State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
2699 Park Avenue, Suite 100
Huntington, WV 25704

Earl Ray Tomblin
Governor

Michael J. Lewis, M.D., Ph. D.
Cabinet Secretary

May 14, 2012

Dear -----:

Attached is a copy of the Findings of Fact and Conclusions of Law for ----- hearing held February 29, 2012. The hearing request was based on the Department of Health and Human Resources' denial of requested Respite Services under the Intellectual and Developmental Disabilities (I/DD) Waiver Program.

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.

Eligibility for services under the I/DD Waiver Program is based on current policy and regulations. Policy for the requested service states that all units of service must be prior authorized before being provided, and that prior authorizations are based on assessed need and services must be within the member's individualized budget (West Virginia Medicaid Provider Manual, Chapter 513 – I/DD Waiver Services, effective October 1, 2011; §513.9.1.10.1).

Information and testimony submitted at the hearing established the Department's denial was not based on budget considerations, but instead on clinical need. For this reason, clinical need cannot be discounted for budgetary reasons. Information and testimony submitted at the hearing established justification for a one-to-one (1:1) ratio in Respite Services. Based on this, the undiscounted level of 6,912 annual units of respite requested is approvable at the 1:1 ratio.

It is the decision of the State Hearing Officer to **reverse** the Department's denial of a request for 6,912 annual units of Respite Services, at a 1:1 ratio, through the I/DD Waiver Program.

Sincerely,

Todd Thornton
State Hearing Officer
Member, State Board of Review

cc: Erika H. Young, Chairman, Board of Review
[redacted] West Virginia Advocates
Pat Nisbet, Department Representative
Jennifer Eva, Department Representative

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

IN RE: **-----,**

Claimant,

v. **ACTION NO.: 12-BOR-333**

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 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 February 29, 2012, on a timely appeal, filed December 22, 2011.

II. PROGRAM PURPOSE:

The Intellectual and Developmental Disabilities (I/DD) Waiver Program is West Virginia's home and community-based services program for individuals with intellectual and/or developmental disabilities. It is administered by the Bureau for Medical Services pursuant to a Medicaid waiver option approved by the Centers for Medicare and Medicaid (CMS). The I/DD Waiver Program reimburses for services to instruct, train, support, supervise, and assist individuals who have intellectual and/or developmental disabilities in achieving the highest level of independence and self-sufficiency as possible. The I/DD Waiver Program provides services in natural settings, homes and communities where the individual resides, works and shops.

III. PARTICIPANTS:

[redacted] Claimant's representative
-----, Claimant's witness
-----, Claimant's witness
Pat Nisbet, Department's representative
Jennifer Eva, Department's representative

Presiding at the hearing was Todd Thornton, State Hearing Officer and a member of the State Board of Review.

All participants offering testimony in the hearing were placed under oath.

IV. QUESTION TO BE DECIDED:

The question to be decided is whether or not the Department was correct in its determination of clinically necessary services for the Claimant under the I/DD Waiver Program.

V. APPLICABLE POLICY:

West Virginia Medicaid Provider Manual, Chapter 513 – I/DD Waiver Services, effective October 1, 2011

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 West Virginia Medicaid Provider Manual, Chapter 513 – I/DD Waiver Services, §513.9.1.10.1
D-2 Denial notice dated December 12, 2011
D-3 Budget document for Claimant, service start dates of December 1, 2011
D-4 Letter dated December 7, 2011

VII. FINDINGS OF FACT:

1) The Claimant, who is a 28-year old recipient of I/DD Waiver Services, received notification of denial for requested services through the program (Exhibit D-2) on or about December 12, 2011. This notice provided the denial reason as "Your request is not determined to be clinically necessary." The notice specified the Claimant's request as 6912 units of *Respite – Agency (1:1)*, with a service code of T1005U1. Under the heading "Approvable Units," the notice states:

> Up to 4,380 units per service year of T1005U1 or up to 6,912 of Respite-Agency (1:2) T1005U5 due to two members living in the home

2) Jennifer Eva, a representative for the Department employed by APS Healthcare (an agency administering aspects of the I/DD Waiver Program for the Department), presented the appropriate policy for this matter (Exhibit D-1) from the West Virginia Medicaid Provider Manual, Chapter 513 – I/DD Waiver Services, effective October 1, 2011. At §513.9.1.10.1, this policy addresses Respite Services as follows:

513.9.1.10.1 Respite: Agency: Traditional Option

Procedure Code: T1005-U1 1:1 ratio
T1005-U5 1:2 ratio
T1005-U6 1:3 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed day program facility and public community locations. When this service is provided in a home setting other than the member's, the home setting must be a certified Specialized Family Care Home.

