November 12, 2024

[redacted]

RE: [redacted]
ACTION NO.: 24-BOR-3322

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: [redacted], APPELLANT **ACTION # 24-BOR-3322**

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'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 her appeal request to the FFM on or about October 1, 2024.

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 September 9, 2024, 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.

The Appellant submitted the following documents as evidence.

Appellant's Exhibits:

A-1 FFM Appeal File

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 by letter dated August 26, 2024, that she was ineligible for Medicaid because her income was excessive.

2) The Appellant testified that she may have underreported her income – reporting her net income instead of gross income – when she completed the FFM application.

3) The Appellant did not otherwise dispute any facts reported on her FFM application.

4) The FFM appeal file (Exhibit A-1) indicated a denial reason code corresponding to an income attestation (by the Appellant) of income below the Medicaid standard, but external income data above the Medicaid standard.

5) The Appellant has two employers – [redacted]

6) The Appellant provided income verification with her appeal file (Exhibit A-1) for one of her two employers.

7) The Appellant did not know the gross amount of income from her employers.

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

To qualify for MAGI Adult Medicaid, household income cannot exceed 133% of the Federal Poverty Level for the needs group size. The income limit for a one-person MAGI Medicaid needs group is $1,670 per month. The Appellant must show by preponderance of the evidence that the FFM determination is in error.

The Appellant testified that she applied for FFM health coverage and did not dispute the facts provided on her application with the exception of possible underreporting her net income amounts instead of the gross income amounts. The Appellant did not provide sufficient income information to refute the FFM determination of excessive income. The FFM Appeal file noted a denial with a reason code corresponding to a denial reason that although the Appellant reported income that was

under the Medicaid standard, or income limit, external data used by the FFM showed that she was over this income limit and was relied on in the FFM denial. The testimony of the Appellant that she provided net income instead of gross income supports the FFM basis for denial. 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 reported net income instead of gross income on her FFM application, the FFM relied on external income data to determine her income eligibility.

2) Because the Appellant provided insufficient income verification, the income determination and denial by the FFM is not refuted.

3) Because the Appellant provided insufficient income verification 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 due to excessive income.

ENTERED this _____ day of November 2024.

_____

Todd Thornton
State Hearing Officer