STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF INSPECTOR GENERAL

Bill J. Crouch
Cabinet Secretary

BOARD OF REVIEW
State Capitol Complex Building 6, Room 817-B
Charleston, WV 25305
Phone 304-558-0955

M. Katherine Lawson
Inspector General

December 20, 2021

[redacted]

RE: [redacted] v. WVDHHR
ACTION NO.: 21-BOR-2389

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,

Tara B. Thompson, MLS
State Hearing Officer
Member, State Board of Review

Encl: Appellant's Recourse to Hearing Decision
Form IG-BR-29

cc: BORC

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

In Re: [redacted], Appellant **Action # 21-BOR-2389**

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 and Human Resources. The Appellant submitted her Appeal request to the FFM on or about November 17, 2021.

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 November 17, 2021, the federal appeals entity electronically transmitted to the Board of Review the Appellant's appeal file. The hearing was convened by telephone on December 7, 2021. The Appellant appeared *pro se*. The Marketplace was not represented. The Appellant was sworn in.

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

Exhibit 1 [redacted] Medicine After Visit Summary, dated August 24, 2021
Physician Letter, signed September 21, 2021
Disability and Leave Approval
Social Security Administration (SSA) Letter, dated November 25, 2021
[redacted] Orders, dated December 3, 2021
Initial Claim Report for Disability Protection, signed December 9, 2021
Statement of Earnings and Deductions

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 assistance with health care through the FFM on November 16, 2021.

2) On November 16, 2021, the Appellant was notified by letter she was not eligible for Medicaid. The letter advised that the Appellant could purchase a 2022 Marketplace plan. The letter stipulated that the Appellant was not eligible for other programs, including a tax credit, because she was eligible to get qualifying coverage through a job or was enrolled in Medicare or Medicaid. No other reasons for denial were provided.

3) The Appellant constitutes a one-person assistance group (AG).

4) At the time of the denial by the FFM, the Appellant was an adult, age 25. She was a tax-filer and filed single claiming no dependents other than herself. She was not claimed as a dependent on anyone else's tax return. The Appellant falls into the Adult coverage group.

5) The maximum allowable monthly income for one person in under the Adult Group is equal to 133% of the Federal Poverty Level which, is $1,428 for a one-person AG.

6) The Appellant is employed at [redacted] and is enrolled in an employer-sponsored health insurance program.

7) The Appellant is not a recipient of Medicare or Medicaid.

8) On the FFM application, the Appellant attested that there were no changes in her income.

9) At the time of the denial, the Appellant was on temporary paid medical leave from her employer for health reasons that include uncontrolled diabetes.

10) On the FFM application, the Appellant attested that her income was $430 per month and $15,000 annually.

11) The Appellant's approved disability period began October 13, 2021. The Appellant may take up to 52 weeks of leave in a rolling 52-week period.

12) The Appellant's estimated recovery date was extended beyond the initial December 14, 2021 estimated return date.

13) At the time of the denial, the Appellant received gross disability payments from her employer every two weeks in the amount of $404.11. This income is converted to a monthly amount as follows: $404.11 x 2.15 = $868.60 gross monthly income.

14) The Appellant's gross monthly income of $868.60 is 81% of the FPL.

APPLICABLE POLICY

West Virginia Income Maintenance Manual (WVIMM) §§ 4.3.1, 4.6.1, 4.4.1.A, 4.4.1.B, 4.4.1.D, 4.7, and 23.10.4 provide in part:

> For Medicaid eligibility, sick benefits from an employer are counted as earned income. Eligibility is determined monthly. Therefore, it is necessary to determine a monthly amount of income to count for the eligibility period. For all cases, the Worker must determine the amount of income that can be reasonably anticipated for the AG.
>
> Use past income only when income from the source is expected to continue into the certification period and the amount of income form the source is expected to be more or less the same. For these purposes, the same source of income means income from the same employer, not just the continued receipt of earned income.
>
> Determine the amount of income received by the Income Group (IG) in the 30 calendar days prior to the application. After the Worker determines all of the income to be considered, the Worker determines the amount of monthly income based on the frequency of receipt and whether the amount is stable or fluctuates. For Biweekly income (every two weeks), multiply the amount by 2.15.
>
> Convert the gross monthly income to a percentage of the Federal Poverty Level (FPL) by dividing the current monthly income by 100% of the FPL for the household size. Applicants with income below the MAGI standard of 133% of the FPL are determined eligible for coverage in the Adult Group.

WVIMM Chapter 4, Appendix A provides:

> For a one-person AG, 100% of the FPL is 1,074 and 133% of the FPL is $1,428.

WVIMM Chapter 1:

> The beginning date of eligibility is the first day of the month of application, if eligible.

WVIMM §23.6 Health Insurance Premium Payment (HIPP) provides:

> This program is used to assist Medicaid-eligible individuals who cannot afford available employer group health coverage. The Bureau for Medical Services (BMS) pays health insurance premiums, along with deductibles and co-payments, for Medicaid-eligible individuals when the available policy is determined cost effective …. To qualify for HIPP, there must be group health insurance available that covers at least one person who is Medicaid-eligible in West Virginia. The

individual may also call the DHHR's Third Party Liability (TPL) contractor at 304-342-4604 to request an application or to obtain additional information about program requirements and the eligibility determination process.

DISCUSSION

The notice advising initial disability approval dates of October 13 through December 14, 2021 indicated that the Appellant may take up to 52 weeks of leave in a rolling 52 week period. The Appellant's exhibits further indicated that her estimated recovery date had been extended beyond the initial December 14, 2021 estimated return date. Because the Appellant is eligible to extend employer-based disability up to 52 weeks and the Appellant's medical condition has not been resolved, this Hearing Officer cannot rule out that the amount of the Appellant's short-term disability income is likely to continue into the certification period. Because the amount of the Appellant's income was below the maximum allowable income limit for the Adult Group, she is determined to be eligible for Medicaid coverage.

Pursuant to the Appellant's hearing request and testimony, the Appellant asserted that she cannot afford medically necessary treatments and medications. Information regarding the Health Insurance Premium Payment (HIPP) program is included in the policy section above. The inclusion of this policy is not a certification of the Appellant's eligibility for the HIPP program and is provided for informational purposes only to advise the Appellant of other programs for which she may apply.

CONCLUSIONS OF LAW

1) To be eligible for Medicaid Adult Group benefits for a one-person AG, the gross monthly income must be equal to or below the 133% Federal Poverty Level of $1,428.

2) The Appellant's gross monthly income is $868.60.

3) The Appellant qualifies for Medicaid Adult Group benefits.

DECISION

It is the decision of the State Hearing Officer that the Appellant is eligible for Medicaid benefits, effective November 2021.

ENTERED this 20th day of December 2021.

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Tara B. Thompson, State Hearing Officer