

**WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW**

In Re: [REDACTED] **Appellant**

Action No. 26-BOR-2428

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 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 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 her Appeal request to the FFM on or about July 27, 2026.

The question of whether the FFM was correct in determining that the Appellant was not eligible for Medicaid at the time of the application is determined *de novo* in this proceeding.

On July 31, 2026, the federal appeals entity electronically transmitted to the Board of Review the Appellant's appeal file.

The hearing was held by telephone on August 19, 2026. The Appellant was self-represented. Appearing as a witness for the Appellant was her son, [REDACTED]. The Marketplace was not represented. The participants were placed under oath.

The Appellant submitted the following documents as evidence in the hearing.

- A-1 2025 Form W-2 - [REDACTED] West Virginia
- A-2 2025 Form W-2 - [REDACTED] Osteopathic Medicine
- A-3 Social Security Administration Award Letter dated May 19, 2026

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 applied for assistance with health care through the Federally Facilitated Marketplace (FFM) on July 27, 2026.

- 2) The Appellant reported \$1,000 a month in earned income from the [REDACTED] Osteopathic [REDACTED] Medicine on the FFM application.
- 3) The Appellant indicated on the FFM application that she had recently been found ineligible for Medicaid.
- 4) The FFM found the Appellant ineligible for Medicaid and she was found eligible for a premium tax credit.
- 5) The Appellant files taxes jointly with her spouse, however, she does not reside with her spouse. The Appellant and her spouse do not claim any dependents on their federal tax return.
- 6) The Appellant falls into the Modified Adjusted Gross Income (MAGI) Adult coverage group.
- 7) The income limit for a one-person assistance group for MAGI Adult Medicaid is \$1,769 or 133% of the Federal Poverty Level (FPL).

APPLICABLE POLICY

West Virginia Income Maintenance Manual Chapter 1 explains the Medicaid application process:

1.2.6.D Federally Facilitated Marketplace

Individuals may apply online at the Federally Facilitated Marketplace for insurance affordability programs and MAGI Medicaid coverage groups, including Parents/Caretaker Relatives, Adult, Pregnant Women, Children Under Age 19, and WVCHIP. When the individual's income is at or below the income limits for Medicaid, the Marketplace will determine the applicant's eligibility for Medicaid or WVCHIP and forward the data file to the eligibility system. The eligibility system will determine the specific Medicaid or WVCHIP coverage group through which Medicaid will be issued without delay.

1.6.11.A.1 Applications Taken by the Marketplace

West Virginia entered into an agreement with the FFM whereby the Department will accept as final the Medicaid and WVCHIP eligibility determinations made by the Marketplace based on MAGI. The Marketplace determines eligibility for MAGI Medicaid groups and WVCHIP only, in real time without delay when possible. Non-financial and financial information about the applicant is matched with the Federal Data Hub (FDH). When completing the eligibility determination for an applicant that submits a single-streamlined application (SLA) to the Marketplace, the Marketplace must:

- Accept the SLA;
- Check for existing Medicaid or WVCHIP coverage;

- Verify citizenship/immigration status, residency, incarceration status, current monthly income and annual income;
- Apply the reasonable compatibility standard and reconcile any differences;
- Apply West Virginia's state eligibility rules;
- Complete the eligibility determination;
- Provide appropriate notices, fair hearing rights, and communications to the client;
- Transfer the eligible client's electronic account to the Department, without delay;
- Transfer applications to the Department for applicants requesting a full determination of Medicaid on a basis other than MAGI; and,
- Transfer to the Department for a full eligibility determination, without delay, the electronic account of a client that indicates on their application potential eligibility for a non-MAGI coverage group.
- If the individual is over income for MAGI Medicaid or WVCHIP, evaluate him for the insurance affordability programs, Advance Premium Tax Credits and Cost Sharing Reductions (APTC/CSR).

Marketplace Determines Eligibility for a MAGI Coverage Group

When the Marketplace determines the applicant is eligible for a MAGI coverage group, the DOHS must:

- Accept electronic accounts transferred from the Marketplace for clients determined Medicaid or WVCHIP eligible based on MAGI.
- Promptly complete enrollment into the correct Medicaid or WVCHIP coverage group.
- Not request any additional information or verifications from the client.
- Provide additional notification of enrollment to the client, including benefits available.

Marketplace Determines Potential Eligibility for a MAGI Coverage Group

When the Marketplace determines the applicant is potentially eligible for a MAGI coverage group, the DOHS must:

- Accept the electronic account for the client who is assessed by the Marketplace as potentially eligible for a MAGI group
- Notify the Marketplace of receipt of the electronic account
- Not request additional information of verifications from the client already verified electronically
- Conduct any additional verifications that may be required
- Promptly determine eligibility without requiring another application; ensure timeliness standards in this chapter are met
- Notify the client and the Marketplace of the final eligibility determination

West Virginia Income Maintenance Manual Chapter 3 explains eligibility determination groups:

3.7 Adult Group

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. Eligibility for this group is determined using Modified Adjusted Gross Income (MAGI) methodologies established in Section 4.7.

