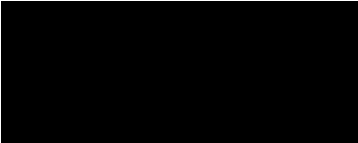




April 29, 2026



RE: [REDACTED] v. WV DoHS/BMS
ACTION NO.: 26-BOR-1391

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 HUMAN SERVICES (DoHS). These same laws and regulations are used in all cases to ensure 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,

Tara B. Thompson, MLS
Certified State Hearing Officer
Member, State Board of Review

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

cc: Anita Mallet and Kesha Walton, Bureau for Medical Services

**WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW**

[REDACTED]

Appellant,

v.

Action Number: 26-BOR-1391

**WEST VIRGINIA DEPARTMENT OF
HUMAN SERVICES
BUREAU FOR MEDICAL SERVICES,**

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 Office of Inspector General Common Chapters Manual. This fair hearing was convened on April 15, 2026.

The matter before the Hearing Officer arises from the decision by The Health Plan on November 6, 2025, to terminate the Appellant's participation in the case management program.

At the hearing, the Respondent appeared by Anita Mallet, Bureau for Medical Services (BMS). Appearing as witnesses for the Respondent were The Health Plan staff [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. The Appellant appeared and was self-represented. All witnesses were placed under oath, and the following documents were admitted into evidence.

Department's Exhibits:

- D-1 Respondent's Timeline Summary
- D-2 The Health Plan Clinical Records and correspondence
- D-3 The Health Plan Email Correspondence
- D-4 Appellant's Correspondence to The Health Plan
- D-5 The Health Plan Notification, dated November 6, 2025
- D-6 Appellant's Handwritten Correspondence, received November 17, 2026

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 is enrolled with The Health Plan, a Medicaid Managed Care Organization (MCO) responsible for providing Mountain Health Trust (MHT) managed care services.
- 2) On November 6, 2025, The Health Plan issued a notice advising that the Appellant was terminated from case management, effective that day, “because of behavior that does not follow rules discussed.” The notice did not include information about the Appellant’s right to appeal the decision by The Health Plan (Exhibit D-5).
- 3) The November 6, 2025 notice advised the Appellant, “some of your recent actions have made it difficult for us to keep working with you safely and respectfully.” The actions listed included:
 - Sending many emails and phone calls to the nurse case manager and others who are no longer a part of your care team;
 - Sending messages every 20 to 30 minutes asking for quick replies, even after we set limits on how often we can respond;
 - Making requests that are inappropriate, such as asking staff to send personal photos (Exhibit D-5).
- 4) On September 30, 2025, The Health Plan care management staff facilitated communication between the Appellant and her primary care provider regarding the Appellant’s health concerns (Exhibit D-2).
- 5) On October 1, 2025, the Appellant emailed The Health Plan Social Worker [REDACTED] (hereafter [REDACTED] and requested a call back. At 12:31 p.m. [REDACTED] replied that someone would call her as soon as possible. At 12:52 p.m., the Appellant replied that she needed help with a [REDACTED] application to resolve a matter with her hearing aids (Exhibit D-3).
- 6) On October 6, 2025, the Appellant emailed [REDACTED] at 11:52 a.m., and 1:16 p.m. requesting to speak to Nurse [REDACTED] and wanting to recognize Nurse [REDACTED] for her help (Exhibit D-3). On that day, care management staff spoke with the Appellant and advised she would be transferred to other case management staff because her case manager would no longer be working in the case management department. Emotional support was provided to the Appellant and no requests for service were expressed by the Appellant at that time (Exhibit D-2).
- 7) On October 6, 2025, care management staff spoke with the Appellant’s mental health provider, expressed the Appellant’s concerns about her medication, and confirmed counseling and medication adjustment appointments for the following day. Care management staff advised the

mental health provider of the Appellant's repeated phone calls to The Health Plan and primary care provider (Exhibit D-2).

