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

Sherri A. Young, DO, MBA, FAAFP
Interim Cabinet Secretary

Christopher G. Nelson
Interim Inspector General

December 27, 2023

[redacted]

RE: [redacted] v. WV DHHR
ACTION NO.: 23-BOR-3282

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,

Lori Woodward, J.D.
Certified State Hearing Officer
Member, State Board of Review

Encl: Recourse to Hearing Decision
Form IG-BR-29

cc: Sandra Brown, BFA, WV DHHR

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WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Appellant,

v. **ACTION NO.: 23-BOR-3282**

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 December 19, 2023, on an appeal filed October 25, 2023.

The matter before the Hearing Officer arises from the Respondent's September 18, 2023 decision to close the Appellant's Parents/Caretaker Relatives Medicaid benefits for failure to complete a medical eligibility review (MREV).

At the hearing, the Respondent appeared by Sandra Brown, Family Support Supervisor. Appearing as a witness for the Respondent was Jessica Geris, Family Support Specialist. The Appellant appeared *pro se*. The witnesses were placed under oath and the following documents were admitted into evidence:

Department's Exhibits:
- D-1 Hearing Summary
- D-2 Medicaid/WV CHIP Coverage review (MREV) form dated July 17, 2023

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 was a recipient of Parents/Caretaker Relatives Medicaid benefits. (Exhibit D-1)

2) On July 17, 2023, the Respondent issued a review form (MREV) notifying the Appellant that her Medicaid/WV CHIP coverage was due for review by August 31, 2023 with instructions to return the completed form to the local DHHR or complete it online by August 1, 2023. (Exhibit D-2)

3) The Appellant did not complete her Medicaid eligibility review by August 1, 2023.

4) On August 18, 2023, the Respondent issued the Appellant notice that her Parent/Caretaker Medicaid benefits would terminate effective September 1, 2023.

5) On September 7, 2023, the Appellant completed her review and was approved for Medicaid.

6) The Appellant's Medicaid coverage was assigned by the Bureau for Medical Services (BMS) as Traditional Medicaid for the month of September.

7) As of October 1, 2023, the Appellant was assigned to a Managed Care Organization (MCO).

APPLICABLE POLICY

WV IMM, Chapter 1, §1.11 MAGI PARENTS/CARETAKER RELATIVES
WV IMM, Chapter 1, §1.11.3 BEGINNING DATE OF ELIGIBILITY
Eligibility begins the first day of the month in which eligibility is established. However, eligibility may be backdated up to three months prior to the month of the application, when the client met all eligibility requirements in the prior month(s). When the client is eligible for backdated coverage, the system must be coded with the month, year on which the backdated period begins. This date is always the first day of the month of backdated coverage.

WV IMM, Chapter 1, §1.11.5 REDETERMINATION
WV IMM, Chapter 1, §1.11.5.A, *Redetermination Schedule*, in pertinent part:
Cases are normally redetermined annually. The redetermination schedule is set automatically by the eligibility system.
…
When the redetermination process cannot be completed automatically, the eligibility system sends a pre-populated form containing case information and require the client to provide additional information necessary to determine continuing eligibility. A signature is required. The pre-populated redetermination form provides the following information:

- A statement that the AG(s) for the individual(s) listed is due for redetermination,
- The address to which the form is returned, if submitted by mail,

- The date by which the information must be submitted,
- Specific information necessary to complete the redetermination,
- The opportunity to report changes,
- A statement that the AG may receive a verification checklist for completion and return, if reported changes require follow-up,
- A statement that the AG(s) will be closed after proper notification, if the redetermination is not completed, and
- Instructions for submitting the pre-populated redetermination form online by using WV PATH. A phone number to call if the individual has questions about submitting the prepopulated redetermination form online.

The client must be given 30 days from the date of the letter to return the information. The information may be submitted by mail, phone, electronically, Internet, or in person. Failure to respond and provide the necessary information will result in closure of the benefit. If the client responds and provides the information within 90 days of the effective date of closure, the agency will determine eligibility in a timely manner without requiring a new application. If the client is found eligible, the coverage must be back dated up to three months.

Bureau for Medical Services (BMS), CHAPTER 527 MOUNTAIN HEALTH TRUST (MANAGED CARE)

BMS, CHAPTER 527.1 MANAGED CARE OVERVIEW

For most Medicaid members, enrollment in an MCO is mandatory; however, some exceptions include but are not limited to Medicare dual eligible and those in residential settings or enrolled in certain Home and Community-Based Services (HCBS) waivers. Generally, the MCO is responsible for providing most services covered under this policy manual. Covered services include medical, dental, and most behavioral health services. Excluded services include residential services, certain home and community-based waiver services, school-administered services as administered in Chapter 538, School-Based Health Services (SBHS), pharmacy with the exception of medications administered in a doctor's office or other medical facility, and early intervention services. MCOs must coordinate non-emergency transportation and certain other services although they are not responsible for providing these benefits.

BMS, CHAPTER 527.2 COVERED MEMBERS

The following Medicaid members must enroll in an MCO:

- Children and their parents or other caretaker relatives;
- Adult Medicaid expansion members;
- Pregnant women; and
- Qualifying individuals receiving Supplemental Security Income (SSI).

The following Medicaid members are not eligible for enrollment in an MCO:

- Members enrolled in HCBS waivers except the Children with Serious Emotional Disorder Waiver (CSEDW)*;
- Members in long-term care placement, i.e. nursing facilities (NF) and intermediate care facilities for individuals with intellectual disability (ICF/IID);
- Dual eligibles, i.e. those members eligible for both Medicare and Medicaid;
- Members in a period of retroactive eligibility, except for newborns; and

- Members receiving organ and tissue transplant services.

