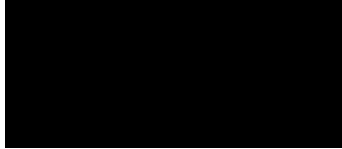




April 2, 2026



RE: [REDACTED] v. WVDohS-BFA  
ACTION NO.: 26-BOR-1538

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 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  
Certified State Hearing Officer  
Member, State Board of Review

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

cc: Carrie Casto, BFA

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

  
**Appellant,**

v.


**Action Number: 26-BOR-1538**

**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 April 1, 2026, on an appeal filed with the Board of Review on March 2, 2026.

The matter before the Hearing Officer arises from the January 16, 2026 decision by the Respondent to terminate Adult Medicaid benefits.

At the hearing, the Respondent appeared by Carrie Casto, Economic Service Supervisor. The Appellant was self-represented. All witnesses were placed under oath and the following documents were admitted into evidence.

**Department's Exhibits:**

- D-1 Benefit Redetermination Form dated December 15, 2025
- D-2 Notice of Decision dated January 16, 2026
- D-3 West Virginia Income Maintenance Manual Chapter 1.2.2.B

**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 recipient of Adult Medicaid benefits.
- 2) The Appellant's Adult Medicaid certification period was set to expire on January 31, 2026.
- 3) On December 15, 2025, the Department issued a redetermination form to the Appellant requiring that she complete the form and return to the local office by January 1, 2026. (Exhibit D-1)
- 4) The Appellant failed to submit the redetermination form by the required date.
- 5) On January 16, 2026, the Department issued a Notice of Decision (Exhibit D-2) informing the Appellant that her Adult Medicaid benefits would terminate effective January 31, 2026, because her benefit certification period expired.

### **APPLICABLE POLICY**

West Virginia Income Maintenance Manual Chapter 1.2.2.B documents:

Periodic reviews of total eligibility for recipients are mandated by federal law. These are redeterminations and take place at specific intervals depending on the program or Medicaid coverage group. Failure by the client to complete a redetermination will result in termination of benefits. If the client completes the redetermination process by the specified program deadline(s) and remains eligible. Benefits must be uninterrupted and received at approximately the same time.

West Virginia Income Maintenance Manual Chapter 1.8.6 documents:

Cases are normally redetermined annually. The redetermination schedule is set automatically by the eligibility system.

When possible, the redetermination process is completed automatically using electronic data matches without requiring information from the client. This redetermination process is initiated which matches current information with the hub.

If determined eligible after completing the redetermination process, the Department will notify the client. The notice will identify information used to determine eligibility. If the client agrees with the information, no further action is

required. If the client does not agree, he is to report the information that does not match the circumstances.

When the redetermination process cannot be completed automatically, the eligibility system sends a pre-populated form containing case information and requires the client to provide additional information necessary to determine continuing eligibility. A signature is required.

Code of Federal Regulations § 435.916 documents:

(a) Frequency of renewals

(1) The eligibility of all Medicaid beneficiaries not described in paragraph (a)(2) of this section must be renewed once every 12 months, and no more frequently than once every 12 months.

### **DISCUSSION**

On January 31, 2026, the Respondent terminated the Appellant's Adult Medicaid coverage due to the Appellant's failure to complete a periodic review of benefits. The Respondent must prove by a preponderance of the evidence that it correctly terminated the Appellant's Medicaid benefits due to an incomplete review.

On December 15, 2025, the Respondent issued the Appellant a periodic redetermination form to determine her continued eligibility for Adult Medicaid. The Respondent required the redetermination form to be completed and returned by January 1, 2026. The Appellant failed to complete the redetermination form; therefore, her Adult Medicaid benefits were terminated effective January 31, 2026. Carrie Casto, Economic Service Supervisor, testified that the Appellant contacted the Department on March 11, 2026 and March 13, 2026, and an additional redetermination form was issued to the Appellant, but to date, no redetermination form has been returned for an eligibility redetermination.

The Appellant admitted that she did not complete the required redetermination form because she received a new insurance card Aetna (the Respondent's Health Maintenance Organization (HMO)) in January 2026; therefore, she assumed that she was approved for benefits.

Federal law mandates the periodic review of eligibility for recipients of the Medicaid program. Because the Appellant failed to complete a redetermination of her Medicaid eligibility prior to end of her certification period, the Respondent was correct in its decision to terminate the Appellant's Medicaid benefits.

### **CONCLUSIONS OF LAW**

1) Federal law mandates the periodic review of eligibility of Medicaid recipients once every 12 months.

- 2) The Appellant was required to complete a redetermination of her Medicaid benefits prior to January 31, 2026, the date of her certification expiration.
- 3) The Appellant failed to complete a redetermination of Medicaid benefits.
- 4) The Respondent's decision to terminate Medicaid benefits is affirmed.

**DECISION**

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to terminate the Appellant's Adult Medicaid benefits.

**ENTERED this \_\_\_\_\_ day of April 2026.**

\_\_\_\_\_  
Eric L. Phillips  
**Certified State Hearing Officer**