- 8) On October 7, 2025, [REDACTED] replied at 7:35 a.m., that the Appellant's October 6, 2025 information was passed on to Nurse [REDACTED]. The Appellant emailed [REDACTED] at 7:47 a.m., 8:05 a.m., 12:54 p.m., 3:24 p.m., 3:33 p.m., and 6:32 p.m. In these emails, the Appellant expressed she was upset at the transition to a new nurse from [REDACTED]. [REDACTED] advised she could not open images sent to her by The Health Plan, expressed her willingness to enter a communication agreement with [REDACTED] and requested call backs from [REDACTED] (Exhibit D-3).
- 9) On October 7, 2025, care management staff contacted the Appellant's providers to advise them of the Appellant's phone calls and emotional response at transitioning from [REDACTED] case management (Exhibit D-2).
- 10) On October 7, 2025, care management staff called the Appellant at 2:45 p.m. During that call, the Appellant expressed disagreement with transferring to another case manager and requested to close her case management case. The Appellant advised she was not going to send out the [REDACTED] application. Care management staff sent the Appellant requested resources and recorded that her case management case would be closed (Exhibit D-2).
- 11) On October 8, 2025, [REDACTED] replied at 8:37 a.m. and 10:35 a.m., that the Appellant's messages were received, and someone would be in touch with the Appellant (Exhibit D-3). The Appellant emailed [REDACTED] at 8:54 a.m., 10:00 a.m., 10:45 a.m., and 1:37 p.m. In these emails, the Appellant inquired about whether [REDACTED] received her messages, attached "stories" that the Appellant wrote, asked if [REDACTED] was mad at her, notified [REDACTED] that the Appellant could not open her attachments, and advised Ms. [REDACTED] of a medication change (Exhibit D-3).
- 12) On October 8, 2025, a care management team meeting was held with the Appellant, who agreed to a scheduled call with Nurse [REDACTED] and Nurse [REDACTED] (hereafter Nurse [REDACTED]) to transition her case management and set up future call times for case management (Exhibit D-2).
- 13) On October 9, 2025, the Appellant emailed [REDACTED] to inquire about the name of an individual who attended her meeting and advised that she did not know who to ask for when she contacted The Health Plan. The Appellant requested a call back as soon as possible (Exhibit D-3).
- 14) On October 9, 2025, care management staff spoke with the Appellant and addressed her concerns about compression stockings and reminded the Appellant of her scheduled case management transition call. The same day, Nurse [REDACTED] spoke with the Appellant and reviewed the Appellant's care management needs (Exhibit D-2).
- 15) On October 15, 2025, care management staff spoke with the Appellant and reminded her of their scheduled phone appointment on October 17, 2025. Care management staff emailed a

provider list to the Appellant upon her request. Nurse [REDACTED] gave the Appellant permission to send her an emailed picture of the Appellant's artwork (Exhibit D-2).

- 16) On October 17, 2025, the Appellant emailed Nurse [REDACTED] at 10:14 a.m. to ask for more frequent contact and asked to be able to contact [REDACTED] for encouragement. At 10:34 a.m., Nurse [REDACTED] replied that she was proud of the Appellant for setting goals and informed her of their call scheduled for October 30, 2025, from 9:00a.m. to 9:30 a.m. At 12:22 p.m., the Appellant replied to Nurse [REDACTED] and confirmed the appointment time and asked for weekly contact (Exhibit D-3).
- 17) On October 17, 2025, care management staff spoke with the Appellant about her goal progress, medications, and upcoming therapy appointments. The Appellant agreed her next call would be in a month but that the Appellant may email to arrange a time to talk sooner (Exhibit D-2).
- 18) On October 19, 2025, the Appellant sent Nurse [REDACTED] a photo of her leg, advised she was pleased with the results of her new medication, and thanked Nurse [REDACTED] for her help. At 12:48 p.m., Nurse [REDACTED] reminded the Appellant of their appointment on October 30, 2025, at 9:30 a.m., and advised the Appellant to contact Nurse [REDACTED] by email if she needed to speak sooner (Exhibit D-3).
- 19) On October 22, 2025, care management staff notified the Appellant's mental health provider of her repetitive emails (Exhibit D-2).
- 20) On October 23, 2025, care management spoke with the Appellant during their scheduled call and reviewed the Appellant's primary care provider updates, and care management needs (Exhibit D-2).
- 21) On Friday, October 24, 2025, the Appellant emailed [REDACTED] at 3:40 p.m., and requested a call back on Monday, at 8:00 a.m. (Exhibit D-3).
- 22) On October 27, 2025, the Appellant sent a message via Helio saying hello to [REDACTED] (Exhibit D-4).
- 23) On October 28, 2025, the Appellant sent two messages to [REDACTED] via Helio. In these messages, the Appellant requested a call back from Nurse [REDACTED], expressed barriers reaching The Health Plan Wellness Program Health Coach, and indicated that [REDACTED] was ignoring and abandoning her (Exhibit D-4).
- 24) On October 28, 2025, care management staff returned the Appellant's phone call, but the Appellant did not want to proceed with the call with a case management supervisor present and ended the call. Later, care management staff spoke again with the Appellant regarding her complaints of transferring to a new case manager (Exhibit D-2).
- 25) On October 29, 2025, the Appellant emailed [REDACTED] at 2:40 p.m., advising [REDACTED] of her barriers contacting The Health Plan Wellness Program Health Coach, and indicated that Nurse [REDACTED] rescheduled her phone call for October 29, 2025, at 3:00 p.m. (Exhibit D-3).

