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

May 5, 2006

_____
By: _____
_____
_____

Dear Ms. _____ _____:

Attached is a copy of the findings of fact and conclusions of law on your hearing held April 4, 2006. Your hearing request was based on the Department of Health and Human Resources' proposed action to discontinue your son's 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 facility-based care. [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) and 42 CFR § 435.225.]

The information submitted at your hearing reveals that the projected 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 discontinue 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-919**

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 April 4, 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 April 4, 2006 on a timely appeal, filed January 17, 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
____, Friend
[redacted] Advocate

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 discontinue 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 January 6, 2006 addressing denial.
D-2 WVDHHR Eligibility Guide for Children with Disabilities Community Services Program (September 1, 1994).
D-3 Related hearing decision dated December 7, 2005
D-4 Letter to Bureau of Medical Services dated September 28, 2005
D-5 Cost Estimate Worksheet for CDCSP received August 3, 2005
D-6 Memorandum dated October 28, 2005 of pending re-certification
D-7 Cost Estimate Worksheet for CDCSP received November 28, 2005
D-8 Member History Profile of Medical Expenses billed

Claimant's Exhibits:

C-1 Estimate sheet created by claimant comparing actual charges with estimated current ICF/MR facility rates.
C-2 Letter from _____'s physician, [redacted] dated April 3, 2006
C-3 Prescription cost history February 10, 2005 thru June 30, 2005.
C-4 Record of Private Insurance payments February 8, 2005 thru December 29, 2005
C-5 Statement from advocate, [redacted] of information gathered regarding current ICF/MR rates

VII. FINDINGS OF FACT:

1) On August 3, 2005, the Bureau for Medical Services, hereinafter BMS, received a Cost Estimate Worksheet submitted on behalf of _____ for the purpose of determining continued eligibility for participation in the Children with Disabilities Community Services Program, hereinafter CDCSP. The Department must insure that the costs of covered medical services needed for a child residing in his home do not exceed the cost of care in an ICF/MR facility. Policy identifies ICF/MR facility cost to be $5,400 monthly or $64,800 annually.

2) The submitted Worksheet (Exhibit D-5) received August 3, 2005 documented Mr. _____'s previous year's expenses to be $74,388.40. This amount included only a partial year's expense for some of his medication. The claimant's physician had provided some samples free of charge during the year. Ms. Striar May concluded that if the full prescription needs had been billed, the **$74,388.40** would be elevated to **$74,904**.

3) [redacted] Service Coordinator, at [redacted] Health Care Services sent a letter of explanation to the Bureau for Medical Services, which was received on October 19, 2005. The letter advised the Department of changes in Mr. _____'s services that reflected a decrease in costs when compared to the previous year. The Office of Behavioral and Alternative Health Care issued a memo (Exhibit D-6) on October 28, 2005 to [redacted] Service Coordinator, at [redacted] Health Care Services requesting an updated Cost Estimate Worksheet that includes all projected expenses including school services (e.g. case management, transportation, etc.).

4) On November 28, 2005, B.M.S. received the updated Cost Estimate Worksheet (Exhibit D-7) reporting projected estimated annual expenses of $63,680. This total excluded $8,500 for discontinued expenses for private occupational and physical therapy, which Mr. _____ was not benefiting from. It also excluded $1,195 for two prescription drugs that Ms. _____ believes she will continued to obtain free of charge by way of samples from her son's physician. This new annual cost however did include $2,160 for occupational therapy that is now provided by the school system free of charge.

If the above cost of $63,680. were given the adjustments mentioned above, the estimated annual cost would be **$62,715.**

$63,680
+ 1,195 for partial cost of prescriptions that could be free with samples. It is unrealistic to depend on free samples for a full year.
- 2,160 for occupational therapy now free through the school system.
=$62,715

5) The Department issued a termination notice on January 6, 2006. This action was taken due to the reported costs on the August 3, 2005 work-sheet exceeded the cost identified in policy for an ICF/MR facility.

6) Advocate [redacted] submitted a signed statement regarding a conversation he had with Kristy Byrd of Office of Behavioral Health (OBHS). He reports that Ms. Byrd advised him that the current average ICF/MR monthly cost being utilized by the OBHS is $6,400. The monthly amount used in DHHR policy is $5,400. or ($64,800).

7) The "cost feasibility," according to testimony offered by the Department, is determined by using the past "billed amount" to determine the projected expenses. Ms. Striar May stated that even though full prescription cost were not billed due to some free samples being provided, the free samples cannot be

expected and the cost of these medications must be considered as a future cost. 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) The annual adjusted and projected cost of $62,715 above is less than the ICF/MR cost of $64,800. as specified in policy.

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.

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 identifies covered Medicaid services to be that which is appropriate and medically necessary. This policy does not dictate a clear and specific manner in which to identify the cost. Federal Regulations 42-CFR-§435.225 uses the term "estimated Medicaid cost". Regulations 42-USC §1396a refers to, "the estimated amount which would be expended for Medicaid assistance". Valley Health Care Services abided by the directives given to them in the October 28, 2005 memo from the Office of Behavioral and Alternative Health Care. The Service Coordinator provided an (updated Cost Estimate Worksheet that includes all projected expenses). Ms. Striar May stated during the hearing that prescription cost not billed in the previous year due to free samples, should be considered in the cost estimate in determining eligibility for the future. This indicates that projected expenses are what are to be considered. It is clear that the estimated projected expenses, which would be expended is what should be looked at in determining future eligibility. These projected expenses were outlined in the Cost Estimate work-sheet (Exhibit D-7). The expenses, which Mr. _____ clearly would no longer have, were omitted as an expense the future.

2) After adjustments in the November 28, 2005 cost estimate for reasonable prescription costs and for occupational therapy, the projected annual costs of $62,715. is clearly below the $5,400. monthly or $64,800. annually which is stipulated in policy.

3) The Department's procedure in this case of using the past "billed amount" and then requesting and considering the projected expenses is proper in determining the most accurate estimated future expense. This method is fair and consistent for applicants and recipients of the CDCSP Program when determining cost feasibility.

IX. DECISION:

It is the decision of the State Hearing Officer to **reverse** the proposed action of the Department to discontinue 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 8th Day of May, 2006.

_____

Sharon K. Yoho
State Hearing Officer