Please Note: These lists are not all inclusive. There may be exceptions to mandatory enrollment based on each individual circumstance. Enrollment is based on the category of eligibility.
*CSEDW services are covered through managed care under one contracted MCO. Please see Chapter 502, Children with Serious Emotional Disorder Waiver (CSEDW) for more information.

BMS, CHAPTER 527.4 COVERED SERVICES

There are two benefit plans that West Virginia Medicaid members are assigned. The benefit plan that a member is assigned depends on the member's eligibility category and medical needs.

- Alternative Benefit Plan: Applies to most Medicaid expansion members who are not medically frail. See Chapter 400, Member Eligibility for additional information.
- Traditional Benefit Plan: Applies to all other managed care members and Medicaid expansion members deemed medically frail, this plan can be found in the Guide to Medicaid.

Certain services are not covered as managed care benefits but must be coordinated by the MCO including, but not limited to, non-emergency transportation and certain out-of-network services. The MCOs may provide value-added services that include additional value benefits that are actual health care services, benefits, or positive incentives that will promote healthy lifestyles and improve health outcomes among members. Examples of such services can be found on the value-added grid.

BMS, CHAPTER 400.1.9 MEMBER FAIR HEARINGS AND APPEALS

Eligibility Hearings: West Virginia Medicaid members can take advantage of the DHHR Fair Hearings process for eligibility determinations if the member is not satisfied with the decision regarding the eligibility application and/or it is not handled within a reasonable period of time; not allowed to file an application; or was treated unfairly in any way. Requests for appeals should be directed to the member's local county DHHR office.

Service Related Hearings: If a member receives a notice of a reduction, suspension, or termination of a Medicaid covered service, the right to appeal the denial or termination may be exercised through the fair hearing process. The notice will include an explanation of the member's appeal rights and a form that must be used to request a fair hearing. Members may represent themselves, use legal counsel, a relative, friend, or other spokesperson during the hearing process. All requests for a Fair Hearing regarding Medicaid services must be submitted in writing to:
Bureau for Medical Services Appeals Section
350 Capitol Street, Room 251
Charleston, WV 25301-3706

Managed Care Hearings: The MCO enrollees have additional avenues of appeal concerning adverse decisions made within their MCO and should call their respective customer service centers. The enrollment broker, who can be reached at 1-800-449-8466, also documents telephone calls involving complaints and appeals that concern managed care issues. The enrollment broker will forward the complaints and concerns to the appropriate entity for evaluation.
Non-covered services are not eligible for a DHHR Fair Hearing. See 42 CFR § 431.220 When a hearing is required for more information. Refer to Chapter 100, General Information for details regarding member appeals.

DISCUSSION

Policy requires that Medicaid coverage groups undergo an annual eligibility review. On July 17, 2023, the Respondent issued the Appellant a Medicaid/WV CHIP Medicaid review form (MREV) notifying her that she was due for an eligibility review for her Parents/Caretaker Relatives Medicaid. The MREV included instructions that the Appellant must complete and return the form to the local DHHR or complete the form online by August 1, 2023. Because the MREV had not been completed by the review due date, the Respondent notified the Appellant that her Parents/Caretaker Relatives Medicaid was being closed at the end of August 2023. On September 7, 2023, the Appellant completed a Temporary Assistance for Needy Families (TANF) and Medicaid review. The Appellant was approved for Medicaid coverage.

The Appellant brings this appeal because she was assigned the benefit plan under Traditional Medicaid and was no longer covered with a MCO which resulted in unpaid medical bills for the month of September due to her care provider not accepting Traditional Medicaid plans. The Appellant avers that during the September 7, 2023 interview, her caseworker reassured her that her medical insurance would be "good to go" the following day. The Appellant asserts that her caseworker should have known that she would be put in a Traditional Medicaid plan.

The Bureau for Family Assistance (BFA) is responsible for making eligibility determinations. The Bureau of Medical Services (BMS) is responsible for assigning benefit plans for Medicaid members. The Appellant's caseworker made the Medicaid eligibility determination and made sure that the Appellant's Medicaid would be active the following day. This is not in dispute. The type of benefit plan is not within the control of the BFA but instead is determined by BMS.

The Appellant also asserted that it was because her caseworker did not return any of the messages she left her in the month of August regarding her missed August 8, 2023 TANF review, it was not the Appellant's fault that she did not complete her Medicaid review prior to closure. The Respondent's representative pointed out that the Medicaid review form could have been completed and mailed into the local office or the Appellant could have completed it online. The Appellant testified that she never received the MREV form. However, the Appellant's statement that she failed to receive the MREV form is given little weight as she did receive the Medicaid closure notice, the Scheduling Order for this hearing, and notice from the post office regarding the exhibit packet sent to the Appellant for the hearing.

Individuals who fail to complete a Medicaid eligibility review, results in closure of the benefit. The evidence and testimony showed that the Appellant did not complete her Medicaid review prior to the end of her certification period of August 31, 2023. However, the Appellant did complete her Medicaid review on September 7, 2023, resulting in Medicaid approval. The Respondent acted within policy in determining the Appellant's Medicaid eligibility.

CONCLUSIONS OF LAW

1) Medicaid eligibility must be reviewed annually to determine continued eligibility.

2) The Appellant failed to complete her Medicaid review prior to the expiration of her Parents/Caretaker Relatives Medicaid certification period on August 31, 2023, but did complete her review on September 7, 2023.

3) The Respondent correctly determined the Appellant's eligibility for Medicaid.

DECISION

It is the decision of the State Hearing Officer to **uphold** the decision of the Respondent to approve the Appellant Medicaid coverage.

ENTERED this 27th day of December 2023

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Lori Woodward, Certified State Hearing Officer