- 26) On October 29, 2025, care management staff spoke with the Appellant and provided emotional support, discussed the role of case management, reinforced boundaries, and discussed the client's current care management goals. (Exhibit D-2).
- 27) On October 30, 2025, the Appellant emailed Nurse [REDACTED] at 2:24 p.m., and 4:07 p.m. to request Nurse [REDACTED] contact her physician. Nurse [REDACTED] replied at 2:07 p.m. and advised the Appellant should ask her physician questions at her next appointment (Exhibit D-3).
- 28) On October 31, 2025, the Appellant emailed Nurse [REDACTED] at 7:01 a.m., and provided her argument for Nurse [REDACTED] speaking to the physician regarding a requested thyroid panel, expressed her difficulty scheduling telehealth therapy appointments, asked for a photo of Nurse [REDACTED], and inquired about Nurse [REDACTED] favorite color and flower. Nurse [REDACTED] replied at 8:08 a.m. that she could not speak to the Appellant's physician due to the Health Insurance Portability and Accountability Act (HIPAA) and reminded the Appellant she just received a thyroid panel in June 2025 that did not reveal medical issues (Exhibit D-3).
- 29) On October 31, 2025, the Appellant emailed Nurse [REDACTED] at 8:28 a.m., 8:33 a.m., 8:35 a.m., 8:50 a.m., 10:41 a.m., 11:22 a.m., 12:18 p.m., and 1:09 p.m. In these emails, the Appellant disputed Nurse [REDACTED] communication barriers due to HIPAA, indicated that Nurse [REDACTED] did not care about the Appellant, argued Nurse [REDACTED] was making excuses, advised she canceled her appointments for that day, advised she had a telehealth appointment with her physician who agreed to order the thyroid panel, apologized for sending harsh emails, and requested several times for Nurse [REDACTED] to call her back (Exhibit D-3).
- 30) On October 31, 2025, care management staff contacted the Appellant's physician and therapist to review the Appellant's concerns, the Appellant's threat to withhold medications, and behavioral health concerns (Exhibit D-2).
- 31) On November 3, 2025, the Appellant emailed Nurse [REDACTED] at 7:25 a.m., 9:51 a.m., and 1:49 p.m. In these emails, the Appellant expressed she was having emotional issues, needed help setting up a patient portal app, had canceled an appointment, implied that Nurse [REDACTED] did not care about her, and requested Nurse [REDACTED] to call her back (Exhibit D-3).
- 32) On November 4, 2025, the Appellant emailed Nurse [REDACTED] at 7:46 a.m. and indicated that Nurse [REDACTED] was ignoring and abandoning her, advised she had stopped all of her medications and threw them in the trash, and requested a photo of Nurse [REDACTED] for her hobby. At 10:19 a.m., Nurse [REDACTED] replied via email with a reminder of her scheduled call with the Appellant on November 5, 2025, at 10:00 a.m., advised her to use "teledoc" information, and informed her she could cancel case management services (Exhibit D-3).
- 33) On November 4, 2025, the Appellant emailed Nurse [REDACTED] at 10:36 a.m., 10:51 a.m., 10:53 a.m., and 10:59 a.m. In these emails, the Appellant indicated that Nurse [REDACTED] was a liar, was making excuses, was not doing her best, and didn't care about her. The Appellant advised she had three missed calls from The Health Plan and inquired whether it was Nurse [REDACTED] that had called (Exhibit D-3). Nurse [REDACTED] replied at 11:34 a.m. and advised the Appellant that she did not call her and that she was helping another patient at that time (Exhibit D-3).

