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

Bill J. Crouch
Cabinet Secretary

BOARD OF REVIEW
Raleigh County DHHR
407 Neville Street
Beckley, WV 25801

Jolynn Marra
Interim Inspector General

November 3, 2021

[redacted]

RE: [redacted] v. WV DHHR
ACTION NO.: 21-BOR-2172

Dear Mr. [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 Health and Human Resources. 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,

Kristi Logan
Certified State Hearing Officer
Member, State Board of Review

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

cc: Bureau for Medical Services

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 21-BOR-2172**

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES,

Respondent.

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 Chapter 700 of the West Virginia Department of Health and Human Resources' Common Chapters Manual. This fair hearing was convened on November 3, 2021, on an appeal filed September 30, 2021.

The matter before the Hearing Officer arises from the July 19, 2021 decision by the Respondent to deny the requested units of Unlicensed Residential Person-Centered Support 1:1 services under the I/DD Waiver Program.

At the hearing, the Respondent appeared by Ashley Quinn, KEPRO. Appearing as witnesses for the Respondent were Stacy Broce and Lori Tyson with the Bureau for Medical Services. The Appellant appeared *pro se*. Appearing as witnesses for the Appellant were [redacted]. All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Notice of Decision dated July 19, 2021
D-2 Bureau for Medical Services Policy Manual §513.17.4.1
D-3 Bureau for Medical Services Policy Manual §513.25.4.2
D-4 Bureau for Medical Services Policy Manual §513.8.1
D-5 Bureau for Medical Services Policy Manual §513.25.2
D-6 Exceptions Request Form – Request for Services Above the Budget dated June 23, 2021
D-7 Individualized Program Plan dated November 4, 2020

Appellant's Exhibits:

A-1 Service Coordination Progress Notes dated January 7, 2020, March 2, 2020, September 11, 2020, and October 6, 2020
A-2 Monthly Case Management Log for May 2021
A-3 Email and Text Correspondence from [redacted]

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 is a recipient of services under the I/DD Waiver Program.

2) The Appellant's annual budget for November 1, 2020 through November 30, 2021 is $148,357 (Exhibit D-7).

3) An Exceptions Request was submitted on behalf of the Appellant on June 23, 2021, requesting additional 35,040 Unlicensed Residential Person-Centered Support (PCS) 1:1 units in excess of the Appellant's assigned I/DD Waiver budget (Exhibit D-6).

3) The Respondent approved 15,996 units of Unlicensed Residential PCS 1:1 for the Appellant and although not requested, approved 19,044 units of Unlicensed Residential PCS 1:2.

4) The Respondent issued a Notice of Denial on July 19, 2021, advising the Appellant that the request for additional units of Unlicensed Residential PCS 1:1 had been denied as the services that can be purchased within the budget were insufficient to prevent a risk of institutionalization (Exhibit D-1).

APPLICABLE POLICY

Bureau for Medical Services Provider Manual §513.8.1 states the Interdisciplinary Team (IDT) participates in the IDT meeting for the purpose of review of assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support outline of service options and training goals, and preparation of interventions or strategies necessary to implement a person-centered plan within the member's individualized budget. The IDT must make every effort to purchase IDDW services with the individualized assessed budget. The IDT must consider all supports available, both paid and unpaid, both IDDW waiver and non-IDDW. In circumstances when individuals wish to live in 24-hour supported settings (intensively support setting (ISS) and group home (GH)), the individualized budget must be considered before signing leases, renting apartments, living in family-owned homes or homes left in trust to the member. The member and the legal representative may want the member to live in a certain setting

or even live alone, but if the individualized assessed budget does not provide enough supports for these settings, then the member or the legal representative need to look at alternatives – roommates, more natural support, supplemental funding from family or trusts, etc. Any services that cannot be purchased within budget must be supported from unpaid or natural supports or services from another program other than the IDDW, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

Bureau for Medical Services Provider Manual §513.17.4.1 states all units of Unlicensed Residential PCS service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

Limitations/Caps for Unlicensed Residential PCS

- The amount of service is limited by the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- All requests for more than an average of 12 hours per day of 1:1 services require BMS approval. Approval of this level of service will be based on demonstration of assessed need not on a particular residential setting.

