January 23, 2025

[redacted]

RE: [redacted]
ACTION NO.: 24-BOR-3904

Dear [redacted]:

Enclosed is a copy of the decision resulting from the hearing held in the above-referenced matter.

In arriving at this decision, the State Hearing Officer was governed by the Public Welfare Laws of West Virginia and the rules and regulations established by the Department of Health and Human Resources and by Federal Regulations at 45 CFR Part 155, Subpart F. 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,

Eric L. Phillips
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

[redacted], **Appellant,** **Action No.: 24-BOR-3904**

DECISION OF STATE HEARING OFFICER

INTRODUCTION

This is the decision of the State Hearing Officer resulting from a fair hearing for [redacted], Jr. 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 December 18, 2024.

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 December 18, 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. Appearing as a witness for the Appellant was [redacted]. The Marketplace was not represented. The Appellant and his witness were sworn in.

The Appellant did not submit any documents as evidence in the hearing.

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) On November 28, 2024, the Appellant utilized the Federally Facilitated Marketplace (FFM) to complete a health care assistance application for the 2025 coverage year.

2) The Appellant is 61 years of age.

3) The Appellant reported a future loss of minimal essential coverage on December 31, 2024.

4) The Appellant was granted a special enrollment period from November 28, 2024 through March 1, 2025.

5) The FFM application results indicated that the Appellant was eligible to enroll in a Marketplace plan until March 1, 2025.

6) The Appellant attested monthly income from a social security benefit in the amount of $2069.00.

7) The FFM application indicated that the Appellant was not eligible for Medicaid assistance due to excessive income.

8) The FFM application notes the Appellant was not eligible for a Premium Tax Credit because he did not attest to a filing status.

9) The FFM application notes that the Appellant was not denied Medicaid coverage.

10) The FFM application notes that the Appellant answered no to the question regarding a full requested medical determination.

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 1.2.6.D documents:

> 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.

West Virginia Income Maintenance Manual Chapter 1.6.11.A documents:

Regardless of where the applicant submits their Single Streamlined Application (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.

West Virginia Income Maintenance Manual Chapter 1.6.11.A.1 documents:

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 an 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.

DISCUSSION

The Appellant appeals the results of his November 28, 2024 application for 2025 health care assistance through the Federally Facilitated Marketplace (FFM). Pursuant to policy, the FFM must complete an eligibility determination for application. The FFM relies on the information collected on the application to decide the applicant's eligibility for insurance affordability programs, including Modified Gross Income (MAGI) coverage groups. The Board of Review may only determine if the FFM correctly decided that the Appellant's Medicaid eligibility.

The Appellant completed an application for FFM healthcare assistance reporting his living situation with his former spouse, along with a monthly income from social security benefits in the amount of $2069.00. The Appellant reported that he was a tax filer for the previous tax year due to limited earnings but would not submit a tax return for the current year due to the onset of his social security benefit. The Appellant offered no dispute to the calculated income but offered his protest to the calculation of his portion of the cost of medical assistance through the FFM. The Appellant reported that he previously was approved for FFM medical assistance in 2024, while a resident of the state of [redacted] and only paid a few cents for his yearly portion. The Appellant testified that he terminated such coverage on December 31, 2024. The Appellant indicated that upon his relocation to West Virginia, his monthly portion was determined at $1600.00 and such amount would contribute to a financial hardship on his household.

The FFM application denotes that the Appellant was granted a special enrollment period application due to the loss of minimum essential coverage. Additionally, the Appellant reported that he had not been denied Medicaid and did not indicate a full requested Medicaid determination. Based on the information provided on the application, the FFM's decision not to review the Appellant's application for Medicaid eligibility is affirmed.

CONCLUSIONS OF LAW

1) Policy requires the FFM to review Medicaid eligibility when requested by the applicant.

2) The Appellant did not indicate on the FFM application that he requested a full review of Medicaid eligibility.

3) The Appellant was granted a special enrollment period due to the loss of minimal essential coverage.

4) The FFM decision to not review the Appellant's application for Medicaid eligibility is affirmed.

DECISION

It is the decision of the State Hearing Officer to uphold the FFM's decision not to review the Appellant's application for Medicaid eligibility.

ENTERED this 23rd day of January 2025.

Eric L. Phillips
State Hearing Officer