STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF INSPECTOR GENERAL
Board of Review
State Capitol Complex
Building 6, Room 817-B
Charleston, West Virginia 25305
Telephone: (304) 558-0955 Fax: (304) 558-1992

Bill J. Crouch
Cabinet Secretary

Jolynn Marra
Interim Inspector General

November 21, 2019

[redacted]

RE: [redacted] v. WV DHHR
Action Number: 19-BOR-1333 and 19-BOR-1591

Dear Ms. [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,

Todd Thornton
State Hearing Officer
Member, State Board of Review

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

cc: Kimberly Stitzinger, Esq., Assistant Attorney General

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 19-BOR-1333 and 19-BOR-1591**

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 August 7, 2019, and reconvened on September 18, 2019, on an appeal filed February 22, 2019.

The matters before the Hearing Officer arise from the November 16, 2018 decision by the Respondent to terminate financial eligibility for the Aged and Disabled Waiver Program (ADW), and the February 13, 2019 decision by the Respondent to terminate medical eligibility for ADW services. The effective date of the November 2018 decision by the Respondent was the "…last day of the month of the effective month of closure," (See Applicable Policy, WVIMM, §1.18.9.A.2) or November 30, 2018. The February 22, 2019 request for hearing was 84 days after the effective date of the negative action under appeal, and is therefore timely based on the time limits specified in the Common Chapters Manual (Chapter 700, Common Chapters Manual, §710.16.B.1).

At the hearing, the Respondent appeared by Kimberly Stitzinger, Esq., Assistant Attorney General. Appearing as witnesses for the Department were Tamra Grueser, Jill Metz, and Cindy Rea. The Appellant appeared by [redacted], Esq. Appearing as witnesses for the Appellant were his wife, [redacted], and [redacted]. All witnesses were sworn and the following documents were admitted into evidence.

EXHIBITS

Department's Exhibits:

D-1 Scheduling Order

D-2	2-22-19 hearing request (financial ineligibility determination appeal)
D-3	2-12-19 Financial Ineligibility Determination
D-4	IG-BR-29 with 2-22-19 hearing request (Final Termination/medical ineligibility determination appeal)
D-5	2-13-19 Final Termination/medical ineligibility determination
D-6	10-15-18 review packet to [redacted]
D-7	10-15-18 review packet to [redacted]
D-8	11-16-18 Closure Lack of Review [redacted]
D-9	11-16-18 Closure Lack of Review [redacted]
D-10	Case Comments 11-21-18 to 4-4-19
D-11	11-26-18 ES 6 to [redacted]
D-12	11-26-18 ES 6 to [redacted]
D-13	4-1-19 Application to re-open benefit
D-14	DHS 2 Yellow Financial Eligibility to KEPRO
D-15	Case Comments 2-25-19 to 4-26-19
D-16	IMM Policy Provisions
D-17	Medicaid Income Limits (IMM)
D-18	Chapter 501, ADW provisions
D-19	12-6-18 KEPRO letter to [redacted] to Schedule PAS Appointment
D-20	12-6-18 KEPRO letter to [redacted] to Schedule PAS Appointment
D-21	1-9-19 KEPRO Case Comments re: home visit
D-22	1-10-19 KEPRO letter to [redacted] re: Inability to Complete Assessment
D-23	1-29-19 KEPRO letter to [redacted] re: Inability to Complete Assessment
D-24	1-29-19 KEPRO letter to [redacted] re: Inability to Complete Assessment (duplicate)
D-25	2-14-19 Request from Case Manager to Close ADW services and Discharge from ADW Program

D-26 Screenshot of Molina billing: last services billed by closing agency 11-1-18

D-27 2-19-19 Screenshot CareConnection – not financially eligible

D-28 4-9-19 Medical Eligibility Request

D-29 5-28-19 Medical eligibility determination and MEL notification

Appellant's Exhibits:

A-1 Pest Control Invoice from [redacted]

A-2 Written record of Mr. [redacted] respite and hospital stays

A-3 Dates summary – [redacted]

A-4 Dates summary - [redacted]

A-5 History of evaluations for Waiver Services – 29 pages – Reverse order from January 2019 thru 2014

A-6 KEPRO Records of PAS Assessments, Statements of Medical Necessity and waiver service receipt – 53 pages – Ascending order from 2014 thru latest Statement of Medical Necessity in November 27, 2018

