State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
P.O. Box 1736
Romney, WV 26757

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

November 30, 2006

_____
_____
_____

Dear Ms. _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held November 13, 2006. Your hearing request was based on the Department of Health and Human Resources' proposed action to deny your son Medicaid coverage under the Children with Disabilities Community Services Program (CDCSP) based on cost-effectiveness.

In arriving at a decision, the State Hearings 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.

Eligibility for the Children with Disabilities Community Services Program (CDCSP) is based on current policy and regulations. Some of these regulations state that services are restricted by limits as set in the Medicaid State Plan. Services must be cost-effective when compared to the cost of services in an ICF\MR. [WV DHHR Eligibility Guide for Children with Disabilities Community Services Program (September 1, 1994), West Virginia Income Maintenance Manual, Chapter & 1.19, 42 U.S.C § 1396a(e)(3) and 42 CFR § 435.225.]

The information submitted at your hearing reveals that the average cost of your son's in-home medical expenses submitted to determine cost feasibility is less than the established standard for ICF/MR facility care.

It is the decision of the State Hearing Officer to **reverse** the action of the Department to deny Medicaid coverage through the Children with Disabilities Community Services (CDCSP) Program.

Sincerely,

Sharon K. Yoho
State Hearing Officer
Member, State Board of Review

cc: Erika H. Young, Chairman, Board of Review
Susan Striar May, B.M.S.

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

____ _____,
By: _____ _____

Claimant,

v. **Action Number: 06-BOR-2538**

West Virginia Department of
Health and Human Resources,

Respondent.

DECISION OF STATE HEARING OFFICER

I. INTRODUCTION:

This is a report of the State Hearing Officer resulting from a fair hearing concluded on November 13, 2006 for ____ _____. This hearing was held in accordance with the provisions found in the Common Chapters Manual, Chapter 700 of the West Virginia Department of Health and Human Resources. This fair hearing was convened on November 13, 2006 on a timely appeal, filed July 26, 2006.

II. PROGRAM PURPOSE:

The Program entitled Children with Disabilities Community Services Program (CDCSP) is set up cooperatively between the Federal and State governments and administered by the West Virginia Department of Health & Human Resources.

The Children with Disabilities Community Service Program provides medical services for disabled children who would otherwise be at risk of institutionalization so that they may reside in their family homes. The medical services must be more cost effective for the State than placement in a medical institution such as a nursing home, ICF/MR facility, acute care hospital or approved Medicaid psychiatric facility for children under the age of 21.

III. PARTICIPANTS:

Claimant's Witnesses:
_____ _____, Claimant's mother
_____ _____, Claimant's father
[redacted] Service Coordinator, Birth To Three
[redacted] Claimant's nurse, Birth To Three
[redacted] Developmental Specialist, Birth To Three

Department's Witnesses:
Susan Striar May, Bureau of Medical Services

Presiding at the Hearing was Sharon K.Yoho, State Hearing Officer and a member of the State Board of Review.

IV. QUESTIONS TO BE DECIDED:

The question to be decided is whether the Department was correct in their decision to deny Medicaid coverage under the CDCSP Program.

V. APPLICABLE POLICY:

WV DHHR Eligibility Guide for Children with Disabilities Community Services Program (September 1, 1994)
West Virginia Income Maintenance Manual, Chapter 1.19
42 U.S.C. 139a (e) (3)
42 CFR 435.225

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 Memorandum dated June 27, 2006 addressing denial
D-2 WVDHHR Eligibility Guide for Children with Disabilities Community Services Program (September 1, 1994).
D-3 Related hearing decision by Hearing Officer Tom Arnett
D-4 Cost Estimate Worksheet for CDCSP
D-5 Itemized listing of in home care costs billed by [redacted] Home Therapies
D-6 Invoices of Interim Healthcare billed costs
D-7 Billed amounts from Birth To Three program
D-8 Prescription medical expenses
D-9 Hospital Billing from UHA
D-10 Vision Therapy Equipment billing
D-11 Emergency Ambulance billing
D-12 [redacted] Hospital billing
D-13 Letter from [redacted] Health Care System dated March 2, 2006

VII. FINDINGS OF FACT:

1) On or near the end of March, 2006, the Bureau for Medical Services, hereinafter B.M.S. received an application packet submitted on behalf of ____ _____ for the purpose of determining eligibility for participation in the Children with Disabilities Community Services Program, hereinafter CDCSP. The Department must insure that the costs of covered medical services provided for a child residing in his home do not exceed the cost of care for that child in an ICF/MR facility. Policy identifies ICF/MR facility cost

to be $5,400 monthly or $64,800 annually. Ms. Striar May verbalized an upgrade to this cost to $6,400 or $76,800 annually.

