STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of the Inspector General
Board of Review

Jeffrey H. Coben, MD
Interim Cabinet Secretary

Sheila Lee
Interim Inspector General

March 15, 2023

[redacted]

RE: [redacted], A PROTECTED INDIVIDUAL v. WV DHHR
ACTION NO.: 23-BOR-1258

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 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: Recourse to Hearing Decision
Form IG-BR-29

cc: Bureau for Medical Services, KEPRO

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WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted], A PROTECTED INDIVIDUAL,

Appellant,

v. **Action Number: 23-BOR-1258**

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], a Protected Individual. 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 March 14, 2023, on an appeal filed February 21, 2023.

The matter before the Hearing Officer arises from the February 6, 2023, decision by the Respondent to deny the requested units of Unlicensed Residential Person-Centered Support 1:1 and Behavioral Support-Professional 1 under the I/DD Waiver Program.

At the hearing, the Respondent appeared by Brittany Riggleman, with KEPRO. Appearing as witnesses for the Respondent were Sharla Craig, RN with KEPRO, and Stacy Broce and Lori Tyson with the Bureau for Medical Services. The Appellant appeared by her guardian, [redacted] Appearing as witnesses for the Appellant were [redacted] The witnesses were sworn in, and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Notice of Decision dated February 6, 2023
D-2 Bureau for Medical Services Provider Manual §513.17.4
D-3 Bureau for Medical Services Provider Manual §513.10.1
D-4 Bureau for Medical Services Provider Manual §513.25.4.2
D-5 Bureau for Medical Services Provider Manual §513.8.1
D-6 Bureau for Medical Services Provider Manual §513.28
D-7 Bureau for Medical Services Provider Manual §513.25.2

D-8 I/DD Waiver Exceptions Request Form dated January 18, 2023, Fire Drill Notes, I/DD Waiver Consumer Snapshot from January 2007 – January 2023, and Inventory for Client and Agency Planning dated November 2, 2021
D-9 Individualized Program Plan for Service Year January – December 2023, Habilitation Program and Task Analysis Supports and Programming dated December 15, 2022, and Crisis Plan
D-10 Request for Nursing Services dated December 13, 2022
D-11 Notice of Budget Determination dated November 10, 2022
D-12 I/DD Waiver Structured Interview dated November 2, 2022
D-13 Consumer Snapshot Purchase Details for Service Year January – December 2023
D-14 Inventory for Client and Agency Planning dated November 2, 2022

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 receives services under the I/DD Waiver Program.

2) On November 2, 2022, the Appellant underwent an annual functional assessment and her individualized budget for service year January 1 through December 31, 2023, was determined to be $165,138 (Exhibits D-11, D-12, and D-14).

3) An Exceptions Request was submitted on behalf of the Appellant on January 18, 2023, requesting additional services in excess of the Appellant's individualized budget (Exhibit D-8).

4) On February 6, 2023, the Respondent issued a Notice of Decision advising that the additional units of Skilled Nursing LPN 1:1, Behavioral Support Professional-IPP Planning, Skilled Nursing RN-IPP Planning, Skilled Nursing RN, Transportation Trips and Transportation Miles had been approved (Exhibit D-8).

5) The Respondent denied the request for the additional 35,040 units of Unlicensed Residential Person-Centered Support (PCS) 1:1 and 300 units of Behavioral Support Professional 1 as the Appellant failed to show that the services that can be purchased within the budget were insufficient to prevent a risk of institutionalization (Exhibit D-8).

6) The Respondent approved 21,604 units of PCS 1:2 and 200 units of Behavioral Support Professional 1 (Exhibit D-8).