A-7 [redacted] loan documents

A-8 Bank Account statements, [redacted]

A-9 New Waiver Application Materials

A-10 Written Summary of Bills and Medical Bills

A-11 Medicare Summary Notice

A-12 Medicaid review documents
Mailing date: October 15, 2018
Date signed: November 20, 2018
Date scanned: November 21, 2018

A-13 Centers for Medicare & Medicaid Services (CMS) letters
Letter dated May 7, 2015 (Re: Affordable Care Act's Amendments to the Spousal Impoverishment Statute); Appendix B: Participant Access and Eligibility
Letter dated May 8, 2019 (Subject: Additional Extension of the Spousal Impoverishment Rules for Married Applicants and Recipients of Home and Community-Based Services)

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 ADW services.

2) The Appellant's son, [redacted], is the legal representative for the Appellant.

3) By notices dated October 15, 2018, the Respondent notified the Appellant and [redacted] (Exhibits D-6 and D-7) that the Appellant's Medicaid coverage was due for review.

4) These notices (Exhibits D-6 and D-7) were from the [redacted] County DHHR local office and were for review of the financial eligibility for the Medicaid coverage group "MALH" for ADW services.

5) These notices (Exhibits D-6 and D-7) read, "Your Medicaid/WV CHIP Coverage is due for review by 11/30/2018."

6) The notices (Exhibits D-6 and D-7) include the review instructions and the review forms.

7) The notices (Exhibits D-6 and D-7) indicate the review may be completed by mail, online, or in person. The option to complete by mail reads, "Complete this form and mail it to the local DHHR office listed above by 11/01/2018."

8) The notices (Exhibits D-6 and D-7) additionally read, "Sign and return the form by 11/01/2018 or complete it online at wvinroads.org. If you do not return the form by this deadline, you will lose your benefits coverage effective 11/30/2018."

9) The Appellant did not return the completed review form by the November 1, 2018 deadline.

10) By notices dated November 16, 2018 (Exhibits D-8 and D-9), the Respondent advised the Appellant that "Your Medicaid benefit(s) is/are being closed. You will receive your last benefit in the month your certification period expires, November 2018."

11) These notices (Exhibits D-8 and D-9) provided the reason for this action as the failure of the Appellant to complete an eligibility review.

12) The Appellant submitted the review form on November 20, 2018, and the review was processed on November 21, 2018. (Exhibits A-12 and D-10)

13) The processing of the Appellant's review required additional information, and the Respondent advised the Appellant of the information needed by notices dated November 26, 2018 (Exhibits D-11 and D-12).

14) These notices (Exhibits D-11 and D-12) set a due date of December 1, 2018 for the Appellant to provide verification of the value of the checking accounts for the Appellant and his wife.

15) The Appellant did not provide the required verifications by the December 1, 2018 deadline.

16) The Appellant's financial eligibility for the Medicaid coverage group for ADW services ended effective November 30, 2018. (Exhibits D-6 and D-7)

17) By notices dated December 6, 2018 (Exhibits D-19 and D-20) the Respondent advised the Appellant and [redacted] of a scheduled assessment of the Appellant's medical eligibility for ADW services.

18) These notices (Exhibits D-19 and D-20) were from KEPRO, the Utilization Management Contractor (UMC) for the Respondent's Bureau for Medical Services and set an appointment date of January 9, 2019 for a KEPRO nurse to assess the Appellant in his home.

19) The Appellant did not participate in the assessment of his medical eligibility for ADW services on January 9, 2019.

20) By notices dated January 10, 2019 and January 29, 2019 (Exhibits D-22, D-23 and D-24) the Respondent advised the Appellant of the missed appointment.

21) These notices (Exhibits D-22, D-23 and D-24) read, "KEPRO has received a referral to complete an assessment for evaluation of your medical necessity for waiver services. A nurse has recently attempted to contact you to schedule your evaluation. We are unable to complete the assessment because you were not available to schedule the appointment."

22) These notices (Exhibits D-22, D-23 and D-24) provided a phone number for the Appellant to contact the Respondent's UMC for rescheduling the medical assessment.

23) The Appellant's home was billed for treatment of a bedbug infestation in his home, with a service date of January 3, 2019. (Exhibit A-1)

24) The Appellant was hospitalized at [redacted], [redacted], [redacted], and [redacted] during the months of January and February 2019. (Exhibits A-4, A-10 and A-11)

APPLICABLE POLICY

The policy regarding financial eligibility for Medicaid – and, specifically, ADW services – is contained in the West Virginia Income Maintenance Manual (WVIMM).

