August 21, 2024

[redacted]

RE: [redacted] v. WV DoHS
ACTION NO.: 24-BOR-2471

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]

Board of Review – Kanawha County Office • 4190 Washington Street, West • Charleston, West Virginia 25313
304.352-0615 • 304.558.1992 (fax) • Angela.D.Signore@wv.gov

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 24-BOR-2471**

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 July 9, 2024.

The matter before the Hearing Officer arises from the April 02, 2024 determination by the Respondent to deny the Appellant's Adult Medicaid.

At the hearing, the Respondent appeared by Rebecca Skeens, Department of Human Services (DoHS). The Appellant was present and was represented by her father, [redacted]. All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Form DFA-SLA-2 for [redacted], dated March 20, 2024
D-2 WV DoHS Notice of Decision, dated April 02, 2024
D-3 West Virginia (WV) People's Access to Help (PATH) eligibility system printout of RSDI Information Response of Monthly Benefit Amount
D-4 WV PATH eligibility system printout of RSDI Information Response of Medicare A and B Coverage
D-5 West Virginia Income Maintenance Manual (WVIMM) §§ 10.4.2.B.1 through 10.4.2.B.2
D-6 WVIMM § 4.12 through 4.12.2.E

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 is a 55-year-old single female with one (1) dependent who began receiving Medicare Part A and B program benefits in 2017. (Exhibits D-1 through D-4)

2) The Appellant began receiving Retirement, Survivors and Disability Insurance (RSDI) benefits in the amount of $2,439.70 per month from the Social Security Administration (SSA) beginning December 2023. (Exhibits D-3 and D-4)

3) The Appellant did not contest the monthly income amount of $2,439.70 per month.

4) On March 20, 2024, the Appellant visited the [redacted] DoHS to apply for full coverage Medicaid Program benefits for an assistance group (AG) of two (2). (Exhibit D-1)

5) On March 20, 2024, at the time of application, the Appellant was given form DFA-SLA-2 - Application for Health Coverage & Help Paying Costs (Short Form) to complete. (Exhibit D-1)

6) Form DFA-SLA-2 - Application for Health Coverage & Help Paying Costs (Short Form) reads, in part: "Who can use this application? … Single adults who: Don't have any dependents and can't be claimed as a dependent on someone else's tax return." (Exhibits D-1 and D-2)

7) On or before April 02, 2024, the Respondent evaluated the Appellant for Medicare Premium Assistance using the Appellant's DFA-SLA-2. (Exhibits D-1 and D-2)

8) On April 02, 2024, the Respondent issued a notice of decision to the Appellant advising that her application for Medicare Premium Assistance was being denied due to the Appellant's income ($2,265.00) exceeding the eligibility income requirement. (Exhibit D-2)

9) In order to apply for Medicare Premium Assistance, forms DFA-QSQ-1, DFA-2, SLA-1 with the SLA-S1, SLA-2 with the SLA-S1, and/or DFA-MA-1 must be used.

10) Form DFA-SLA-2 - Application for Health Coverage & Help Paying Costs is for single individuals with no dependents who are applying for healthcare coverage only.

11) The Respondent failed to evaluate the Appellant for other types of Medicaid before issuing the notice of denial on April 02, 2024.

12) The Appellant contested the Respondent's decision and requested a Fair Hearing on June 14, 2024.

APPLICABLE POLICY

West Virginia Income Maintenance Manual (WVIMM) § 1.3.4.A.1 provides, in part:

The SLA, also known as the Application for Health Coverage and Help Paying Cost, allows individuals to apply with the Department for all health coverage programs including WVCHIP.

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The DFA-SLA-1 and DFA-SLA-2 (short form) are the shelf document (paper) versions of the single-streamlined application used to apply for health coverage only. These applications collect information needed to determine eligibility for health care coverage groups on the basis of Modified Adjusted Gross Income (MAGI).

- The DFA-SLA-1 is used for a family, or when there is more than one individual in the household.
- The DFA-SLA-2 is used by a single individual.

WVIMM § 1.6.1 provides, in part:

Applicants for all Medicaid coverage groups can use the DFA-2, WV PATH, the single streamlined application (DFA-SLA-1 or DFA-SLA-2, with supplement if required) or the Federally Facilitated Marketplace (FFM, the Marketplace) to apply.