APPLICABLE POLICY

Bureau for Medical Services Provider Manual Chapter 513 explains eligibility for the I/DD Waiver Program:

513.25.4.2 Service Authorization Process

The Utilization Management Contractor (UMC) will conduct the functional assessment up to 90 days prior to each member's anchor date. If determined medically eligible, the member or their legal representative and case management provider will receive an individualized budget calculated pursuant to the methodology which is available on BMS website. Once the member's budget has been calculated, the member will receive a notice each year that sets forth the member's individualized budget for the Individual Program Plan (IPP) year and an explanation for how the individualized budget was calculated. The UMC, the member, the legal representative, the case manager, 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 member 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 member 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 member 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 member or their legal representative shall notify the UMC through their case manager within 5 days of the assessment date, and the UMC shall resolve the issue by conferring with the member and/or the legal representative to come to an agreement on the answers on the assessment. If the member or their legal representative still disputes the answers on the assessment, then the issue can be appealed through a Medicaid Fair Hearing. The Assessment Data Modification Request (WV-BMS-IDD-13) form must be fully completed must cite the items in question. The member will receive notice of his or her budget calculation, which will include an explanation for how the budget was calculated and instructions for seeking services that cost in excess of the budget. The budget calculation is not a decision about the services the member will be eligible to receive.

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.

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 member and/or the legal representative (or the case manager 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 member or his or her legal representative believe 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 member or his or her legal representative believes the member 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 member's individualized budget. No services for the IPP year will be authorized unless this primary section is completed. The member 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 member's individualized budget is clinically researched and reviewed by BMS. Such request may also be negotiated between the member or their legal representative, the case manager/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 member 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 member 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 member 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 member has met his or her burden to receive services in excess of the budget, the three-person panel shall consider, among other things:

- The member's most recent ICAP, Structured Interview, and all IPPs from the current year.
- Any information provided by the member in his or her application for an exception.
- The feasibility of rearranging services within the member'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 member, and limitations on those supports.

If BMS concludes that the member 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 member safe and healthy and avoid a risk of institutionalization, and the IPP will be finalized. If BMS determines that the member 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 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 member 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. As is stated in the Letter of Denial, a member will have the ability to appeal the decision made through the exceptions process by requesting a Medicaid Fair Hearing. The hearing officer will apply the same standard applied by BMS's exceptions process panel, i.e., whether the member has met his or her burden of showing that services in excess of the individualized budget are necessary to avoid a risk of institutionalization.

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 units of Unlicensed Residential PCS 1:1 and Behavioral Support Professional 1 that was submitted in January 2023 as the documentation did not support that the need for additional units in excess of the budget were necessary to prevent her institutionalization.

The Appellant resides in a 2-person Intensively Support Setting (ISS) with a roommate. [redacted] testified that the Appellant is non-ambulatory and requires total care. [redacted] contended that the Appellant has had a decline in her mental and physical health and the Appellant requires 1:1 care for safety. [redacted] referred to a fire that occurred in the Appellant's home during a shift change and purported that had additional staff not been present, the Appellant and her roommate would not have been able to vacate the home safely with only 1:2 support. [redacted] stated that the Appellant has become combative and will pinch or scratch when agitated and screams throughout the night.

The Respondent argued that there was no documentation submitted with the Exceptions Request to support that the Appellant has had a significant decline in her mental or physical health. There were no changes in her medical condition from previous years and there were no reports submitted to the Respondent's Incident Management System documenting behavioral incidents.

The Appellant and her representatives have the burden of proof to demonstrate that services requested in excess of the approved annual budget are required to prevent institutionalization. There was no documentation submitted to support the claim that the Appellant has experienced a significant change in her mental or physical conditions to warrant the additional services. Without

documentation to confirm a change in the Appellant's medical condition, PCS 1:1 and Behavioral Support Professional services exceeding the annual budget cannot be approved.

Whereas the testimony and documentation failed to support that services requested in excess of the Appellant's individualized annual budget were necessary to prevent institutionalization of the Appellant, the Respondent's decision to deny additional units of PCS 1:1 and Behavioral Support Professional 1 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 has had a significant change in her physical and mental conditions that requires additional services in excess of the individualized annual budget.

3) The Respondent correctly denied the Appellant's request for additional PCS 1:1 and Behavioral Support Professional 1 services.

DECISION

It is the decision of the State Hearing Officer to **uphold** the Respondent's denial of the additional 35,040 units of Unlicensed Residential Person-Centered Support 1:1 and 300 units of Behavioral Support Professional 1 under the I/DD Waiver Program.

ENTERED this 15th day of March 2023.

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Kristi Logan
Certified State Hearing Officer