- 34) On November 4, 2025, the Appellant emailed Nurse [REDACTED] at 11:36 a.m., 12:46 p.m., 2:27 p.m., 3:39 p.m., 3:42 p.m., and 4:04 p.m. In these emails, the Appellant argued that she needed Nurse [REDACTED] more than the other patient did, demanded for Nurse [REDACTED] to call her or she would call Nurse [REDACTED] repeatedly advised that she was waiting for Nurse [REDACTED] calls, expressed she was not happy with Nurse [REDACTED] argued Nurse [REDACTED] was making excuses and didn't keep her promises to the Appellant, and requested for Nurse [REDACTED] to call her immediately (Exhibit D-3).
- 35) On November 4 and November 5, 2025, care management staff spoke with the Appellant regarding her recent appointments, current treatment, and concerns (Exhibit D-2).
- 36) On November 5, 2025, the Appellant emailed Nurse [REDACTED] at 10:28 a.m., 12:16 p.m., and 1:40 p.m. In these emails, the Appellant advised that Nurse [REDACTED] was late calling in to their 10:00 a.m. phone appointment, apologized to Nurse [REDACTED], and advised that she had video links she wanted to send to Nurse [REDACTED] (Exhibit D-3).
- 37) On November 6, 2025, the Appellant emailed Nurse [REDACTED] at 6:28 a.m., 6:47 a.m., 9:01 a.m., 12:36 p.m., and 3:57 p.m. In these emails, the Appellant inquired about receipt of the video links, requested a photo of Nurse [REDACTED] sent Nurse [REDACTED] a list of her appointments, requested help with transportation arrangements, requested help switching therapy from video to in-person appointments, asked Nurse [REDACTED] what her favorite color was, informed her of a new appointment, and requested several times for Nurse [REDACTED] to call her back (Exhibit D-3).
- 38) On November 7, 2025, the Appellant emailed Nurse [REDACTED] once and requested a call back (Exhibit D-3).
- 39) On November 7, 2025, the Appellant sent two messages via Helio, saying that she was in crisis and needed Nurse [REDACTED] or [REDACTED] to call her back as soon as possible, and complained that she could not use case management services (Exhibit D-4).
- 40) On November 7, 2025, care management staff contacted the Appellant's therapist and primary care provider regarding the Appellant's messages about being in crisis and the recent termination of the Appellant's care management services (Exhibit D-2).
- 41) On November 7, 2025, care management contacted the Appellant to tell her she was dismissed from case management (Exhibit D-2).

APPLICABLE POLICY

Care Management

42 CFR 438.208(b)(1)-(2) *Care and Coordination of Services for all MCO Enrollees* stipulates that each MCO must implement procedures to deliver care and to coordinate services for all MCO enrollees. The procedures must ensure that each enrollee has an ongoing source of care appropriate to his or her needs, has a person or entity formally designated as primarily responsible for

coordinating the services accessed by the enrollee, and coordinates the services the MCO furnishes to the enrollee.

Social Security Act (SSA) § 1905(a) [42 U.S.C. 139d] defines *medical assistance* as payment of part or all of the cost of the following care and services or the care and services themselves, or both ... for individuals ... whose income and resources are insufficient to meet all of such cost. (19) case management services (as defined in section 1915(g)(2)).

SSA § 1915(g)(2) [42 U.S.C. 139n] provides that for the purposes of the subsection, the term *case management* means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

SSA § 1915(b) [42 U.S.C. 139n] permits the State agency, to the extent found to be cost-effective and efficient and not inconsistent with the purposes of this title, may waive such requirements of section 1902 (other than subsections (s), 1902(a)(15), 1902 (bb), and 1902(a)(10)(A) insofar as it requires provision of the care and services described in 1905(a)(2)(C)) as may be necessary for a State —

- (1) to implement a primary care case-management system ...
- (2) to allow a locality to act as a central broker in assisting individuals (eligible for medical assistance under this title) in selecting among competing health care plans ...
- (3) to share (through provision of additional services) with recipients of medical assistance under the State plan cost savings resulting from use by the recipient of more cost-effective medical care, and
- (4) to restrict the provider from (or through) whom an individual (eligible for medical assistance under this title) can obtain services (other than in emergency circumstances) ...

