# Application for a §1915(c) Home and Community-Based Services Waiver

## PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

## Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

### 1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
The following changes to the Aged and Disabled Waiver (ADW) Program are being made in this renewal application:

1. Quality Improvement System (QIS): The primary data source for Aged and Disabled Waiver (ADW) quality management information is the periodic review of providers conducted by the operating agency. Changes to this process have been made to incorporate strategies developed with the assistance of CMS technical assistance contractors. These changes include 1)Requiring the annual submission of evidence by each ADW provider to document their continued compliance with certification standards (which include requirements for direct-care staff training and professional licensure), and 2) Reviewing a representative sample of files from members served statewide, ensuring that at least one member file from each provider site is reviewed.

2. Services: This application does not include the Medical Adult Day Care service included in prior ADW Waiver Applications. There are currently no certified ADW Adult Medical Day Care service providers in West Virginia.

The Homemaker Service defined in the current approved ADW application has been renamed - Personal Assistance/Homemaker Service to more accurately reflect the services provided. Also, Transportation, Nursing, and RN Assessment Services (defined in the current approved ADW application as Skilled Nursing) have been incorporated as components of the newly defined Personal Assistance/Homemaker Service.

3. Service Plan: The service planning process has been revised to more fully comply with CMS's expectations that members direct and are engaged in the planning of services. In addition, the use of an Interim Service Plan when necessary to assure health and safety while the Service Plan is fully developed, has also been included.

## Application for a §1915(c) Home and Community-Based Services Waiver

### 1. Request Information (1 of 3)

**A.** The **State** of **West Virginia** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

**B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):
**Aged and Disabled Waiver**

**C. Type of Request: renewal**

**Requested Approval Period:***(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

☐ **Migration Waiver** - this is an existing approved waiver

☑ **Renewal of Waiver:**

Provide the information about the original waiver being renewed

**Base Waiver Number:** 0134

**Amendment Number** (if applicable):

**Effective Date:** *(mm/dd/yy)* 07/01/10

**Waiver Number: WV.0134.R05.00**

**Draft ID: WV.006.05.00**

**Renewal Number:** 05

**D. Type of Waiver** *(select only one)*:

Regular Waiver

**E. Proposed Effective Date:** *(mm/dd/yy)*

07/01/10

**Approved Effective Date: 07/01/10**

## 1. Request Information (2 of 3)

**F. Level(s) of Care**. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

## 1. Request Information (3 of 3)

**G. Concurrent Operation with Other Programs.**This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

**Specify the §1915(b) authorities under which this program operates** *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

**H. Dual Eligiblity for Medicaid and Medicare.**

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

## 2. Brief Waiver Description

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Aged and Disabled Waiver (ADW) program provides home and community-based services to West Virginia residents who are both medically and financially eligible to participate in the program. Members must also be at least eighteen (18) years of age and choose home and community-based services rather than nursing home placement. The purpose of the ADW is to prevent unnecessary institutionalization by providing cost-effective services in the community. The goals and objectives of this program are focused on providing services that are person-centered and a program that promotes choice, independence, participant-direction, respect, dignity and community integration.

The Bureau for Medical Services (BMS) contracts with another State Agency, the Bureau of Senior Services, to operate the program. BMS also contracts with an Administrative Services Organization (ASO)to assess medical eligibility for program applicants, as well as, annual re-evaluations for those receiving Waiver services. The ASO also authorizes ADW services for eligible members. BMS contracts with a claims processing entity to process claims and with a Fiscal Employer Agent (FE/A) to support Waiver members who choose to direct their own services through the participant-directed model within the ADW.

Members of the ADW can choose one of two service delivery models - Traditional or Participant-Directed. Members choosing the Traditional Model receive their services from certified ADW Personal Assistance/Homemaker and Case Management Agencies. The services they can access include Case Management and Personal Assistance/Homemaker Services. (Personal Assistance/Homemaker, RN Assessment, Nursing and Transportation).

Members who choose the Participant-Directed Model are allotted a monthly budget which they can use to hire employees to meet their direct-care needs. Members in the Participant-Directed Model can also use up to one-thousand (1000) dollars of their budget each year to purchase Participant-Directed Goods and Services (PDGS). The use of PDGS allows members to purchase items to address long-term care needs that are not provided via the Traditional Service Delivery Model.

The number of direct-care hours an eligible member can receive under the Traditional Model and the amount of an individual's monthly budget allotment if they choose the Participant-Directed Model is based upon their assessed Level of Care.

The operating agency is responsible for implementing the Quality Improvement System (QIS) for the ADW program. Operating agency monitoring staff review providers every twelve (12) months to ensure provider qualifications and the delivery of quality services. Case Management agencies have front line responsibility for ensuring the health and safety of ADW members. The West Virginia Incident Management System (IMS) is a web-based application that requires providers to report, track and trend incidents. Operating agency staff use the WVIMS to monitor and track critical incidents in real time and generate monthly statewide reports.

A fifteen (15) member Quality Improvement Advisory Council representing a wide range of stakeholders reviews and evaluates all quality management data and makes quality improvement recommendations to BMS and the operating agency. Specific quality improvement goals and objectives are incorporated into the Quality Management Plan. The Quality Management Plan is used to guide the work of the Quality Improvement Advisory Council, BMS and operating agency staff. It is reviewed and revised as appropriate during the annual Quality Improvement Advisory Council Retreat.

## 3. Components of the Waiver Request

**The waiver application consists of the following components.***Note: Item 3-E must be completed.*

**A. Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

**B. Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

**C. Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

**D. Participant-Centered Service Planning and Delivery.Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

**E. