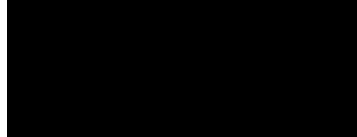




Ann Urling
Inspector General

August 11, 2026



RE: [REDACTED] v. WV DoHS/BFA
ACTION NO.: 26-BOR-1925

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 (DoHS). 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.

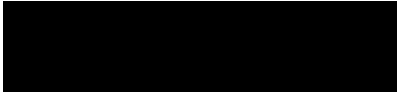
Sincerely,

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

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

cc: Leslie Riddle, DoHS

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


Appellant,

v.

Action Number: 26-BOR-1925

**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 June 30, July 14, and August 5, 2026.

The matter before the Hearing Officer arises from the Respondent's April 17, 2026 decision to deny the Appellant's eligibility for continued Medicaid eligibility.

At the hearing, the Respondent appeared by Leslie Riddle, DoHS. The Appellant appeared and was self-represented. All witnesses were placed under oath, and the following documents were admitted into evidence.

Department's Exhibits:

- D-1 Medicaid Review (Form MREV), mailed March 16, 2026
- D-2 Verification Checklist, mailed May 4, 2026
- D-3 Paystubs for Child 
- D-4 DoHS Case Comments, May 1 through May 19, 2026
- D-5 DoHS Notice, dated May 14, 2026
- D-6 DoHS Notice, dated May 14, 2026
- D-7 DoHS Case Comments, April 1 through May 1, 2025

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) On March 16, 2026, the Respondent mailed the Appellant a Medicaid review form which advised she must complete and return by April 1, 2026, or her Medicaid coverage would end effective April 30, 2026. The form advised that the Appellant could complete the form by mail, online, or in-person (Exhibit D-1).
- 2) Under *What we need for Medicaid*, the review form advised:
We need information about each person living in your household or listed on your tax return ...
We will check your answers using information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration, and the Department of Homeland Security. If the information doesn't match, we may ask you to provide more information (Exhibit D-1).
- 3) On April 17, 2026, the Respondent mailed a notice advising the Appellant her Parent/Caretaker Medicaid benefits would be terminated after April 2026, because she did not complete an eligibility review. The notice advised that if the Appellant completes her review, her benefits may be re-opened but may be delayed.
- 4) The Respondent received the Appellant's completed review form on April 30, 2026 (Exhibit D-1).
- 5) The Appellant marked *No* to the question, "Will anyone in the household file a federal tax return next year to report income earned this year?" (Exhibit D-1).
- 6) Members of the Appellant's household included the Appellant and her juvenile children: Child ■■■, Child ■■■, Child ■■■, Child ■■■ and Child ■■■. (Exhibit D-1).
- 7) At the time of the Appellant's review form submission, Child ■■■ was seventeen years old (Exhibit D-1).
- 8) On the review form, the Appellant handwrote "N/A" to Section 6 *Tell us about work* (Exhibit D-1).

- 9) Section 7 reflected pre-populated other income that included: \$248 Child Support Direct Payment for Child [REDACTED]; \$994 Supplemental Security Income for Child [REDACTED]; and \$994 Supplemental Security Income for Child [REDACTED] (Exhibit D-1).
- 10) On May 1, 2026, Respondent Worker EW54CD verified the amount of child support and pended the Appellant's Medicaid eligibility after reviewing the amount of Child [REDACTED] fourth quarter 2025 earnings (Exhibit D-7).
- 11) On May 1, 2026, Respondent Worker EW54CD recorded, [REDACTED] has decent amount Q4 2025 wage match at [REDACTED] (Exhibit D-7).
- 12) On May 4, 2026, Respondent Worker EW5466 informed the Appellant via telephone that proof of April 2026 income for Child [REDACTED] was needed (Exhibit D-4).
- 13) On May 4, 2026, the Respondent mailed the Appellant a *Verification Checklist* advising she must submit proof of gross earned income for Child [REDACTED], by May 13, 2026. Specifically, the appellant was required to submit "Proof of gross earned income, such as paystubs/employer statement/ [REDACTED] 04-10-2026; 04-24-2026" (ExhibitD-2).
- 14) On May 13, 2026, the Appellant submitted paystubs for Child [REDACTED]: \$277.05 gross income for pay period March 29 through April 4, 2026; \$277.03 gross income for pay period April 5 through April 11, 2026; \$283.98 gross income for April 12 through April 28, 2026; and \$246.73 gross income for April 19 through April 25, 2026 (Exhibit D-3).
- 15) On May 14, 2026, the Respondent mailed a notice advising the Appellant she was approved for Medicaid eligibility, beginning on June 1, 2026. The notice reflected \$1,166.15 in monthly earned income (Exhibit D-6).