Bureau for Medical Services Provider Manual §513.25.4.2 describes the process in determining a participant's I/DD Waiver Program budget.

Service Authorization Process

The Utilization Management Contractor (UMC) will conduct the functional assessment up to 90 days prior to each person's anchor date. If determined medically eligible, the person or their legal representative and Service Coordination provider will receive an individualized budget calculated pursuant to the methodology described below. Once the person's budget has been calculated, the person will receive a notice each year that sets forth the person's individualized budget for the Individualized Program Plan (IPP) year and an explanation for how the individualized budget was calculated. The UMC, the person, the legal representative, the service coordinator, and any other members of the Interdisciplinary Team (IDT) that the member wishes to be present will attend the annual assessment. The UMC will work with the person and his or her team to complete three forms: the Inventory for Client and Agency Planning (ICAP), the Adaptive Behavior Assessment System II (ABAS II) and the Structured Interview.

The person and/or his legal representative shall sign an acknowledgment that they participated in the assessment and were given the opportunity to review and concur with the answers recorded during the assessment. If the person or his legal representative declines to sign the acknowledgment for any reason (e.g., he or she does not believe the answers were recorded accurately), the person or their legal representative shall notify the UMC through their service

coordinator within 5 days of the assessment date, and the UMC shall resolve the issue by conferring with the person and/or the legal representative to come to an agreement on the answers on the assessment. If the person or their legal representative still disputes the answers on the assessment, then the issue can be appealed through a Medicaid Fair Hearing.

Exceptions Process

The IDT has an obligation to make every attempt to purchase services it deems necessary within the individualized budget. If the IDT determines after careful consideration that funds beyond the individualized budget are still necessary to avoid a risk of institutionalization, the person and/or the legal representative (or the Service Coordinator on their behalf), after consultation with the IDT, may submit a request for services in excess of the budget to BMS through the UMC web portal, along with any supporting documentation.

If the person or his or her legal representative believes services in excess of the budget are necessary, they will fill out an additional section of the IPP that reflects all the additional services that person or his or her legal representative believes the person needs. Even if the IDT believes that services in excess of the budget are necessary, the IDT must complete the primary section of the IPP and specify services that can be purchased within the person's individualized budget. No services for the IPP year will be authorized unless this primary section is completed. The person or their legal representative must sign off on the request for services in excess of the budget. Services requested in excess of the budget, described in the additional section of the IPP, cannot be authorized unless and until an exception is approved through the exceptions process.

An "exceptions process" request for services exceeding the person's individualized budget is clinically researched and reviewed by BMS. Such request may also be negotiated between the person or their legal representative, the Service Coordinator/IDT and BMS. A panel of three individuals employed by DHHR or its contractor will review the "exceptions" request to determine if any errors were made in the service authorization process, including if any technical errors were made in the assessment, and/or if funds in excess of the budget are needed to purchase clinically appropriate services necessary to prevent a risk of institutionalization. At least one individual on the panel will have medical training. A decision will be made by the Exceptions Panel within 20 business days after the Exceptions Panel has received submission explaining the basis for the exceptions request with any/all supporting documentation.

The individual seeking additional services through the "exceptions process" has the burden of showing that services in excess of the individualized budget are necessary to avoid a risk of institutionalization. To make this showing, the person or his legal representative must provide a clear explanation on the "exceptions process" request as to which additional services are requested and why they are necessary to prevent a risk of institutionalization and may provide documentation to support his or her position. All documentation must be attached/enclosed/provided if the person would like BMS to consider such documents in making its decision during the "exceptions process." Referring to documents on the "exceptions process" form is NOT sufficient; any documents the person would like BMS to consider must be attached to the "exceptions process" form and specific sections highlighted for BMS to review.

