July 23, 2024

[redacted]

RE: [redacted] v. WV DOHS
ACTION NO.: 24-BOR-2463

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,

Lori Woodward, J.D.
Certified State Hearing Officer
Member, State Board of Review

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

cc: Ann Hubbard, WVDOHS/BFA

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 24-BOR-2463**

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 16, 2024.

The matter before the Hearing Officer arises from the June 4, 2024 decision by the Respondent to deny the Appellant's Medicaid benefit application.

At the hearing, the Respondent appeared by Ann Hubbard, Economic Services Supervisor. The Appellant appeared *pro se*. The witnesses were placed under oath and the following documents were admitted into evidence.

Department's Exhibits:
- D-1 Hearing Summary
- D-2 Verification checklist (DFA-6), dated May 21, 2024
- D-3 Notice of denial, dated June 4, 2024
- D-4 WV Income Maintenance Manual (WV IMM), Chapter 7, §7.2.3 (excerpt)

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 Respondent received the Appellant's Federally Facilitated Marketplace (FFM) application for Medicaid benefits on April 26, 2024. (Exhibit D-1)

2) On May 13, 2024, the Respondent processed the Appellant's Medicaid application and was alerted to an unspecified discrepancy between the Appellant's reported income and information from the Federal Data Hub (FDH) and/or the Income and Eligibility Verification System (IEVS).

3) Because of the discrepancy in the reported income, on May 21, 2024, the Respondent requested that the Appellant verify: any employment income from April 21, 2024 to May 20, 2024; income from self-employment, if any; or if no longer employed, to provide a written statement regarding when her most recent employment ended. (Exhibit D-2)

4) The requested verifications were required to be submitted by May 31, 2024. (Exhibit D-2)

5) The Appellant failed to submit the requested verifications by the due date.

6) On June 4, 2024, the Respondent sent notification of the denial of the Appellant's Medicaid benefit application based upon not returning the requested information. (Exhibit D-3)

APPLICABLE POLICY

Code of Federal Regulations, 42 CFR 435.907(a):

(a) ***Basis and implementation.*** In accordance with section 1413(b)(1)(A) of the Affordable Care Act, the agency must accept an application from the applicant, an adult who is in the applicant's household, as defined in § 435.603(f), or family, as defined in section 36B(d)(1) of the Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant, and any documentation required to establish eligibility—

(1) Via the internet Web site described in § 435.1200(f) of this part;

(2) By telephone;

(3) Via mail;

(4) In person; and

(5) Through other commonly available electronic means.

(b) The application must be—

(1) The single, streamlined application for all insurance affordability programs developed by the Secretary; or

(2) An alternative single, streamlined application for all insurance affordability programs, which may be no more burdensome on the applicant than the application described in paragraph (b)(1) of this section, approved by the Secretary.

(c) For individuals applying, or who may be eligible, for assistance on a basis other than the applicable MAGI standard in accordance with § 435.911(c)(2) of this part, the agency may use either—
(1) An application described in paragraph (b) of this section and supplemental forms to collect additional information needed to determine eligibility on such other basis; or
(2) An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard. Such application must minimize burden on applicants.
(3) Any MAGI-exempt applications and supplemental forms in use by the agency must be submitted to the Secretary.
(4) Any MAGI-exempt applications and supplemental forms must be accepted through all modalities described at paragraph (a) of this section.
(d) ***Requesting information from applicants.***
(1) If the agency needs to request additional information from the applicant to determine and verify eligibility in accordance with § 435.911, the agency must—
(i) Provide applicants with a reasonable period of time of no less than 15 calendar days, measured from the date the agency sends the request, to respond and provide any necessary information;
(ii) Allow applicants to provide requested information through any of the modes of submission specified in paragraph (a) of this section; and
(iii) If the applicant subsequently submits the additional information within 90 calendar days after the date of denial, or a longer period elected by the agency, treat the additional information as a new application and reconsider eligibility in accordance with the application time standards at § 435.912(c)(3) without requiring a new application; and
(2) The agency may not require an in-person interview as part of the application process.

WV IMM, Chapter 1, §1.2.6.D, Federally Facilitated Marketplace:
Individuals may apply online at the Federally Facilitated Marketplace (FFM, the 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.
The Marketplace's responsibility of determining eligibility for Medicaid is limited to Medicaid coverage implemented through the Affordable Care Act (ACA) in West Virginia effective October 1, 2013 and includes MAGI groups only. The Marketplace is not responsible to assess or determine eligibility for other Medicaid or other Department programs, benefits, or services. When the Worker identifies the individual's potential eligibility, the Worker notifies the individual of the application process for any other programs or services.

WV IMM, Chapter 1, §1.6.11.A, Coordination between DOHS and the Federally Facilitated Marketplace:
The Affordable Care Act (ACA) established standards and guidelines for ensuring a coordinated and timely process for performing eligibility determinations, for facilitating enrollment into coverage and for transferring the applicant's information between the Department and the Federally Facilitated Marketplace (FFM or Marketplace).