APPLICABLE POLICY

West Virginia Income Maintenance Manual (WVIMM) § 1.2.2.B Redetermination Process provides that periodic reviews of total eligibility for recipients are mandated by federal law. These redeterminations 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.

The redetermination process involves basically the same activities described in the *Application Process*. Eligibility system changes and client notification of any changes resulting from the redetermination conclude the process.

WVIMM § 1.2.2.A Application Process provides that the application may be held, pending receipt of necessary information or verification, but there are processing time limits that must be met. All applications must have a final disposition and the client must be notified of the decision.

WVIMM § 1.2.4 *Client Responsibility* stipulates that it is the client’s responsibility to provide complete and accurate information about his circumstances so that the Worker is able to make a correct determination about his eligibility.

WVIMM § 1.2.11 *Redeterminations* provides that if coverage is closed for failure to submit a redetermination form, or necessary information, but the client responds and provides the information within 90 days of the effective date of closure, the Worker must determine eligibility in a timely manner without requiring a new application. Eligibility may be back dated up to three months, provided all eligibility requirements were met.

WVIMM § 3.10 *Parents/ Caretaker Relatives Group* Modified Adjusted Gross Income (MAGI) methodology is based on the Internal Revenue Service (IRS) 36B tax rules for determining how income is counted and how household composition and size are determined when establishing financial eligibility. To be eligible, the parent or caretaker relative must be living in the household with a dependent child for whom they assume primary responsibility.

WVIMM § 3.10.1 *The MAGI Household Income Group (IG) and Needs Group (NG)* provides that the methodology for determining the Medicaid household’s IG and NG is the same as found in Section 3.7.

WVIMM § 3.7.2 *The MAGI Household Income Group* provides that income of each member of the individual’s MAGI household is counted. The income group is determined using the MAGI methodology established in Section 3.7.3. EXCEPTION: Income of children, or other tax dependents, who are not expected to be required to file an income tax return is not counted, whether or not the individual actually files a tax return. 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 renewal. Information regarding “Who Must File” a tax return can be found in Appendix G of Chapter 4.

WVIMM Chapter 4, Appendix G *Whose Income Counts for MAGI* provides that if the individual is a child under age 19, and the MAGI household includes both the child and his parent and the child’s income is below the tax filing threshold, the child’s MAGI-based income is excluded. However, if the child’s income is not below the tax filing threshold, the child’s MAGI based income is included. These rules apply regardless of the tax dependent’s age and whether the individual actually files a return.

WVIMM § 10.6.2 *Client Reporting Requirements* provides that clients must report all changes in circumstances such as, but not limited to, income, assets, household composition, and change of address

WVIMM § 10.11.1 *Change in Income* instructs that when a change in income is reported, eligibility for the AG must be re-evaluated. Changes include the onset or termination of income, as well as income increases and decreases.

WVIMM § 7.2.1 When Verification is Required instructs that verification of a client's statement is required when:

- Policy requires routine verification of specific information.
- The information provided is questionable. To be questionable, it must be:
 - Inconsistent with other information provided; or
 - Inconsistent with the information in the case file; or
 - Inconsistent with information received by the Department of Human Services (DoHS) from other sources; or
 - Incomplete; or
 - Obviously inaccurate; or
 - Outdated.

WVIMM § 7.2.4 Worker Responsibilities provides that the Worker has the following responsibilities in the verification process:

- At application, redetermination, and anytime a DFA-6 is used, the Worker must list all required verification known at the time. The Worker should only request additional verification if information provided is incomplete or additional information is necessary to determine eligibility ...

WVIMM § 7.2.5.A Reasonable Compatibility – Medicaid Coverage Groups and WVCHIP Only: Definitions provides that the provide definitions apply to all Medicaid and WVCHIP coverage groups.

Reasonable Compatibility means that information provided by an applicant through self-attestation does not vary significantly, or in a way that is meaningful for eligibility when compared to information obtained through electronic data sources. Under reasonable compatibility, the Worker can require verification documentation only when the difference between the attestation and data source affects eligibility.

DISCUSSION

The Respondent terminated the Appellant's Medicaid eligibility after April 30, 2026, because the Appellant failed to complete her review by April 1, 2026. During the hearing, the Appellant contested the Respondent's delay in retroactive approval of her Medicaid eligibility and argued that her benefits should not have been stopped after April 30, 2026.

Pursuant to the authority granted to the Board of Review, the Hearing Officer may not pass judgement on the policy and may only decide whether the Respondent correctly followed the policy when terminating and reinstating the Appellant's Medicaid eligibility. The Respondent had to prove by a preponderance of evidence that the Appellant's Medicaid eligibility was correctly terminated after April 30, 2026, that the Appellant's review was processed within the period permitted by policy, and that the Appellant's eligibility decision was not delayed.

