



February 18, 2026



RE: [REDACTED] v. WV DoHS BFA
ACTION NO.: 26-BOR-1097

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 ensure that all people 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,

Amy Hayes
State Hearing Officer
Member, State Board of Review

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

cc: Kristyne Hoskins, Department Representative

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

████████████████████

Appellant,

v.

Action Number: 26-BOR-1097

**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 ██████████
██████████ 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
February 10, 2026.

The matter before the Hearing Officer arises from the October 17, 2025 decision by the Respondent
to close Medicaid benefits.

At the hearing, the Respondent appeared by Kristyne Hoskins, Economic Service Worker Senior,
West Virginia Department of Human Services (DoHS). The Appellant was present but was
represented by ██████████ The Appellant testified on his own behalf. All witnesses were
placed under oath and the following documents were admitted into evidence.

Department's Exhibits:

None

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 Appellant was a resident of [REDACTED]
- 2) The Appellant previously received Medicaid benefits in [REDACTED]
- 3) The Appellant moved to West Virginia, on or about October 2024, and lived with his father at [REDACTED]
- 4) When the Appellant moved to [REDACTED] West Virginia, he canceled his Medicaid benefits in [REDACTED] and applied for Medicaid benefits through the Department of Human Services (DoHS) of West Virginia.
- 5) The Appellant was found eligible to receive Medicaid benefits in West Virginia.
- 6) The Appellant moved in with his girlfriend, [REDACTED] on or about December 2024, and reports a physical address of [REDACTED] West Virginia.
- 7) On or about September 2025, the Respondent received a Public Assistance Reporting Information System (PARIS) match indicating that the Appellant was receiving Medicaid in [REDACTED]
- 8) On October 17, 2025, the Respondent sent notice to the Appellant at [REDACTED] West Virginia, that he was no longer eligible for Medical Assistance because he was not a resident of West Virginia.
- 9) The Appellant did not receive correspondence from the Respondent because he moved to [REDACTED] West Virginia, and did not report his new address to the Respondent.
- 10) On January 15, 2026, the Appellant requested a fair hearing.

APPLICABLE POLICY

The Code of Federal Regulations, Title 42, Chapter IV, Subchapter C, Part 435, Subpart J describes Eligibility in the States, and specifically describes Income and Eligibility Verification Requirements for Medicaid, in pertinent part:

§ 435.945 General requirements.

(a) Except where the law requires other procedures (such as for citizenship and immigration status information), the agency may accept attestation of information needed to determine the eligibility of an individual for Medicaid (either self-attestation by the individual or attestation by an adult who is in the applicant's household, as defined in § 435.603(f) of this part, or family, as defined in section 36B(d)(1) of the Internal Revenue Code, an authorized representative, or, if the individual is a minor or incapacitated,

someone acting responsibly for the individual) without requiring further information (including documentation) from the individual.

(b) The agency must request and use information relevant to verifying an individual's eligibility for Medicaid in accordance with §§ 435.948 through 435.956 of this subpart.

(c) The agency must furnish, in a timely manner, income and eligibility information, subject to regulations at part 431 subpart F of this chapter, needed for verifying eligibility to the following programs:

(1) To other agencies in the State and other States and to the Federal programs both listed in § 435.948(a) of this subpart and identified in section 1137(b) of the Act;

(2) Other insurance affordability programs;

(3) The child support enforcement program under part D of title IV of the Act; and

(4) SSA for OASDI under title II and for SSI benefits under title XVI of the Act.

(d) All State eligibility determination systems must conduct data matching through the Public Assistance Reporting Information System (PARIS).

§ 435.952 Use of information and requests of additional information from individuals.

(a) The agency must promptly evaluate information received or obtained by it in accordance with regulations under § 435.940 through § 435.960 of this subpart to determine whether such information may affect the eligibility of an individual or the benefits to which he or she is entitled.

(b) If information provided by or on behalf of an individual (on the application or renewal form or otherwise) is reasonably compatible with information obtained by the agency, including information obtained in accordance with § 435.948, § 435.949, § or 435.956, the agency must determine or renew eligibility based on such information.

(c) An individual must not be required to provide additional information or documentation unless information needed by the agency in accordance with § 435.948, § 435.949, § or 435.956 cannot be obtained electronically or information obtained electronically is not reasonably compatible, as provided in the verification plan described in § 435.945(j) with information provided by or on behalf of the individual.

(1) Income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual, and resource information obtained through an electronic data match shall be considered reasonably compatible with resource information provided by or on behalf of an individual, if both the information obtained electronically and the information provided by or on behalf of the individual are either above or at or below the applicable standard or other relevant threshold.

(2) If information provided by or on behalf of an individual is not reasonably compatible with information obtained through an electronic data match, the agency must seek additional information from the individual, including—

(i) A statement which reasonably explains the discrepancy; or

(ii) Other information (which may include documentation), provided that documentation from the individual is permitted only to the extent electronic data are not available and establishing a data match would not be effective, considering such factors as the administrative costs associated with establishing and using the data match compared with the administrative costs associated with relying on

paper documentation, and the impact on program integrity in terms of the potential for ineligible individuals to be approved as well as for eligible individuals to be denied coverage;

(iii) The agency must provide the individual a reasonable period to furnish any additional information required under paragraph (c) of this section.