The Department must enter into an agreement with the Marketplace which outlines the responsibilities of each agency to ensure prompt determination of eligibility and enrollment in the appropriate insurance affordability program based on the date the single-streamlined application (SLA) is submitted to either the Department or the Marketplace.
The Act also requires that no matter where the applicant submits the SLA, the Department or the Marketplace, they will receive an eligibility determination for any insurance affordability program and be able to enroll in the appropriate coverage, if eligible, without delay.
Regardless of where the applicant submits their SLA, eligibility can be determined for insurance affordability programs including MAGI coverage groups based on the information collected on the application without requiring additional action by the applicant.
NOTE: The SLA does not provide sufficient information for the Department to determine eligibility for non-MAGI coverage groups. If the client indicates potential eligibility for a non-MAGI coverage group, the Department must provide the client with the DFA-SLA-S1 to obtain the additional information needed to determine eligibility. See Section 23.8.2 for information regarding determining eligibility between MAGI and non-MAGI coverage groups.

WV IMM, Chapter 6, §6.1 INTRODUCTION:
There are two main electronic sources that provide verifications to the Department of Human Services (DOHS). These are the Federal Data Hub (FDH) and the Income and Eligibility Verification System (IEVS). The IEVS is a computerized information system that performs data matches against several agency databases to verify certain types of income and/or assets. The information provided by these two main sources overlaps in some areas. The Worker accesses all information through the eligibility system.
In general, the two sources are used in the following ways:

- When the Worker evaluates for Medicaid eligibility, he tests for Modified Adjusted Gross Income (MAGI) coverage groups first. That requires a check of results primarily from the Hub.
- If the test fails for a MAGI coverage group, the Worker evaluates for Non-MAGI coverage groups, which uses data exchange information from IEVS.
- Data exchange information available at both application and review may also be used by the Worker to evaluate discrepancies in the client's statement when it disagrees with Hub data.
- For determination of eligibility for benefits other than MAGI Medicaid, Hub data may be used only if it was obtained when trying to determine MAGI Medicaid eligibility. Otherwise, it is not used. It is never used to determine Supplemental Nutrition Assistance Program (SNAP) benefits.

WV IMM, Chapter 6, §6.1.1, FEDERAL DATA HUB (FDH), in part:
The FDH is the primary source the Worker uses to verify reported information for MAGI Medicaid and the West Virginia Children's Health Insurance Program (WVCHIP). When no information is returned from the Hub or when discrepancies exist that are not reasonably compatible, the Worker must utilize all sources available before requesting verification from the client. See Section 7.2.

WV IMM, Chapter 6, §6.3, FEDERAL DATA EXCHANGES, in part:
For individuals applying for MAGI Medicaid and WVCHIP, the primary data source used by the Worker is the Hub. When the Hub returns no information or when discrepancies exist between an

individual's self-attestation and Hub information, the Worker seeks verification from other electronic sources including those listed below. The reasonable compatibility provision applies to financial information. See Section 7.2.5.

WV IMM, Chapter 7, §7.2.1, WHEN VERIFICATION IS REQUIRED:
Verification of a client's statement is required when:

- Policy requires routine verification of specific information.
- The information provided is questionable. To be questionable, it must be:
  - Inconsistent with other information provided; or
  - Inconsistent with the information in the case file; or
  - Inconsistent with information received by the Department of Human Services (DOHS) from other sources; or
  - Incomplete; or
  - Obviously inaccurate; or
  - Outdated.
- Past experience with the client reveals a pattern of providing incorrect information or withholding information. A case recording must substantiate the reason the Worker questions the client's statement.
- The client does not know the required information.

WV IMM, Chapter 9, §9.2.1, DFA-6, NOTICE OF INFORMATION NEEDED: The DFA-6 may be used during any phase of the eligibility determination process. At the time of application, it is given or mailed to the applicant to notify him of information or verification he must supply to establish eligibility. When the DFA-6 is mailed at the time of application, the client must receive the DFA-6 within five working days of the date of application. If the client fails to adhere to the requirements detailed on the DFA-6, the application is denied or the deduction disallowed, as appropriate. The client must be notified of the subsequent denial by form DFA-NL-A. This form also notifies the client that his application will be denied, or a deduction disallowed, if he fails to provide the requested information by the date specified on the form. The Worker determines the date to enter to complete the sentence, "If this information is not made available to this office by ..." as follows.

WV IMM, Chapter 9, §9.2.1.C, Medicaid and WVCHIP: The date entered in the DFA-6 must be at least 10 days from the date of issuance or a time agreed upon with the applicant. See Due Date of Additional Information in Section 1.6.4.

WV IMM, Chapter 7, §7.2.3, CLIENT RESPONSIBILITIES, in part:
The primary responsibility for providing verification rests with the client.
It is an eligibility requirement that the client cooperate in obtaining necessary verifications, with an exception being that a client must never be asked to provide verification that he is or is not either a fleeing felon or a probation/parole violator. The client is expected to provide information to which he has access and to sign authorizations needed to obtain other information.
Failure of the client to provide necessary information or to sign authorizations for release of information results in denial of the application or closure of the active case, provided the client has access to such information and is physically and mentally able to provide it.
<u>For Medicaid Coverage Groups and WVCHIP Only</u>:

- Client self-attestation is verified by electronic data sources.
- The client must not be required to provide verification unless information cannot be obtained electronically or self-attestation, and electronic data sources are not reasonably compatible. See Section 7.2.5 below.

