented which mandated the Respondent to provide continuous coverage to Medicaid recipients without consideration of routine eligibility criteria. The continuous coverage provisions expired on April 1, 2023, and all recipients were again subject to

eligibility requirements. MAGI Medicaid groups consist of: Parents and other Caretaker Relatives; Pregnant Women; Children Under 19; and Adult Group (age 19 years or older and under age 65 years).

The Appellant, a recipient of disability benefits through the Social Security Administration, became eligible for and began receiving Medicare Part A and B in June 2023, while receiving MAGI Medicaid benefits during the COVID-19 PHE-related coverage. Upon initial recertification after the PHE expiration, the Respondent discovered the Appellant's receipt of Medicare part A and B assistance and terminated his eligibility for MAGI Medicaid assistance. The Respondent bears the burden of proof and had to demonstrate by a preponderance of evidence that the Appellant was not eligible for MAGI Medicaid benefits due to his Medicare part A and B eligibility.

On February 06, 2024, the Respondent issued a notice of decision to the Appellant informing him that, effective February 01, 2024, his MAGI Medicaid benefits would end, due to the Appellant's enrollment in Medicare Part A and B. During the hearing, the Appellant's witness argued that per the Respondent's February 06, 2024 denial notice, the Appellant should have been evaluated for other Medicaid coverage groups. She testified that due to the Appellant's disability, without the Respondent's guidance, the Appellant would have no way of knowing which programs he may be eligible for. She further testified that because the Respondent's letter informed the Appellant that he would be evaluated for other programs, the Appellant was awaiting their response. The Appellant's witness further testified that the Appellant had previously requested an application for Medicare Premium Assistance, but it was never received.

When questioned on whether the Appellant had been evaluated for other programs, the Respondent's witness testified that after the Appellant's MAGI Medicaid termination, the Appellant was evaluated for all other MAGI Medicaid programs but was not eligible. As a result, the Respondent issued the February 06, 2024 termination notice. She further testified that Medicare Premium Assistance was not evaluated because the program requires a different application. The Respondent testified that an additional notice was issued on February 06, 2024, that informed the Appellant of his ineligibility for all other MAGI Medicaid programs, though the Appellant testified that he did not receive it nor was one provided in the Respondent's packet of evidence.

The Respondent further testified that during "multiple conversations" with the Appellant, he was advised of other programs for which he may be eligible; however, no time frame was provided other than "a while back." It should be noted that the Appellant's witness objected to the Respondent's statement, arguing that the Appellant was not informed. However, testimony provided by both parties revealed that the Respondent did inform the Appellant of Medicare Premium Assistance on at least one prior conversation. Further, the evidence submitted by the Appellant included a September 2023 notice of denial for Medicare Premium Assistance. It should

be noted that at the onset of the hearing, the parties agreed that the hearing was requested due to the termination of the Appellant's MAGI Medicaid, and not due to subsequent eligibility determinations for different programs. Although beyond the scope of the hearing, the Appellant's potential eligibility for other programs was discussed and a post-hearing conference was planned between the Respondent and the Appellant.

Pursuant to the policy, MAGI Medicaid coverage is provided to individuals between the ages of 19 and 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 coverage* [emphasis added]. Upon expiration of the COVID-19 PHE, which provided continuous Medicaid coverage regardless of routine eligibility criteria, the Appellant was required to complete a recertification of benefits by January 01, 2024. The evidence revealed that the Appellant was enrolled in Medicare parts A and B, effective June 01, 2023. As established by the policy, because the Appellant is a Medicare recipient, he is not eligible for MAGI Medicaid benefits.

However, the policy provides that, Adult MAGI Medicaid is "closed the month following the month of the change and after advance notice for the adverse action." Additionally, a client must receive advance notice at least 13 days prior to the first day of the month in which the benefits are affected in all situations involving adverse actions except those described in WVIMM § 9.3.1.B. The evidence revealed that the Appellant's medical review forms were processed on February 05, 2024, but the Respondent's February 06, 2024 termination notice documented February 01, 2024, as the effective date of ineligibility. Because the Respondent's February 06, 2024 notice reflected a termination date prior to the date shown on the notification letter, the Respondent failed to issue proper notice.

CONCLUSIONS OF LAW

1) Medicaid coverage is provided to individuals age 19 or older and under age 65 who are not otherwise eligible for and enrolled in another mandatory Medicaid coverage group and are not entitled to or enrolled in Medicare Part A or B.

2) The Appellant became eligible for and began receiving Medicare Part A and B in June 2023.

3) Due to the Appellant's receipt of Medicare assistance, he no longer meets the eligibility requirements for Adult MAGI Medicaid benefits.

4) The Respondent is required to issue advance notice of at least 13 days prior to the first day of the month in which the benefits are affected in all situations involving adverse actions.

5) Because the Respondent's February 06, 2024 notice reflected a termination date of February

01, 2024, the Respondent failed to issue advance notice of adverse action.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Respondent's decision to terminate the Appellant's Adult MAGI Medicaid eligibility. It is hereby **ORDERED** that the Appellant's Adult MAGI Medicaid benefits be reinstated retroactively to the date of termination. The matter is **REMANDED** for issuance of adequate notice of adverse action.

ENTERED this _____ day of August 2024.

_____

Angela D. Signore
State Hearing Officer