Coverage group-specific information, including the need for supplemental application forms, is provided below in the sections about each coverage group.

WVIMM § 1.6.6 provides, in part:

When the application is not processed within agency time limits, the application must be processed immediately upon discovery of the delay and coverage must be backdated for any prior eligibility period. This may be more than three months if due to an agency error.

If the Department simply failed to act promptly on the information already received, benefits are retroactive to the date eligibility would have been established had the Department acted in a timely manner.

WVIMM § 1.16.1 provides, in part:

The DFA-QSQ-1 is the primary application to apply for QMB. SLIMB or QI-1. No DFA-R/R-1 is required when using this form.

Additional ways a client can apply for the Medicare Premium Assistance (MPA) programs, also see section 1.3:

- WV PATH is the client portal where a client can apply for all benefits. Depending on how the client applies on the site, WV PATH may not collect

asset information. Worker may need to have the client complete the DFA-SLA-S1 to collect asset information.

- The DFA-2
- The SLA-1 with the SLA-S1
- The SLA-2 with the SLA-S1
- The DFA-MA-1 can be used to apply for MPA programs when the client is also applying for Long Term Care Medicaid.

When Low Income Subsidy (LIS) files are received from the Social Security Administration (SSA), applicants who are not current Medicaid Premium Assistance clients are issued a DFA-QSQ-1 through the eligibility system.

WVIMM § 1.16.1.A provides, in part:

When the QMB, SLIMB or QI-1 client requests an application, the Worker must explain:

- The date of application for QMB, SLIMB or QI-1 coverage is the day the signed application form, which contains a name and address, is received in the DOHS office or submitted through WV PATH.
- The processing time frame is 30 days, beginning with the date of application.
- In addition to QMB, SLIMB, or QI-1, the client may qualify for other coverage groups, but additional information or contact may be required.

WVIMM § 1.16.7 provides, in part:

When the Department fails to request necessary verification, the Worker must immediately send the eligibility system verification checklist or form DFA-6 to request it. He must inform the client that the application is being held pending. When the verification is received and the client is eligible, medical coverage is retroactive to the date eligibility would have been established for QMB, SLIMB or QI-1.

When the QMB, SLIMB or QI-1 application is not processed within agency time limits, the application must be processed immediately upon discovery of the delay. QMB, SLIMB and QI-1 cases must have the eligibility period backdated.

The QMB client is eligible to receive direct reimbursement for out-of-pocket medical expenses if the Department has not acted on the application within a reasonable period of time.

WVIMM § 1.20.5 provides, in part:

The SLA, also known as the Application for Health Coverage and Help Paying Cost, allows individuals to apply with the Department for all health coverage programs including WVCHIP.

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
- 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 § 4 Appendix A provides, in part:

Income limits for the three (3) categories of Medicare Premium are:

For a one (1) person Assistance Group (AG), 100% of the FPL = $1,255

For a one (1) person Assistance Group (AG), 120% of the FPL = $1,506

For a one (1) person Assistance Group (AG), 135% of the FPL = $1,695

WVIMM § 9.3.1.A provides, in part:

The Department of Human Services (DOHS) buys in for clients in the following Medicaid categories when they are eligible for Medicare.

- Supplemental Security Income (SSI) Recipients
    - SSI recipients who are age 65 or older and who are enrolled in Medicare Part B
    - SSI recipients who are under age 65 and who have been receiving monthly Social Security Administration (SSA) Disability or Railroad Retirement Board (RRB) Benefits under Title II of the Social Security Act for 24 months
- Deemed SSI Recipients
- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary program (SLIMB)
- Qualified Individual-1 (QI-1)
- Qualified Disabled Working Individuals (QDWI)

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).

WVIMM § 25.1.3.B provides, in part:

The following benefits are available to Medicare enrollees:

- Medicare Part A – Hospitalization Insurance Benefits (HIB)

The Buy-In Unit controls the purchasing and payment of Part A premiums for all uninsured eligibles. The State is billed for the Part A premiums for all Medicare eligibles who are not eligible for premium-free Medicare Part A because they lack the necessary quarters of coverage, have enrolled voluntarily, and pay a premium.