Bureau for Medical Services (BMS) Manual Chapter 527 Mountain Health Trust (Managed Care) Background provides that Mountain Health Trust is the BMS managed care program authorized under 1915(b) waiver ... The BMS contract with the Managed Care Organization (MCO) contains clauses ensuring compliance with all state and federal mandates as well as state programmatic initiatives ... The waiver and MCO service provider agreement govern implementation of the program and requirements the MCOs must meet.

BMS Manual §527.4 Covered Services provides that 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 MCO 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.

BMS Manual § 527.4.2 Care Management provides that the MCO must put in place care management systems with respect to medical and behavioral health services.

BMS Manual Chapter 527 Glossary provides that *care management* is the coordination of benefits and services to assist Medicaid members in achieving access to needed care, in navigating their way through complex systems, and increasing the management and advocacy skills of Medicaid member necessary to become informed and engaged.

Notification

Code of Federal Regulations 42 CFR 438.404(a) through (c) *Timely and Adequate Notice of Adverse Benefit Determination* provides that the MCO must give enrollees timely and adequate notice of an adverse benefit determination in writing that provides the enrollee's right to request an appeal of the MCO's adverse benefit determination, including information on exhausting the MCO's one level of appeal described in § 438.402(b) and the right to request a State fair hearing consistent with § 438.402(c). For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCO must mail the notice within the timeframes specified in §§ 431.211, 431.213, and 431.214 of the chapter.

Code of Federal Regulations 42 CFR 431.211 *Advanced Notice* provides that the agency must send notice at least 10 days before the date of action, except as allowed under §§ 431.213 and 431.214

Grievance and Appeal

Code of Federal Regulations 42 CFR §§ 438.402(a) through (b) *General Requirements, Grievance and Appeal System* provides that each MCO must have a grievance and appeal system in place for enrollees. Each MCO may have only one level of appeal for enrollees.

Code of Federal Regulations 42 CFR § 438.402(c)(1)(i)(A) *Filing Requirements, Authority to File* provides that an enrollee may file a grievance and request an appeal with the MCO. An enrollee may request a State fair hearing after receiving notice under § 438.408 that the adverse benefit determination is upheld.

Deemed exhaustion of appeals process provides that in the case of an MCO that fails to adhere to the notice and timing requirements in § 438.408, the enrollee is deemed to have exhausted the MCO's appeal process and may initiate a State fair hearing.

Code of Federal Regulations 42 CFR §§ 438.408(a), (b), and (c)(3) *Resolution and Notification, Grievances and Appeals* provide that each MCO must resolve each grievance and appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within the State-established timeframes that may not exceed the timeframes specified in this section.

For standard resolution of a grievance and notice to the affected parties, the timeframe is established by the State but must not exceed 90 calendar days from the day the MCO receives the grievance.

For standard resolution of appeals and notice to the affected parties, the State must establish a time frame that is not longer than 30 calendar days from the day the MCO receives the appeal.

In the case of an MCO that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's appeal process and may initiate a State fair hearing

SSA § 1902(a)(3) [42 U.S.C. 1396a] provides that a State plan for medical assistance must provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.

BMS Manual § 527.6.3 *Member Services Requirements* provides that each MCO must have a member services department to provide information about, and assistance with:

- Covered services;
- Specialty services;
- Provider choice and how to change;
- Disenrollment;
- Grievances;
- Continuity of care;
- Confidentiality of medical information;
- New member orientation;
- Wellness education; and
- Member responsibility for payment of non-covered services

Each MCO must develop a member handbook with information about these and other topics which can be found on each MCO's website accessible through the BMS Managed Care website.