(3) ***Exception for special circumstances.*** The agency must establish an exception to permit, on a case-by-case basis, self-attestation of individuals for all eligibility criteria when documentation does not exist at the time of application or renewal, or is not reasonably available, such as in the case of individuals who are homeless or have experienced domestic violence or a natural disaster. This exception does not apply if documentation is specifically required under title XI or XIX, such as requirements for verifying citizenship and immigration status, as implemented at § 435.956(a).

(d) The agency may not deny or terminate eligibility or reduce benefits for any individual on the basis of information received in accordance with regulations under § 435.940 through § 435.960 of this subpart unless the agency has sought additional information from the individual in accordance with paragraph (c) of this section, and provided proper notice and hearing rights to the individual in accordance with this subpart and subpart E of part 431.

West Virginia Income Maintenance Manual, Chapter 6 describes the Data Exchange, in pertinent part:

6.3.3 Public Assistance Reporting Information System (PARIS)

The PARIS data match occurs quarterly. There are three types of PARIS matches on income and medical benefits: Federal, Interstate and Veterans Affairs. PARIS conducts matches on income and health coverage information. Verification is received through data exchange and is compared to the information in the case record. The client's Social Security Number (SSN) is used to retrieve the information.

6.3.3.B Interstate Match

A return on this match indicates an individual is enrolled for benefits in two or more states. Automatic disenrollment for the West Virginia program occurs for the matched individuals. If the individual is the primary person in the entire case, it will close.

This process is administered by the Office of Inspector General's (OIG) Investigations and Fraud Management Unit. When the OIG determines worker action is necessary, it will notify the worker. The information received from OIG is considered verified upon receipt. The worker has 10 days to take the action specified.

NOTE FOR MEDICAID AND WVCHIP COVERAGE GROUPS ONLY: Eligibility cannot be denied/terminated based solely on a data match from PARIS. **If the information obtained from any third-party data source is inconsistent with approving eligibility or suggests a change in circumstances for a current enrollee impacting eligibility, the agency must provide the individual opportunity to provide an explanation or other documentation prior to closure. If no alternative documentation or explanation is provided, the agency must deny or terminate eligibility.**

NOTE FOR SNAP ONLY: The agency must provide the household with the Notice of Match Results (NCHZ), and the matched individual must be given 10 days to contest the findings.

West Virginia Income Maintenance Manual, Chapter 10 describes the Case Maintenance Process, in pertinent part:

10.2.1.B.2 Closure Due to Loss of Contact

Loss of contact occurs when the client moves and does not notify the DOHS. The Worker may become aware of this when a Medical ID card, or other correspondence is returned. The Federal Data Hub (FDH) may also indicate a client's updated address.

The Worker must first check the address in the eligibility system. If it is incorrect due to a data entry error, the Worker must correct it and release the benefit(s) to the correct address. For Supplemental Security Income (SSI) Medicaid recipients, the Worker must check State On-Line Query (SOLQ).

If the address is correct and/or the United States Postal Service (USPS) indicated a new address on the returned correspondence, the Worker sends a DFA-6 to the client's new address. If the DFA-6 is returned as undeliverable, or if the client does not report his new address by the date indicated on the form, the AG is closed, after advance notice. If the USPS indicates no new address on the returned correspondence, the AG is closed, after advance notice.

Medicaid Only:

Mail returned with an in-state forwarding address is not an indication of a change affecting eligibility. The USPS in-state forwarding address is acceptable to update the client's record while sending a DFA-6 to the current address. The client's coverage is not terminated if the DFA-6 is not returned.

Mail returned with an out-of-state address must be confirmed by sending a DFA-6 to the client's current address to verify state residency. If the client fails to respond, or the information provided does not establish the client's state residency status, the worker must terminate coverage with advance notice and fair hearing rights.

Mail returned with no forwarding address must be confirmed by sending a DFA-6 to the client's current address in the eligibility system. If the client fails to respond, the worker must terminate coverage with advance notice and fair hearing rights. **If the client later provides or notifies the worker of the updated address, the coverage must be reinstated with the originally scheduled renewal dates.**

West Virginia Income Maintenance Manual, Chapter 10 describes the Case Maintenance Process, Section 10.6 describes the process for Medicaid, in pertinent part:

10.6.2 Client Reporting Requirements

Clients must report all changes in circumstances such as, but not limited to, income, assets, household composition, and change of address.

The client must report changes as soon as possible after he becomes aware of them. This allows the Worker to update the case and allows for advance notice, if the reported information results in an adverse action.

When a client reports a change during the Medicaid certification period that affects eligibility, the Worker must only request the information on the change reported.

For Modified Adjusted Gross Income (MAGI) coverage groups only, when the Worker receives the information, he evaluates the client for rolling redetermination. If the Worker has enough information available to renew eligibility with respect to all the eligibility criteria, he must begin a new 12-month certification period for the client.