Chapter 24 of the WVIMM addresses Long Term Care, and at §24.28 the manual specifies common waiver information for ADW and other waiver categories, and reads, "Waiver coverage groups use the same common eligibility requirements as Supplemental Security Income (SSI)-Related Medicaid. See Chapter 2." Additionally, the determination of which income sources to count is the same as SSI-Related Medicaid (§24.30) and the determination of countable asset sources is the same as for SSI-Related Medicaid (§24.31). At §24.37.4, policy addresses the redetermination process for ADW financial eligibility and reads:

> A redetermination of eligibility is completed once a year; a face-to-face interview is not required. The Worker receives an alert in the eligibility system when a redetermination is due. The Worker must manually set an alert to schedule the redetermination for SSI and Deemed SSI waiver clients. The same financial criteria used at application applies at each annual redetermination. Medical necessity must be verified annually at redetermination with a Notice of Decision letter or document from the UMC stating the client continues to be eligible. If the client continues to meet financial and medical requirements, Medicaid eligibility for waiver services is established. Continued medical eligibility for services is monitored by the Bureau for Medical Services (BMS).

Chapter 1 of the WVIMM, at §1.2.2, provides an overview of the eligibility determination process and, at §1.2.2.B, addresses the redetermination process as follows:

> 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…

At §1.2.4, policy addresses the client responsibility in the eligibility determination and redetermination process, and reads, "The client's responsibility is to provide complete and accurate information about his circumstances so that the Worker is able to make a correct determination about his eligibility."

At §1.2.11, WVIMM policy regarding redeterminations reads, "Each program and Medicaid coverage group has its own policies related to redetermination. Please see the program-specific sections for details." At §1.2.11.A, policy regarding redeterminations submitted by mail reads:

> Clients of some Medicaid coverage groups, WVCHIP, and other programs receive an instruction letter and redetermination form that is submitted by mail, along with appropriate verifications. The client must complete, sign, and mail or bring

> the form and other required information to his local DHHR office or the Customer Service Reporting Center as directed by the letter. The client may always request a face-to-face interview.

Program-specific policy for the SSI-Related Medicaid coverage group is located in §1.18 of the WVIMM, and at §1.18.9.A.2 reads, "The ending date of eligibility is the last day of the month of the effective month of closure."

The policy regarding medical eligibility for ADW services is contained in the Bureau for Medical Services' Provider Manual, Chapter 501. At §501.6, this policy reads as follows (emphasis added):

> Applicants for the ADW program must meet all of the following criteria to be eligible for the program:
> - Be 18 years of age or older.
> - Be a permanent resident of West Virginia. The individual may be discharged or transferred from a nursing home in any county of the state, or in another state, as long as his/her permanent residence is in West Virginia.
> - **Meet the Medicaid Waiver financial eligibility criteria for the program** as determined by the county DHHR office, or the Social Security Administration (SSA), if an active SSI (Supplemental Security Income) recipient.
> - **Be approved as medically eligible** for nursing home level of care and in need of services.
> - Choose to participate in the ADW program as an alternative to nursing home care.

Chapter 501 reiterates the policy requirement for both financial and medical eligibility as conditions of ADW eligibility from initial application to enrollment. Applicants to the ADW Program "…must complete financial eligibility before they can proceed with medical eligibility." (§501.7) When a slot becomes available for ADW services, "continued financial eligibility must be confirmed…" and "**ADW services cannot be paid until an applicant's financial eligibility is established** and the enrollment process has been completed with the OA. (Refer to Section 501.10 Enrollment)" (§501.8, emphasis added) Finally, "Once an applicant has been determined both financially and medically eligible, the case manager, if applicable, must request program enrollment from the OA by completing an Enrollment Request Form." (§501.10)

BMS policy addresses medical reevaluations at §501.9.3, and reads, "Annual reevaluations for medical eligibility for each person on the ADW must be conducted…After receiving the reevaluation request, the UMC will attempt to contact the person (or legal representative) to schedule an assessment, allowing at least two weeks notification…If the UMC is unable to contact the person (or legal representative) within three attempts, a Potential Closure letter will be sent to the member (or legal representative)…If no contact is made with the UMC within 10 business days of the date of the Potential Closure letter, the UMC will send the Final Denial letter to the person (or legal representative)…"

DISCUSSION

The Appellant has appealed the Respondent's decision to terminate ADW eligibility. ADW eligibility comprises both a financial eligibility component and a medical eligibility component. Both components are required for ADW services to be approved. The Respondent must prove by a preponderance of the evidence that the Appellant did not establish ADW eligibility by either the failure to meet the financial eligibility components or the failure to meet medical eligibility components.

