March 6, 2025

REMOVED

RE: REMOVED
ACTION NO.: 25-BOR-1157

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 Health. 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,

Todd Thornton
State Hearing Officer
Member, State Board of Review

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

cc: Board of Review

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

In Re: REMOVED, APPELLANT **ACTION # 25-BOR-1157**

DECISION OF STATE HEARING OFFICER

INTRODUCTION

This is the decision of the State Hearing Officer resulting from a fair hearing for REMOVED. This hearing was held in accordance with the provisions found in 45 CFR Part 155, Subpart F as a result of the Federally Facilitated Marketplace (FFM) having denied Medicaid coverage to the Appellant and the Appellant's having chosen to appeal that denial and have the appeal heard by the appeals entity for the State of West Virginia. That entity is the Board of Review within the West Virginia Department of Health. The Appellant submitted his appeal request to the FFM on or about January 23, 2025.

The question of whether the FFM was correct in determining that the Appellant was ineligible for Medicaid at the time of the application is determined de novo in this proceeding.

On January 23, 2025, the federal appeals entity electronically transmitted to the Board of Review the Appellant's appeal file.

The hearing was held by telephone. The Appellant appeared *pro se*. The Marketplace was not represented. The Appellant was sworn in. No documents were submitted as 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 completed an application for health care assistance through the Federally Facilitated Marketplace (FFM) and was notified that he was denied because he was recently denied for Medicaid.

2) The Appellant's application was submitted online.

3) The Appellant testified the FFM denial was based on his reporting that he was recently denied for Medicaid.

4) The Appellant speculated that the basis for the incorrect information on his application was because he clicked on an incorrect button during the online application process.

5) The Appellant based his speculation on his experience with similar Medicaid applications in the past.

6) The Appellant could not clearly answer how long he had received Medicaid benefits.

7) The Appellant could not clearly answer his tax filing status.

8) The Appellant could not clearly report when he was receiving Medicaid on his own case and when he was receiving Medicaid on his mother's case.

APPLICABLE POLICY

West Virginia Income Maintenance Manual Chapter 23.10.4 states, in pertinent part**:**

> As a result of the Affordable Care Act (ACA), the Adult Group was created, effective January 1, 2014. Eligibility for this group is determined using MAGI methodologies established in Section 4.7. Medicaid coverage in the Adult Group is provided to individuals who are aged 19 or older and under age 65.
>
> To be eligible for the Adult Group, income must be equal to or below 133% of the Federal Poverty Level (FPL).

West Virginia Income Maintenance Manual Chapter 3.7.3 states, in pertinent part:

> The needs group is the number of individuals included in the Modified Adjusted Gross Income (MAGI) household size based upon the MAGI rules for counting household members.
>
> To determine the MAGI household size, the following step-by-step methodology is used for each applicant. For purposes of applying the MAGI methodology:
> • Child means natural, adopted, or stepchild;
> • Parent means natural, adopted, or stepparent;
> • Sibling means natural, adopted, half, or stepsibling.
>
> In the case of married couples who reside together, each spouse must be included in the MAGI household of the other spouse, regardless of whether they expect to file a joint tax return or whether one spouse expects to be claimed as a tax dependent by the other spouse. The MAGI household of the pregnant woman also includes her unborn child(ren).
>
> This methodology must be applied to each applicant in the MAGI household separately:
>
> STEP 1: IS THE APPLICANT A TAX FILER (and will NOT be claimed as a tax dependent)?
> IF NO: Move to STEP 2.

IF YES: The applicant's MAGI household includes themselves, each individual he expects to claim as a tax dependent, and his spouse if residing with the tax filer.

This is known as the tax filer rule.

STEP 2: IS THE APPLICANT CLAIMED AS A TAX DEPENDENT ON SOMEONE ELSE'S TAXES?
IF NO: Move to STEP 3.
IF YES: Test against the three exceptions below. If the answer to any of these exceptions is 'yes', then the applicant's MAGI household size must be calculated using STEP 3.
1. The applicant is claimed as a dependent by someone other than a spouse or parent.
2. The applicant is a child under 19 who lives with both parents, but both parents do not expect to file taxes jointly.
3. The applicant is a child under 19 who is claimed as a tax dependent to a non-custodial parent(s).

If none of these exceptions are true, then the applicant's Medicaid household consists of the applicant, the tax filer claiming him as a dependent, this could be two people filing jointly, any other dependents in the tax filer's household, and the applicant's spouse if they reside together. This is known as the tax dependent rule.