3.7.2 The MAGI Household Income Group

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

3.7.3 The MAGI Needs Group

The needs group is the number of individuals included in the 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.

STEP 4: CASES WHERE APPLICANT CANNOT REASONABLY ESTABLISH TAX DEPENDENT STATUS If an applicant/tax filer cannot reasonably establish that reported household members will be tax dependents of the applicant for the tax year in which Medicaid is sought, the inclusion of such individual in the MAGI household of the tax filer is determined using rules in **STEP 3**.

West Virginia Income Maintenance Manual Chapter 4 Appendix A lists income limits for Medicaid:

133% FPL for a one-person assistance group is \$1,769

133% FPL for a two-person assistance group is \$2,399

DISCUSSION

West Virginia entered into an agreement with the FFM whereby the DoHS will accept as final the Medicaid and WVCHIP eligibility determinations made by the Marketplace based on MAGI. The FFM determines eligibility for MAGI Medicaid groups and WVCHIP only, in real time without delay when possible. Non-financial and financial information about the applicant is matched with the Federal Data Hub (FDH). If the FFM determines an applicant may be potentially eligible for MAGI Medicaid, the application is transmitted to the DoHS for evaluation.

The Appellant applied for health coverage through the FFM on July 27, 2026, and was determined eligible for a premium tax credit. The Appellant was not evaluated for Medicaid eligibility by the FFM as she indicated on the application that she had recently been determined ineligible for Medicaid. The Appellant filed an appeal through the FFM on July 27, 2026.

The Appellant reported earned income from the [REDACTED] West Virginia and from the [REDACTED] Osteopathic [REDACTED] Medicine. W-2 tax statements from 2025 were submitted as evidence to verify the Appellant's earned income: [REDACTED] Osteopathic [REDACTED] Medicine - \$6,258.75 and the [REDACTED] West Virginia - \$2,107.63 (Exhibits A-1 and A-2). The Appellant testified that she

also works for [REDACTED] earning \$960 monthly, but she will separate from this employment at the end of August.

The Appellant had been receiving Medicaid until she reported the onset of Social Security Retirement of \$779 monthly (Exhibit A-3). The Appellant contended that she received the Social Security Award Letter in May 2026 and reported the income to the DoHS. However, the Appellant will not receive her first Social Security check until September 2026 and the DoHS added the new income to her case when it was reported. The Appellant surmised that the Social Security income, although not yet received, coupled with her earned income exceeded the income limits for Medicaid.

The Appellant stated she is married but she does not reside with her spouse. The Appellant files taxes jointly with her spouse, claiming no dependents. The FFM application listed a MAGI household income of \$60,178.80. When questioned about this amount, the Appellant's son, [REDACTED] testified that amount was his parents' federal adjusted gross income as listed from their 2025 federal income tax return.

Pursuant to policy, eligibility for MAGI Medicaid groups is determined by using an individual's modified adjusted gross income. The Appellant's modified adjusted gross income exceeded \$60,000 in 2025 as she files federal income taxes jointly with her spouse. Although the Appellant does not reside with her spouse, her spouse's income must be included in determining her eligibility for MAGI Adult Medicaid.

Whereas verification of the Appellant's income with [REDACTED] and verification of her spouse's income was not provided, a determination of the Appellant's eligibility for MAGI Adult Medicaid benefits cannot be established.

This decision does not preclude the Appellant's right to appeal the July 2026 Medicaid termination through the DoHS or to reapply for benefits.

CONCLUSIONS OF LAW

- 1) Eligibility for MAGI Adult Medicaid is determined by an individual's modified adjusted gross income.
- 2) The Appellant files federal income taxes jointly with her estranged spouse.
- 3) The Appellant's modified adjusted gross income for 2025 was over \$60,000.
- 4) The Appellant did not provide verification of her earnings with [REDACTED] or verification of her spouse's income.
- 5) The Appellant indicated on her FFM application that she had recently been found ineligible for Medicaid; therefore, FFM did not evaluate her for Medicaid eligibility.

- 6) Eligibility for MAGI Adult Medicaid cannot definitively be made without verification of all income sources for all members of the Appellant's MAGI income group.
- 7) The Appellant may appeal the July 2026 termination of Medicaid by the DoHS by contacting the Board of Review or the DoHS.

DECISION

It is the determination of the State Hearing Officer that the Appellant is eligible for a premium tax credit. The documentation submitted failed to establish the Appellant's eligibility for MAGI Adult Medicaid.

ENTERED this 25th day of August 2026.

Kristi Logan
Certified State Hearing Officer