2) All submitted annual medical costs were considered in their entirety by B.M.S. to produce a figure of $187,000 in total billed amounts for this claimant. B.M.S. then compared the $187,000 to the $76,800 annual cost of care for an ICF/MR facility care to determine that cost feasibility was not met and the applicant was ineligible. The Department sent a memorandum, Exhibit (D-1), dated June 27, 2006, to the County Community Services Manager. This memorandum stated: "According to all the documentation submitted, Isaac's monthly average costs are more than the **same services** (emphasis added) delivered in an institution and are not cost effective."

3) The portion of the $187,000 in medical cost which was for medical services provided outside of an institution was $69,048.14 which falls below the $76,800 ICF/MR facility cost of care. The remainder of the submitted billed charges was for hospital care and for numerous surgeries. These surgeries were for both diagnostic reasons and for correction to birth defects.

4) The claimant's medical expenses for months April 2005 thru March 2006 which were provided outside of an institution were documented as:

Care Partners Home Therapies	$35,944.61	Exhibit (D-5)
Interim Health Care	$13,915.25	Exhibit (D-6)
Birth To Three services	$10,489.21	Exhibit (D-7)
Prescription / Pharmacy	$ 8,430.07	Exhibit (D-8)
Vision Therapy Equipment	$269.00	Exhibit (D10)
Total	$69,048.14	or $5754.01 monthly

5) The claimant and witnesses addressed concerns regarding the Department using hospital charges when comparing the cost of care outside of an ICF/MR facility to the cost of care in an ICF/MR facility. Ms. Striar May responded with testimony explaining that if a resident of an ICF/MR facility were to need hospitalization, the Department would not pay for care in both the hospital and the ICF/MR facility for the same time period.

7) The "cost feasibility," according to testimony offered by the Department, is determined by using the past twelve months "billed amount" to determine the average monthly cost of medical care. Mrs. Striar May also explained that the full "billed amount" is considered because it prevents deductions in medical expenses that would create an unfair advantage to individuals who have resources, insurance or private pay, to bring monthly medical expenses under the cost feasibility amount. Further, it is unreasonable for the Department to convert billed expenses to the amount Medicaid pays on every case. The "billed amount" is fair and consistently applied to all applicants/recipients.

8) Some testimony was given by the claimant's witnesses and by the Department regarding an application date of August 2005. Indications are that [redacted] Health Care Systems may have failed to send the packet to the Department in August and or failed to follow up when the claimant's mother advised that she had not heard back from the Department. It is clear that B.M.S. could find no information regarding this claimant prior to the March 2006 packet being received.

9) The WVDHHR Eligibility Guide for Children with Disabilities Community Services Program (September 1, 1994) states:

> Covered Medicaid services as appropriate and medically necessary must be cost-effective when compared to the cost of facility-based care. Cost of services in an ICF/MR $5,400 / month. (new amount not in manual yet, $6,400 / month.)

10) West Virginia Income Maintenance Manual, Chapter 1.19(A) states that the following forms must also be completed as part of the eligibility determination process for the CDCSP Program. This information is sent directly to BMS by the Case Management Agency.

- Form DD-2A: This is the medical form the child's physician uses to submit necessary information to allow a determination of medical eligibility.

- DD-6: Cost estimate worksheet for medical services that must be completed and used by the Case Management Agency:

  - Assure the program plan is cost feasible, i.e., community services cost less than placement in a medical institution; and

  - Follow through with the school system, health care providers and other agencies to assure that the community services are implemented and consistently remain cost-effective.

  - Program Plan: The program plan must be developed by an interdisciplinary team (IDT) consisting of the child, family or legal representative, service providers, advocates, professionals, paraprofessionals and other stakeholders needed to ensure the delivery of the necessary level of services. This contains the same elements of the State DD-5 form.

  - Evaluations: Additional evaluations, as appropriate, to determine medical eligibility and services for the specific disability group such as psychological or psychiatric reports, social assessments, discharge plan, etc.