The Respondent notified the Appellant of his upcoming review of ADW financial eligibility on October 15, 2018, with instructions to return the completed review form by November 1, 2018. The Appellant did not complete the form and return it by November 1, 2018. On November 16, 2018, the Respondent advised the Appellant that his Medicaid benefits (under the coverage group for ADW services) would be terminated on November 30, 2018. The Appellant submitted the review form after this closure letter, on November 20, 2018. However, submitting the review form does not constitute completion of the review process in all instances. Arguably part of the intent in setting a deadline for recipients to return the review form (November 1, 2018) so far in advance of the last day of Medicaid coverage (November 30, 2018) is to allow for the Respondent's adverse notification requirements and to allow the Appellant time to provide verifications that may be deemed necessary after the Respondent processes the review form.

Because of changes in the Appellant's financial circumstances, additional verifications were necessary in the Appellant's case to determine financial eligibility and to complete the review process. Testimony on the Appellant's behalf contended that the Appellant's wife and son knew what the necessary verifications would be and provided them two times – first with the review form submitted on November 20, 2018, and a second time after the Respondent's verification request letter sent November 26, 2018.

This testimony is particularly unconvincing for several reasons. First, the Appellant's son claimed to have turned in the review form with the necessary verifications attached, in a drop box at the [redacted] County DHHR Office. The Respondent received, scanned and processed the review form, but had no record of receiving any verifications with it. The Appellant speculated that the review form and the attached verifications could have become separated in the drop box, but this is also unconvincing as the verifications were checking account statements with identifiers that would have easily allowed the Respondent to recompile them with the correct review form. Second, the Appellant's wife claimed to have turned in the required verifications but specifically admitted in testimony that her memory was not reliable. Finally, the policy for the ADW Medicaid coverage group – especially the policy, exceptions and special considerations regarding the treatment of assets – is complex enough that local DHHR offices generally dedicate a specialized unit of workers who are familiar with the policy. For this reason, it is extremely unlikely that a layperson – even a person who has completed prior ADW reviews – would know what verifications would be necessary without communicating with a worker with specialized training in Long Term Care Medicaid. The Respondent correctly terminated the Appellant's financial eligibility for the ADW Medicaid coverage group for failure to complete the review process.

Without financial eligibility for the ADW Medicaid coverage group, the Appellant was not eligible for ADW services. However, the Bureau for Medical Services contracts with its UMC KEPRO to administer the medical eligibility for ADW services, and KEPRO proceeded to schedule an assessment of medical eligibility with the Appellant. When the Appellant did not complete this assessment with the KEPRO nurse, the Respondent sent two letters advising the Appellant that the assessment could be rescheduled if requested. The Respondent may have been following these procedures out of caution because the Bureau for Medical Services or KEPRO were unaware of the Appellant's terminated financial eligibility, but even an assessment resulting in a favorable medical eligibility determination would not have resolved the issue for the Appellant at this point. ADW applicants and recipients must establish both financial and medical eligibility to receive ADW services. The Respondent was correct to terminate the Appellant's medical eligibility for ADW services based on the failure to complete a medical assessment.

The Appellant requested payment for costs incurred while Medicaid coverage was closed. Because the Respondent properly closed the Appellant's Medicaid coverage, there is no provision for such a payment.

CONCLUSIONS OF LAW

1) Because the Appellant did not provide the verifications necessary to complete the review process for financial eligibility of the ADW Medicaid coverage group, the Appellant was financially ineligible, and the Respondent was correct to terminate the Appellant's Medicaid.

2) Because the Appellant did not complete an assessment of medical eligibility for ADW services, the Appellant was medically ineligible, and the Respondent was correct to terminate the Appellant's ADW services.

3) ADW policy requires both medical and financial eligibility, and, without either, the Respondent was correct to discontinue the Appellant's participation in the ADW Program.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to terminate ADW services based on determinations of financial and medical ineligibility.

ENTERED this ____Day of November 2019.

_____

Todd Thornton
State Hearing Officer