BMS Manual § 527.6.5 *Member Appeals and Grievances* provides that Medicaid enrollees may file a grievance regarding any aspect of service delivery provided or paid for by the MCO at any time. The enrollee may file an appeal to seek a review of an adverse action taken by the MCO as defined in 42 CFR § 438.400(b).

Code of Federal Regulations 42 CFR § 438.400(b) *Definitions* provides:

Adverse benefit determination means in the case of an MCO ..., any of the following:

- (1) The denial or limited authorization of a requested service ...
- (2) The reduction, suspension, or termination of a previously authorized service.
- (3) The denial, in whole or in part, of payment for a service ...
- (4) The failure to provide services in a timely manner, as defined by the State.
- (5) The failure of an MCO ... to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
- (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right under § 438.52(b)(2)(ii), to obtain services outside the network.
- (7) The denial of an enrollee's request to dispute a financial liability ...

DISCUSSION

The Appellant is enrolled with The Health Plan, a Medicaid Managed Care Organization (MCO) responsible for providing Mountain Health Trust (MHT) managed care services. On November 6, 2025, The Health Plan terminated the Appellant's participation in the case management program, effective that day. During the hearing, the Appellant contested the Respondent's decision and argued that her medical care has suffered because she is unable to access care coordination services. The Respondent contended that because case management is a free service offered by the

MCO, rather than a paid benefit, the Appellant was not entitled to advanced notification of termination or a grievance process.

Per the November 6, 2025 notice, the Appellant's case management was ended due to her failure to follow rules "discussed" and because her actions made it difficult for The Health Plan to continue working with her "safely and respectfully." The actions listed included sending many emails and phone calls to the nurse case management staff, messaging every 20-30 minutes asking for quick replies, and asking staff to send personal photos.

The Respondent bears the burden of proof. To prove that the Respondent correctly stopped the Appellant's case management services, the evidence had to demonstrate that the Appellant's behaviors violated established rules and prevented continuation of case management services due to safety issues. Further, the evidence had to prove that the Appellant was not entitled to advanced notification of termination or a grievance process.

Grievance and Appeal

Even though the Respondent affirmed that The Health Plan case management system was a managed care program administered by MHT policy, the Respondent's representative and witnesses argued that grievance procedures were not applicable because case management is a complimentary MCO program, not a paid benefit.

MHT is authorized by the Social Security Act (SSA) 1915 (b) waiver, which permits the State agency to waive certain requirements of Section 1902. However, pursuant to the agency's policy, the State agency follows the federal requirement to permit an enrollee to appeal termination of a benefit provided or paid for by the MCO. SSA § 1915(g)(1) provides that the State may disregard requirements in sections 1902(a)(1) and 1902(a)(10)(B) when providing case management services but does not authorize the State agency to disregard the appeal provisions granted in section 1902(a)(3).

Federal regulations stipulate that the MCO must give enrollees timely and adequate notice of an adverse benefit determination in writing that provides information about the enrollee's right to request an appeal of the MCO's adverse benefit determination. Further, the regulations stipulate that the notice must include information on exhausting the MCO's one level of appeal. In this case, no evidence was given to indicate that the Appellant met an exception to the advance notice period or that advanced notice was not required due to probable fraud by the beneficiary.

As the MCO had to comply with BMS, state, and federal rules, the Appellant should have been permitted to appeal the termination of case management through the MCO's one-level appeal process. Federal regulations provide that when an MCO does not adhere to the notice and timing requirements for appeals, the enrollee is considered to have exhausted the MCO's appeal process and may initiate a State fair hearing. In this case, the MCO did not meet the notification requirements or supply the Appellant with an appeal process within the required period. As the SSA defined case management as medical assistance and the MCO denied the Appellant the opportunity to appeal the MCO's decision, the Appellant's case is ripe for adjudication with the Board of Review.

Care Management

Each MCO must implement procedures to deliver care and coordinate services that are furnished to the enrollee by the MCO. The MCO must ensure that each enrollee has an ongoing source of care appropriate to her needs, and has a person or entity formally appointed as primarily responsible for coordinating the services accessed by the enrollee. Further, the agency's policy provides that the MCO is responsible for coordinating services, such as non-emergency transportation, that are not covered as managed care benefits.