10.6.4.B Change of Address

The Worker makes a change of address in the eligibility system as soon as the client reports it. Any other changes that the client reports, in addition to the address change, are also acted on at the same time when notice requirements permit.

Also see 10.2.1.B.2 Closure Due to Loss of Contact.

DISCUSSION

The Appellant appealed the determination by the Respondent that his Medicaid benefits must close because he was not a resident of West Virginia. The Respondent's representative, Kristyne Hoskins, argued that she received a report from the Public Assistance Reporting Information System (PARIS) in September 2025, indicating that the Appellant was receiving Medicaid in [REDACTED]. The Respondent had to prove by a preponderance of the evidence that it correctly closed the Appellant's Medicaid benefits.

Federal regulations require the Respondent to verify eligibility through PARIS, an electronic data match. Federal regulations also state that if information provided by or on behalf of an individual is not reasonably compatible with information obtained through an electronic data match, the agency must seek additional information from the individual, including a statement which reasonably explains the discrepancy. Regulations require the Respondent to provide an individual a reasonable period to furnish any additional information to reasonably explain the discrepancy.

Policy stipulates that, for Medicaid, eligibility cannot be denied/terminated based solely on a data match from PARIS. If the information obtained from any third-party data source is inconsistent with approving eligibility or suggests a change in circumstances for a current enrollee impacting eligibility, the agency must provide the individual the opportunity to provide an explanation or other documentation prior to closure. If no alternative documentation or explanation is provided, the agency must deny or terminate eligibility.

The Appellant testified that he previously lived in [REDACTED], and was a recipient of Medicaid

there. However, he testified that he moved to West Virginia, on or about October 2024, and lived with his father at [REDACTED] West Virginia. The Appellant and his representative, [REDACTED], testified that, when the Appellant moved to [REDACTED] West Virginia, he canceled his Medicaid benefits in [REDACTED]. They testified that the Appellant applied for Medicaid benefits through the Department of Human Services (DoHS) of West Virginia, and was found eligible to receive Medicaid benefits in West Virginia, at that time.

The Appellant testified that he moved in with his girlfriend, [REDACTED], on or about December 2024, and from that time has resided at [REDACTED] West Virginia. The Appellant did not receive correspondence from the Respondent because he moved to [REDACTED] West Virginia, and did not report his new address to the Respondent. This was a loss of contact between the Respondent and the Appellant. It was the Appellant's responsibility to report all changes in circumstances such as, but not limited to, change of address.

Ms. Hoskins testified that, after receiving the PARIS match indicating that the Appellant received Medicaid in [REDACTED], the Respondent attempted to contact the Appellant to give him an opportunity to explain why information received from the data exchange was inconsistent with the information he reported, but did not indicate how they attempted to contact the Appellant. Ms. Hoskins testified that the Respondent notified the Appellant that he must provide an explanation or other documentation prior to closure. The Respondent did not receive an explanation from the Appellant and did not receive returned mail with a forwarding address. Ms. Hoskins testified that the Respondent notified the Appellant at his [REDACTED] West Virginia address, that his Medicaid would close on October 31, 2025. However, these notices were not provided at the hearing. Ms. Hoskins testified that they had not received information from [REDACTED], regarding the status of the Appellant's Medicaid in that State, but it is unknown what, if any, attempts were made to acquire that information.

Policy stipulates that, for Medicaid, when there is a loss of contact with the client, if the client fails to respond, the worker must terminate coverage with advance notice and fair hearing rights. If the client later provides or notifies the worker of the updated address, the coverage must be reinstated with the originally scheduled renewal dates.

The Appellant and his witness credibly testified that he still lives in West Virginia, that he canceled his Medicaid benefits in [REDACTED], and they provided a reasonable explanation for the loss of contact. The Appellant also reasonably explained the discrepancy between the information in the PARIS match and his reported circumstances. During the hearing, the Appellant testified as to his updated address. Coverage must be reinstated as of the date of closure.

CONCLUSIONS OF LAW

- 1) Federal regulations require the Respondent's eligibility determination systems to conduct data matching through the Public Assistance Reporting Information System (PARIS) and the Respondent received information in a PARIS match indicating that the Appellant was receiving Medicaid in [REDACTED]

- 2) Policy requires that Medicaid eligibility cannot be terminated based solely on a data match from PARIS and that the agency must provide the individual an opportunity to provide an explanation or other documentation prior to closure. The Respondent failed to provide any physical evidence documenting attempts to contact the Appellant to provide explanation.
- 3) If, after a loss of contact, the client later provides or notifies the worker of the updated address, the coverage must be reinstated with the originally scheduled renewal dates. This requirement was fulfilled at the time of hearing.
- 4) The Appellant's testimony that he canceled his Medicaid in [REDACTED], when he moved to West Virginia, reasonably explains the discrepancy found in the PARIS match and his coverage must be reinstated.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the decision of the Respondent to close the Appellant's Medicaid benefits on October 31, 2025. Benefits shall be reinstated from November 2025, as long as it complies with the originally scheduled renewal dates, as the Appellant may have been due for a review between time of closure and the fair hearing.

ENTERED this 18th day of February 2026.

**Amy Hayes
State Hearing Officer
Member, State Board of Review**