Definition of Service:

Respite: Agency services are specifically designed to provide temporary substitute care normally provided by a family member or a Specialized Family Care Provider. The services are to be used for relief of the primary care-giver(s) to help prevent the breakdown of the primary care-giver(s) due to the physical burden and emotional stress of providing continuous support and care to the dependent member. Respite Services consist of temporary care services for an individual who cannot provide for all of their own needs.

Respite Agency services may be used to:

- Allow the primary care-giver to have planned time from the caretaker role;
- Provide assistance to the primary care-giver in crisis and emergency situations; and
- Ensure the physical and/or emotional well-being of the primary care-giver by temporarily relieving them of the responsibility of providing care.

Agency staff providing Respite: Agency services may attend and participate in IDT meetings and the annual functional assessment for

eligibility conducted by ASO if requested by the member or their legal representative.

Documentation:

Documentation must be completed on the Direct Care Service Log (WV-BMS-I/DD-07) to include the items listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues the agency staff should complete the accompanying Direct Care Progress Note to detail the issue. The Direct Care Service Log must include all of the following items.

- Member's Name
- Service Coordination Provider Name
- Month of Service
- Year of Service
- Day of Service
- Service Code including modifier to indicate staff to member ratio
- Start time
- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- Respite: Agency services are not available to members living in ISS or licensed group home settings.
- Respite: Agency services are not to replace natural supports available to the member.
- Respite: Agency services may not be provided by an individual living in the member's own or family residence in which the member resides or within the Specialized Family Care Home where the member resides.
- Respite: Agency is not available in medical hospitals, nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.
- Up to 48 units/12hours of Respite Services every three months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral

intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may bill for providing training to staff providing Respite: Agency Services.

- Respite: Agency Services may not be provided in an ICF/MR facility,
- 6,912 units/1,728 hours per year (averages out to 144 hours/month or 4.73 hours/day) per member's annual IPP year.
- This service may not be billed concurrently with any other direct care service.
- Agency staff to member ratios for this service are 1:1, 1:2, and 1:3.
- Only 1:1 or 1:2 ratios are allowed to be utilized in a member's family residence or in a Specialized Family Care Home.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met.

3) Patricia Nisbet, a representative for the Department's Bureau for Medical Services, testified that the Claimant was notified that the request was determined to be not clinically necessary. This determination was based in part on a budget document (Exhibit D-3) showing approved services for the Claimant, which includes 3,132 units of *Person-Centered Support – Agency* (PCS-A) and 8,784 units of *Person-Centered Support – Family*. Ms. Nisbet testified that this represents* PCS-A at the rate of 3 hours per day, 5 days per week, and PCS-F at the rate of 6 hours per day, 7 days per week.

4) Ms. Nisbet noted an excerpt from a letter (Exhibit D-4) – from -----of PAIS, Inc., the Claimant's I/DD Waiver Service Provider for at least the last three years – which states that the Claimant "…prides herself in volunteering at a local nursing home in her community Monday through Friday, three hours per day, thus the request for annual Person Centered Support Agency units." Ms. Nisbet argued that the daily hours in PCS-A represents the equivalent of Respite care for the Claimant's caregivers, because another person is caring for the Claimant during that time. The "approvable units" section of the denial notice to the Claimant (Exhibit D-2) represents what the Department has determined clinically necessary for the Claimant, given these factors.

*Services can be expressed in terms of units per service year or hours per day. A unit – for PCS-A, PCS-F, and Respite Services – equals fifteen minutes. The annual units of 3,132 and 8,784 shown on Exhibit D-3 convert approximately into the three hours daily and six hours daily amounts quotes in testimony. Converting daily hours quoted into annual amounts, allowing for an approximate number of weeks per year, yields slightly lower amounts than the approved budget amounts: 3 hours/day x 5 days/week x 52 weeks/year x 4 units/hour = 3,120 units per year, and 6 hours/day x 365 days/year x 4 units/hour = 8,760 units/year.