Refusal to cooperate, failure to provide necessary information, or failure to sign authorizations for release of information, provided the client has access to such information and is physically and mentally able to provide it, may result in one of the following:

- Denial of the application
- Closure of the assistance group (AG)
- Determination of ineligibility
- Disallowance of an income deduction or an incentive payment.

No case may be determined ineligible when a person outside the AG or income group (IG) fails to cooperate with verification. The following individuals are not considered part of the AG or IG but must provide verification:

WV IMM, Chapter 7, §7.2.5, REASONABLE COMPATIBILITY – MEDICAID COVERAGE GROUPS AND WVCHIP ONLY, in part:

§7.2.5.A, Definitions: These definitions and provisions apply to all Medicaid and WVCHIP coverage groups.

REASONABLE COMPATIBILITY Reasonable compatibility means that information provided by an applicant through self-attestation does not vary significantly, or in a way that is meaningful for eligibility when compared to information obtained through electronic data sources. Under reasonable compatibility, the Worker can require verification documentation only when the difference between the attestation and data source affects eligibility.

REASONABLE EXPLANATION The applicant must be given an opportunity to provide an explanation for discrepancies between self-attested information, and information reported by an electronic data source. The Worker must determine if the client's explanation is reasonable.

REASONABLE COMPATIBILITY STANDARD FOR INCOME ONLY The Reasonable Compatibility Standard is an acceptable level of variance between self-attested income and income information obtained through electronic data sources. When the difference between the self-attestation and data source incomes affects eligibility, the reasonable compatibility test is applied by the eligibility system. Refer to 7.2.5.D

WV IMM, Chapter 7, §7.2.5.B, Reasonable Compatibility Policy: Eligibility determinations for Medicaid and WVCHIP will be based, to the maximum extent possible, on applicant self-attestation verified by information obtained from electronic data sources.

- When income and asset information obtained through electronic data sources is reasonably compatible with an applicant's attestation, the self-attested information is considered verified.
    - Self-attestation information and information from data sources are reasonably compatible when any difference or discrepancy between the two sources does not impact the eligibility of the application.
- If income and asset information obtained through electronic data sources is not reasonably compatible with an applicant's attestation, additional documentation may be required.

- Under reasonable compatibility, the Worker can require verification documentation only when the difference between the self-attestation and data source income and asset information affects eligibility.
- The applicant must be given an opportunity to provide an explanation for discrepancies between self-attested information and income and asset information reported by an electronic data source. The Worker must determine if the client's explanation is reasonable.

DISCUSSION

The Appellant applied for Medicaid through the Federally Facilitated Marketplace (FFM). On April 26, 2024, the FFM forwarded the Appellant's Medicaid application to the Respondent. On May 13, 2024, the Respondent processed the Appellant's Medicaid application. Because the Respondent's data base resources indicated that there was a discrepancy with the Appellant's self-reported income, a verification request was sent to the Appellant on May 21, 2024, requesting: any employment income from April 21, 2024 to May 20, 2024; or income from self-employment, if any; or, if no longer employed, to provide a written statement regarding when her most recent employment ended. This information was due by May 31, 2024. On June 4, 2024, the Respondent sent notification of the denial of the Appellant's application due to the Appellant's failure to provide the requested information.

Policy requires that when a forwarded Medicaid application from FFM contains a discrepancy in the self-attested income and information obtained through electronic data resources which is not reasonably compatible, additional documentation may be required. The Respondent's representative, Ann Hubbard, testified that because the agency received an alert that there was an unspecified discrepancy between the Appellant's reported income and the electronic data sources, additional information was necessary before the Appellant's Medicaid application could be processed. Therefore, a request for information of additional income, if any, was needed to complete the Appellant's application. Policy requires that an applicant be given at least 10 days to respond to the request for additional information. The May 21, 2024, verification request was due by May 31, 2024. No response was made by the Appellant to the request for information.

The Appellant testified that there was not enough time for her to respond to the Respondent's request for information. The Appellant stated she was confused about the information request and attempted to phone the local office but failed to reach a worker. Additionally, the Appellant stated she did send in a letter but did not specify when or whether she was referring to the June 12, 2024, request for a fair hearing in which she made some statements. Ms. Hubbard testified that no other correspondence was received from the Appellant. Ms. Hubbard also stated that she did attempt to return the Appellant's phone messages but was unable to reach her.

Because the Appellant failed to submit the requested verification regarding her income by the established due date of May 31, 2024, the Respondent correctly denied the Appellant's Medicaid benefits.

CONCLUSIONS OF LAW

1) Policy requires verification of income at all applications and redeterminations.

2) Because the Appellant failed to return the requested verification, the Respondent correctly denied the Appellant's Medicaid benefits.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's June 4, 2024, denial of the Appellant's Medicaid application.

ENTERED this 23rd day of July 2024.

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Lori Woodward**,** Certified State Hearing Officer