- Medicare Part B – Supplementary Medical Insurance Benefits (SMIB)

An individual enrolled in Part B pays a monthly premium. If he is receiving RSDI or Railroad Retirement Board (RRB) Benefits, the premium is deducted from his benefit; otherwise, he must pay the premium from his income.

See Chapter 25.2 below for a list of those for whom the DOHS buys in.

- Medicare Part D – Medicare Prescription Drug Benefit

An individual who is already enrolled in Medicare Part A or Part B may receive the Medicare Prescription Drug Benefit. The Part D Prescription Drug Benefit is not administered by the SSA. The benefit is obtained by enrolling in a Prescription Drug Plan (PDP). Enrollees must pay a monthly premium, unless financially qualified for extra help, also known as the Low Income Subsidy (LIS). The LIS pays all or part of the drug benefit premium, co-pays, and deductibles that may be required. Workers must assist individuals who request it to complete an application for the LIS. The application must be submitted on an original Social Security form (SSA-1020-OCR-SM) or submitted on the internet using the SSA website.

Medicaid clients enrolled in Medicare automatically qualify for LIS and are automatically enrolled in a PDP. With a few exceptions, Medicaid will not pay for prescription drugs for individuals age 65 or over who are eligible for, and do not enroll in, a PDP. This also applies to Medicare enrolled individuals under age 65 who are identified by DOHS.

DISCUSSION

The Appellant, a recipient of disability benefits through the Social Security Administration, became eligible for and began receiving Medicare Part A in February 2017 and Medicare Part B in December 2017. On March 20, 2024, the Appellant visited the [redacted] DoHS to apply for Medicaid Program benefits for an assistance group (AG) of two (2). On April 02, 2024, the Respondent issued a notice of decision advising the Appellant that her application for Medicare Premium Assistance was being denied due to the Appellant's income exceeding the eligibility limit. The Respondent bears the burden of proof and had to demonstrate by a preponderance of evidence that the Appellant was not eligible for Medicaid Premium Assistance benefits due to income and that she was further evaluated for other Medicaid coverage groups, including SSI-Related Medicaid with a spenddown.

At the time of the hearing, the Respondent testified that an incorrect income of $2,265.00 per month was used to calculate eligibility for Medicare Premium Assistance benefits, when the Appellant's actual income is $2,439.70. However, even with the reduced amount, the Respondent

testified that the Appellant's income still exceeds the income limit to be eligible for Medicare Premium Assistance benefits. The Appellant's representative testified he accompanied the Appellant to the [redacted] DoHS office on March 20, 2024. He reported that the Appellant did not make a specific request for Medicare Premium Assistance, but that she requested an application to apply for a "Medicaid card." The Respondent's worker provided the Appellant with form DFA-SLA-2 – an application for Medicaid, but only for single adults without dependents. The Appellant's representative testified that, upon completion, the Respondent worker informed the Appellant that meeting face-to-face with a case worker was not necessary, as the application could be processed without. He argued that not only was the Appellant unknowledgeable of the various Medicaid programs, but that she was deprived of the additional support a case worker could offer, as they were advised that no one was available to meet with them. The Appellant's representative testified that the DoHS should have made the Appellant aware of all Medicaid programs that she may be potentially eligible for and specifically expressed interest in SSI-Related Medicaid with a spenddown. Additionally, he recommended the Department only staff knowledgeable individuals at the front desk in order to avoid future misinformation and delay to others.

When questioned whether the Department evaluated the Appellant's potential eligibility for other Medicaid programs, the Respondent testified that because the Appellant's March 2024 application was program specific for Medicare Premium Assistance, eligibility for other Medicaid programs was not considered. However, the Appellant was not provided with the Medicare Premium Assistance specific application (form DFA-QSQ-1), but instead, she was given form DFA-SLA-2. Pursuant to the policy, form DFA-SLA-2 is used to determine single individuals with no dependents eligibility for health care coverage on the basis of Modified Adjusted Gross Income (MAGI). The policy provides that 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. Not only is the Appellant enrolled in Medicare Parts A and B, but she also has one (1) dependent. Policy further provides that the DFA-QSQ-1 is the primary application to apply for QMB, SLIMB, or QI-1. A client can apply for Medicare Premium Assistance programs utilizing form SLA-2; however, the SLA-S1 also accompanies the application. No evidence or testimony was provided to show that the Appellant completed form SLA-S1. It is unclear how the Department managed not to screen the Appellant for other Medicaid programs, yet was capable of screening her for Medicare Premium Assistance with only the submission of application form DFA-SLA-2.