The SSA includes case management services as a form of medical assistance and defines case management as services which assist eligible individuals in gaining access to needed medical, social, educational, and other services. During the hearing, the Respondent's representative affirmed that The Health Plan's case management program is a care management system administered under MHT policy.

During the hearing, the Respondent's representative argued that the Appellant failed to comply with an agreement between The Health Plan and the Appellant regarding communications with The Health Plan. The evidence revealed that the Appellant emailed and called care management staff frequently. Periodically, the Appellant asked Nurse [REDACTED] her favorite color, favorite flower, and on multiple occasions, requested a photograph of Nurse [REDACTED]. Pursuant to the November 6, 2025 termination notice, these communications were characterized as inappropriate and contributed to The Health Plan being unable to continue working with the Appellant safely and respectfully.

On October 19, 2025, Nurse [REDACTED] instructed the Appellant to email her if she needed to speak to Nurse [REDACTED] sooner than their next appointment. According to the evidence, Nurse [REDACTED] gave the Appellant permission to send her emailed photographs of the Appellant's artwork. Nothing within the email correspondence established that the Appellant's requests were malicious in nature or threatened Nurse [REDACTED] safety.

While the MCO's communication records contained vague references of agreements for care management staff to contact the Appellant at an appointed time, no evidence was submitted to indicate that the Appellant was ever informed in writing, or signed agreement to specific procedures or expectations for communicating with care management staff. Further, no evidence was given to establish that the Appellant was informed in writing that calling frequently or requesting photos of staff would result in her dismissal from the case management program. While the Appellant's email correspondence was demanding and combative at times, no records of safety threats against care management staff were revealed by the evidence provided. Although the policy requires the MCO to have a member services department to provide information and assistance to enrollees and develop a member handbook, no information was presented during the hearing to establish what rules of the member handbook the Appellant violated to constitute permissible discharge from the case management program.

According to the evidence, care management staff communicated with the Appellant's mental health provider and primary care physician on many occasions to convey the Appellant's emotional status and frequent phone and email contact. At the time of the MCO's termination of the Appellant's case management, the Appellant still required care coordination services.

Since the Appellant's termination from case management, The Health Plan asserted that the Appellant has access to an assigned individual to answer questions about her benefits. The Appellant argued that she is frequently unable to reach the individual and has barriers coordinating her own care. As the MCO is required by federal regulations to coordinate services that the MCO furnishes to the enrollee, and the agency's manual requires the MCO to coordinate non-emergency transportation and other out-of-network services for the enrollee, the evidence failed to prove that the MCO made reasonable effort after terminating the Appellant's case management to align sufficient replacement for care coordination services as required by the controlling regulations.

CONCLUSIONS OF LAW

- 1) Medicaid Managed Care Organizations (MCOs) must implement procedures to deliver care and coordinate services for all MCO enrollees.
- 2) Case management is a form of medical assistance. The Health Plan case management system is a managed care program administered by Mountain Health Trust.
- 3) Medicaid enrollees may file a grievance regarding any aspect of service delivery provided or paid for by the MCO at any time.
- 4) The preponderance of evidence did not prove that the MCO provided the Appellant with timely and adequate notice of termination or provided her with information about her right to request an appeal of the MCO's termination of her case management program participation.
- 5) Each MCO must implement procedures to deliver care and coordinate services that are furnished to the enrollee by the MCO. The MCO must ensure that each enrollee has an ongoing source of care appropriate to her needs, and has a person or entity formally appointed as primarily responsible for coordinating the services accessed by the enrollee.
- 6) The preponderance of evidence did not prove that the MCO made reasonable effort to align sufficient replacement for care coordination services before ending the Appellant's case management program participation.
- 7) The preponderance of evidence did not prove that the Appellant signed a communication agreement, was informed in writing of specific procedures or expectations for communicating with care management staff, or was informed in writing that engaging in certain behavior would result in case management termination.
- 8) As the preponderance of evidence did not prove that the Appellant violated rules of the member handbook or violated an established written communication agreement, the MCO's decision to terminate the Appellant's participation in the case management program was incorrect.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the decision by the Managed Care Organization, to terminate the Appellant's participation in the case management program.

ENTERED this 29th day of April 2026.

**Tara B. Thompson, MLS
Certified State Hearing Officer**