11) The Federal Code of Regulations, found at 42 CFR § 435.225, states that individuals under age 19 who would be eligible for Medicaid if they were in a medical institution.

> (a) The agency may provide Medicaid to children 18 years of age or younger who qualify under section 1614(a) of the Act, who would be eligible for Medicaid if they were in a medical institution, and who are receiving, while living at home, medical care that would be provided in a medical institution.

> (b) If the agency elects the option provided by paragraph (a) of this

section, it must determine, in each case that the following conditions are met:

1) The child requires the level of care provided in a hospital, SNF, or ICF.

2) It is appropriate to provide that level of care outside such an institution.

3) The estimated Medicaid cost of care outside an institution is no higher than the estimated Medicaid cost of appropriate institutional care.

(c) The agency must specify in its State plan the method by which it determines the cost-effectiveness of caring for disabled children at home.

12) Regulations found at 42 USC § 1396a (e) (3) state:

(3) At the option of the State, any individual who-

(A) Is 18 years of age, or younger and qualifies as a disabled individual under section 1382c (a) of this title;

(B) With respect to whom there has been a determination by the State that-

(i) the individual requires a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded,

(ii) it is appropriate to provide such care for the individual outside such institution, and

(iii) the estimated amount which would be expended for medical assistance for the individual for such care outside an institution is not greater than the estimated amount which would otherwise be expended for medical assistance for the individual within an appropriate institution; and

(C) If the individual were in a medical institution, would be eligible for medical assistance under the State plan under this subchapter,

shall be deemed, for the purposes of this subchapter only, to be an individual with respect to whom a supplemental security income payment, or State supplemental payment, respectively, is being paid under subchapter IVI of this chapter.

VIII. CONCLUSIONS OF LAW:

1) WVDHHR CDCSP policy of September 1, 1994 states that the covered medically necessary services must be cost effective when compared to the cost of facility-based care. This policy does not dictate a clear and specific manner in which to determine cost effectiveness. The Department's representative did advise that hospital services and ICF/MR services would not be paid for the same period. Therefore; if he were an ICF/MR resident while he is in the hospital, Medicaid would be paying for his hospital stay and NOT his ICF/MR stay for those days. If he was not residing in an ICF/MR and had to be hospitalized, Medicaid would be paying for his hospital stay and NOT his in-home care (the care that would otherwise be provided in an ICF/MR). Either way, Medicaid pays for the hospital stay, so the hospital costs should not be considered when the Department is looking at what was spent on services that he would have received in an ICF/MR as compared to what would be spent on those services if he were not in an ICF/MR. It is clear that it would be more cost effective for this child to reside in his home as opposed to an ICF/MR facility.

2) Federal Regulations 42-CFR-§435.225 (c) states:

> "The estimated Medicaid cost of care outside an institution is no higher than the estimated Medicaid cost of appropriate institutional care. The agency must specify in its State plan the method by which it determines the cost-effectiveness of caring for disabled children at home."

This policy refers to costs of care outside an institution. The WVDHHR written policy for the CDCSP program has failed to clearly state its method by which to determine cost-effectiveness. The memo, Exhibit (D-1) does indicate that the services outside of a facility must be compared to the **same services** (emphasis added) delivered in an institution. Surgeries and related care are not service that would be delivered in an ICF/MR facility and therefore should not be considered when determining cost effectiveness.

3) Regulations 42-USC §1396a states that:

> "the estimated amount which would be expended for medical assistance for the individual for such care outside an institution is not greater than the estimated amount which would otherwise be expended for medical assistance for the individual within an appropriate institution."

Surgeries clearly are not services that can be expended outside an institution and would not otherwise be expended within an ICF/MR facility. It is clear that these billed hospital charges should not be considered when determining cost effectiveness when the comparison is being made with the cost of care inside an ICF/MR facility.

4) Policy is clear in the Federal Code of Regulations and in the United States Code that Hospital billed amounts should not have been considered in this case to determine cost effectiveness. B.M.S. policy and State plan is governed by these codes and it fails to specify clearly the method by which it determines the cost-effectiveness for caring for disabled children at home. This has led to varied interpretations of the CDCSP policy as it is written in Exhibit (D-2).

IX. DECISION:

It is the decision of the State Hearing Officer to **reverse** the action of the Department to deny this claimant's participation in the CDCSP Program.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 30th Day of November, 2006.

_____

Sharon K. Yoho
State Hearing Officer