In determining whether the person has met his or her burden to receive services in excess of the budget, the three-person panel shall consider, among other things:

- The person's most recent ICAP, Structured Interview, and all IPPs from the current year.
- Any information provided by the person in his or her application for an exception.
- The feasibility of rearranging services within the person's budget.
- The availability of less expensive services that can be substituted for more expensive services.
- The availability of services covered outside the IDDW program by Medicaid or by private insurance.
- The natural supports (if any) available to the person, and limitations on those supports.

If BMS concludes that the person has demonstrated that funds in excess of the individualized budget are necessary to prevent a risk of institutionalization, BMS will authorize funds in excess of the budget to the extent necessary to keep the person safe and healthy and avoid a risk of institutionalization, and the IPP will be finalized. If BMS determines that the person did not demonstrate that funds in excess of the individualized budget are necessary to avoid a risk of institutionalization, BMS will not authorize funds in excess of the budget. If BMS determines that an error was made in the service authorization process, it will take the steps necessary to correct the
error.

If during the "exceptions process", BMS determines there was not an error, or that the requested additional services and funding are not warranted, a Letter of Denial will be sent to the person or their legal representative, which will include an explanation as to why the services(s) and funding were denied, how to file for a Medicaid Fair Hearing and free legal services available. All decisions during the "exceptions process" shall be reviewed and/or issued by BMS.

DISCUSSION

An I/DD Waiver participant's budget is determined annually based upon the budget methodology outlined in policy as determined by the participant's functional assessment. If services cannot be purchased within the participant's annual budget, policy allows for the submission of an Exceptions Request to determine if services exceeding the assigned budget are necessary to prevent institutionalization of the I/DD Waiver participant.

The Respondent denied the Appellant's request for additional Unlicensed Residential PCS 1:1 units that was submitted in June 2021 as the documentation did not support that the need for units in excess of the budget was necessary to prevent his institutionalization.

The Appellant resides in his own home which is designated as a 2-person Intensively Support Setting (ISS). The Appellant does not have a roommate and did not have a roommate as of the implementation of his Individualized Program Plan in November 2020 for the current service year. The Appellant's representatives argued that they have had difficulty finding a roommate for the Appellant, in part due to his unwillingness to accept one. [redacted]

[redacted] testified that the Appellant requires 24-hour supervision to keep him safe. The Appellant does not have any natural support to rely on and [redacted] has sent referrals to other agencies for assistance with the Appellant, with no response. [redacted] conceded that the Appellant is not at risk of institutionalization but stated [redacted] cannot continue to provide the support he needs on his budget.

The individual seeking additional services through the exceptions process has the burden of showing that services in excess of the individualized budget are necessary to avoid a risk of institutionalization. There was no testimony or documentation provided to support that additional units of Unlicensed Residential PCS 1:1 would prevent the institutionalization of the Appellant. Additionally, the approval of Unlicensed Residential PCS 1:1 to accommodate 24-hour supervision must be based on need, and not due to the participant's particular residential setting. The Respondent's decision to deny additional services in excess of the Appellant's annual budget is affirmed.

CONCLUSIONS OF LAW

1) Policy allows for the approval of services exceeding an I/DD Waiver participant's approved annual budget if those services are necessary to reduce the participant's risk of institutionalization.

2) The evidence failed to demonstrate that the Appellant required additional Unlicensed Residential Person-Centered Support 1:1 services in excess of his individualized budget to avoid a risk of institutionalization.

3) The Respondent correctly denied the Appellant's request for accommodation to receive services in excess of the Appellant's I/DD Waiver Program budget.

DECISION

It is the decision of the State Hearing Officer to **uphold** the decision of the Respondent to deny the Appellant's request for additional units of Unlicensed Residential Person-Centered Support 1:1 services in excess of his individualized budget.

ENTERED this 3rd day of November 2021.

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Kristi Logan
Certified State Hearing Officer