5) -----, parent and legal guardian for the Claimant, testified that the Claimant is currently unable to do her volunteer job because she does not have a provider. She testified that the Claimant has not had a provider for over a month. She testified that the Claimant frequently cannot keep providers due to her "challenging behaviors." Ms. Eva testified that the Department could only base its decision on the information available to them at the time – that the Claimant was working a volunteer job. Ms. Nisbet testified that if these hours – PCS-A hours – were not being utilized, the Claimant's Service Coordinator could modify units listed on Exhibit D-3, alternating between PCS-A units and Respite units.

6) ----- testified that the need for Respite Services for the Claimant is exceptional due to her aggressive behavior, her sleep habits, and her unpredictability resulting from her Post-traumatic Stress Disorder (PTSD). ----- testified that the Claimant can be loud and aggressive if the Claimant is not in very close proximity to her at all times and in all settings. She testified that the Claimant sometimes sleeps only two hours per night and does not appear to be tired the next day. She testified that when the Claimant is not sleeping, she has dismantled her bed. She testified that as a result of the Claimant's PTSD, they do not know what triggers her outbursts. She summarized the need for requested Respite Services as because she or her husband work the six hours of PCS-F daily, because they do not receive an equivalent to Respite through PCS-A because the time is unstaffed due to the Claimant's behavior, and because she is up at night on a regular basis because the Claimant will not sleep.

7) [redacted] representative for the Claimant, contended that the Claimant requires Respite Services at a 1:1 ratio of service worker to member. -----, parent and legal guardian to the Claimant, speculated that a worker offering 1:2 services would leave because they would not be able to handle the two individuals in his home at the same time. ----- testified that a 1:2 ratio would require them to change service providers for the Claimant because their current service provider refuses to offer staff at the 1:2 ratio. ----- testified that the Claimant's Respite provider is female and has been with the Claimant for the last twelve or thirteen years. She testified that the other I/DD Waiver recipient in the home has a male Respite provider, and the Claimant cannot have a male Respite provider due to her PTSD.

VIII. CONCLUSIONS OF LAW:

1) Policy for the I/DD Waiver Program states that before services may be provided, a prior authorization process must be completed. Services approved are based on the assessed need of the program recipient, and in consideration of their individualized budget. Testimony and evidence revealed that the Department's decision to deny requested Respite Services is the result of an assessment of clinical need for the Claimant.

2) The Department's denial letter to the Claimant, under the heading "approvable units," includes two proposed service levels – based on the assessment that the Claimant has a reduced need for Respite Services due to existing PCS-A services. A determination of clinical need cannot have two outcomes. Clinical need for a service is expressed in units of time, budgets are expressed in terms of dollars, and the two may not necessarily correspond. For the Department to propose 6,912 units of Respite Services for the Claimant but only offer 4,380 units at the Claimant's requested ratio (1:1 instead of 1:2) is to discount clinical need in favor of budgetary considerations. The Claimant's clinical need is established as 6,912 units per year of Respite Services – based on the Department's own determination.

3) The appropriate ratio of Respite Services in this case comes into consideration because the Claimant resides with another individual receiving I/DD Waiver Services. Testimony on the Claimant's behalf clearly established a need for her to continue to receive Respite Services at a 1:1 ratio. Switching to a 1:2 ratio would force the Claimant to change her Respite staff to match the needs of the other I/DD Waiver Services recipient in the home. Testimony from the Claimant's guardian that one worker would not be able to "handle" both individuals in the home is convincing, considering the testimony regarding the severe maladaptive behaviors of the Claimant. For these reasons, the Claimant has established the appropriate ratio of Respite Services to be 1:1.

4) The clinical need of the Claimant is established as 6,912 units per year of Respite Services, and the appropriate ratio of services is established as 1:1. The Claimant's request has been documented as clinically necessary, and the Department was incorrect to deny the request.

IX. DECISION:

It is the decision of the State Hearing Officer to **reverse** the decision of the Department to deny the Claimant's request for services offered through the I/DD Waiver Program – specifically, Respite – Agency (1:1) services, coded T1005U1, in the amount of 6,912 units per service year.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this _____ Day of May, 2012.

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Todd Thornton
State Hearing Officer