Further, per policy, it is the Respondent worker's responsibility to explain and make available all of the DoHS programs for which an applicant could qualify. The worker is obligated to evaluate potential eligibility for all programs based on the available information, unless the applicant specifically states he/she is not interested in being considered. Additionally, the Respondent worker has the duty to address all questions and concerns a client may have, as well as explaining the benefits of each program and informing the client of his/her right to apply for any or all of them. No person is denied the right to apply for any program administered by the Division of Family Assistance (DFA) or the Bureau for Medical Services (BMS). In addition, a person must be afforded the opportunity to apply for all programs on the date he/she expresses interest. When it is not feasible for the applicant to be interviewed on the date he/she expresses interest, they must be allowed to complete the process at a later date by scheduling an appointment or returning at their convenience. When the Appellant was provided with the incorrect application, she was denied her right to apply. Additionally, the Respondent worker failed to address the Appellant's questions

and concerns, and further deprived her of the right to understanding each program and how they may or may not be beneficial to her AG. The Respondent worker also failed to evaluate the Appellant for all other Medicaid coverage groups, which includes SSI-Related Medicaid with a Spenddown.

Because the Respondent failed to evaluate the Appellant for all Medicaid coverage groups at the time of application, an agency delay occurred. Policy provides that when the client is determined eligible, medical coverage is retroactive to the date eligibility would have been established. Policy further clarifies that when eligible, coverage may be back-dated up to three months prior to the month of application - in the Appellant's case, an application date of March 20, 2024, with backdated coverage to December 01, 2023 - if beneficial to the Appellant. As the Appellant was not properly evaluated for all Medicaid programs for which she may qualify, the Respondent's decision to deny Medicaid Premium Assistance benefits cannot be affirmed.

CONCLUSIONS OF LAW

1) As a recipient of Medicare Part A and B, the Appellant does not meet the eligibility requirements for Adult MAGI Medicaid benefits.

2) At the time of application, the Respondent worker erred when providing form DFA-SLA-2 for the Appellant to complete.

3) The Respondent worker further erred when evaluating the Appellant for Medicare Premium Assistance based on the information contained in the DFA-SLA-2 submitted March 20, 2024.

4) The Respondent worker erred in determining the Appellant's eligibility based on her $2,265.00 per month income.

5) The Respondent worker failed to evaluate the Appellant for all Medicaid programs for which she may qualify.

6) Because the Respondent worker failed to evaluate the Appellant for all Medicaid programs for which she may qualify, the Appellant was not evaluated for SSI-Related Medicaid with a spenddown at the time of application.

7) Because the Appellant was provided the wrong form at the time of application, the Respondent's decision to deny Medicaid Premium Assistance benefits cannot be affirmed.

8) The Respondent must evaluate the Appellant for all Medicaid programs for which she may qualify, specifically SSI-Related Medicaid with a spenddown, as an AG of two (2).

9) Because an agency delay occurred, if the Appellant is determined eligible, medical coverage will be retroactive to the date eligibility would have been established – March 20, 2024.

10) Policy provides that when eligible, coverage may be back-dated up to three months prior to the month of application.

11) Because the policy allows coverage to be back-dated up to three months prior to the date of application, the Respondent must back-date the Appellant's potential eligibility to December 2023.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Respondent's decision to deny the Appellant's Medicaid Premium Assistance eligibility. It is hereby **ORDERED** that the matter is **REMANDED** to the Respondent for further assessment of the Appellant's eligibility for all Medicaid coverage groups. If found eligible, it is further **ORDERED** that the Respondent must back-date the Appellant's eligibility to December 2023, if advantageous to the Appellant to do so. Subsequent notices of Medicaid eligibility determination should include the Appellant's right to fair hearing.

ENTERED this _____ day of August 2024.

_____

Angela D. Signore
State Hearing Officer