The policy stipulates that the client is required to provide complete and accurate information so that the Worker can make a correct eligibility decision. According to the submitted Medicaid

review form, the Appellant was advised that she must provide information for members of her household, that the Respondent would check the information, and that the Appellant may be required to provide more information if the supplied information did not match.

According to the policy, when information is inconsistent with other information provided or information in the case file is incomplete, is obviously inaccurate, or is outdated, verification is required. When information provided by a client by self-attestation varies significantly when compared to information obtained through electronic data sources, reasonable compatibility is not established. Pursuant to the policy, the Worker may require verification documentation when the difference between the attestation and data sources affect eligibility.

Pursuant the Appellant's late-submitted review form, she did not report earned income for any member of her household. On May 1, 2026, Respondent Worker EW54CD found that Child [REDACTED] had a "decent amount" of fourth quarter 2025 earnings. Because information provided by the Appellant on her review form was not reasonably compatible with information obtained through electronic data sources, the Respondent was required to verify the earned income information.

During the hearing, the Appellant questioned whether a juvenile's income should be considered for determining Medicaid eligibility. Pursuant to the policy, if a child's income is not below the tax filing threshold, the child's MAGI based income is included when determining MAGI Medicaid eligibility. As the information provided by the Appellant did not match the information obtained by the Respondent, and the earned income amount for Child [REDACTED] could not be readily determined by the supplied information, a verification checklist was issued to provide the Appellant with an opportunity to verify the household's earned income.

Delay in eligibility approval

According to the policy, once received, the application may be held pending for the receipt of necessary information or verification. The submitted evidence revealed that the Appellant was informed on March 16, 2026, that she was required to return her completed review form by April 1, 2026, or her benefits would end after April 30, 2026. On the review form, the Appellant was informed in writing that if the information she provided on the form did not match information provided by computer data sources, she may be asked to provide more information. Because the Appellant submitted her review form late and eligibility could not be determined based on the information supplied, the Respondent correctly pended her application to seek verification of the household's earned income.

According to the policy, if coverage is closed for a failure to submit a redetermination form, or necessary information, but the client responds and provides the information within 90 days of the effective date of closure, the Worker must determine eligibility in a timely manner without requiring a new application. Eligibility may be back dated up to three months, provided all eligibility requirements were met.

Although a copy of a notice of retroactive eligibility decision was not provided during the hearing, the Respondent's representative testified that the Appellant's eligibility was approved and backdated to May 1, 2026, the day after her eligibility termination. The Appellant did not dispute that her eligibility was restored to May 1, 2026, but contested the gap in coverage that occurred

between the date of eligibility termination and her May 14, 2026 retroactive eligibility restoration. Pursuant to the evidence, on May 13, 2026, the Appellant complied with the Respondent's verification requests, and a timely eligibility decision was made by the Respondent on May 14, 2026. As the Respondent acted to retroactively restore the Appellant's Medicaid eligibility to May 1, 2026, no further relief can be granted.

CONCLUSIONS OF LAW

- 1) When a client fails to complete a redetermination, Medicaid benefits may be terminated. If the client completes the redetermination process by the specified program deadline and remains eligible, benefits must be uninterrupted and received at approximately the same time.
- 2) The Appellant was required to submit her redetermination form by April 1, 2026, to avoid benefit termination after April 30, 2026.
- 3) The preponderance of evidence revealed that the Appellant did not submit her review form by April 1, 2026.
- 4) Because the Appellant did not submit her review form by the required date, her eligibility was correctly terminated after April 30, 2026.
- 5) If coverage is closed for a failure to submit a redetermination form but the client provides the information within 90 days of the effective date of closure, the Worker must determine eligibility in a timely manner without requiring a new application.
- 6) The preponderance of evidence revealed that the Appellant submitted the review form within 90 days of the effective date of closure but failed to indicate earned income information for any member of the household.
- 7) The application for eligibility may be held, pending the receipt of necessary information or verification.
- 8) Because the information provided by the Appellant was not reasonably compatible with information revealed by computer data sources, and eligibility could not be determined based on the information supplied, the Respondent correctly pended her case to seek verification of the household's income.
- 9) The preponderance of evidence proved that once requested income verification was received, the Respondent determined the Appellant's Medicaid eligibility in a timely manner and retroactively restored the Appellant's Medicaid eligibility. There was no agency delay in the restoration of the Appellant's Medicaid eligibility.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to terminate the Appellant's Medicaid eligibility after April 30, 2026.

ENTERED this 11th day of August 2026.

Tara B. Thompson, MLS
Certified State Hearing Officer