STEP 3: IF THE APPLICANT IS NOT A TAX FILER, IS NOT CLAIMED AS A TAX DEPENDENT OR MEETS ONE OF THE EXCEPTIONS IN STEP 2:
The Medicaid household consists of the applicant and the following individuals as long as they reside with the applicant:
• The applicant's spouse;
• The applicant's child(ren) under age 19;
• For applicants under 19, their parents, and their siblings who are also under 19.

This is known as the non-filer rule.

West Virginia Income Maintenance Manual Chapter 4.7.1 states that the income of each member of the individual's MAGI household is counted. The MAGI household is determined using the MAGI methodology established in Chapter 3.

EXCEPTION: Income of children, or other tax dependents, who are not expected to be required to file an income tax return is excluded from the MAGI household income. NOTE: A reasonable determination as to whether an individual will be required to file a tax return can be made based on the individual's current income for the applicable budget period. Such a determination would be based on information available at the time of application or renewal. Information regarding "Who Must File" a tax return can be found in Appendix F.

West Virginia Income Maintenance Manual Chapter 4.7.3 states that the only allowable income disregard is an amount equivalent to five percentage points of 100% of the Federal Poverty Level (FPL) for the applicable MAGI household size. The 5% FPL disregard is not applied to every MAGI eligibility determination and should not be used to determine the MAGI coverage group for which an individual may be eligible. The 5% FPL disregard will be applied to the highest MAGI income limit for which an individual may be determined eligible.

West Virginia Income Maintenance Manual Chapter 4.7.4 states that the applicant's household income must be at or below the applicable MAGI standard for the MAGI coverage groups.

> Step 1: Determine the MAGI-based gross monthly income for each MAGI household income group (IG).
> Step 2: Convert the MAGI household's gross monthly income to a percentage of the FPL by dividing the current monthly income by 100% of the FPL for the household size. Convert the result to a percentage. If the result from Step 2 is equal to or less than the appropriate income limit, no disregard is necessary, and no further steps are required.
> Step 3: If the result from Step 2 is greater than the appropriate limit, apply the 5% FPL disregard by subtracting five percentage points from the converted monthly gross income to determine the household income.
> Step 4: After the 5% FPL income disregard has been applied, the remaining percent of FPL is the final figure that will be compared against the applicable modified adjusted gross income standard for the MAGI coverage groups.

West Virginia Income Maintenance Manual Chapter 4, Appendix A, states that the income limit for a one-person MAGI Medicaid needs group is $1,670 (133% of the Federal Poverty Level).

DISCUSSION

The Appellant requested a hearing to appeal a Medicaid denial by the Federally Facilitated Marketplace (FFM). The Appellant must show by preponderance of the evidence that the FFM determination is in error.

The Appellant did not provide new documents for the hearing. The Appellant did not have the FFM file with him at the time of the hearing, and these documents were not entered into evidence. This hearing officer reduced the weight given to the Appellant's testimony regarding an application made several months earlier without the FFM file or other documents to support or prompt recollection of exact details.

The Appellant claimed the basis for the FFM denial is due to *his own* reporting that he was recently denied for Medicaid. The Appellant testified that he did not intend to do so. The Appellant testified that during the online application or review process there was a 'button' on the screen and the Appellant believed he clicked this button in error. The Appellant based this speculation on his past experience with online Medicaid applications but could not clearly establish how long he had

received Medicaid benefits on his own. The Appellant could not clearly establish his tax filing status or when it may have changed.

Without documentation, the Appellant's testimony cannot be confirmed. The Appellant's speculation about the reason for his denial cannot be confirmed. If the Appellant reported to the FFM that he was recently denied for Medicaid the FFM correctly denied his application on that basis. Without clear information on all eligibility factors, including tax filing status, Medicaid eligibility cannot be established. Household composition and income eligibility cannot be determined without this information.

Based on the limited information available, the FFM decision is affirmed. The Appellant testified regarding his need for Medicaid to help with multiple prescription medications he requires. The Board of Review cannot create policy or make policy exceptions. The evidence provided by the Appellant is insufficient to refute the FFM denial or determine FFM eligibility anew. The FFM denial is affirmed.

CONCLUSIONS OF LAW

1) Because the Appellant did not clearly establish that he erroneously reported his recent Medicaid eligibility status, Medicaid eligibility cannot be approved from what would be a false application.

2) Because the Appellant provided insufficient information, including tax filing status, for a *de novo* Medicaid determination, the Medicaid denial is affirmed.

DECISION

It is the determination of the State Hearing Officer that the Appellant is ineligible for Medicaid benefits through the FFM.

ENTERED this _____ day of March 2025.

_____

Todd Thornton
State Hearing Officer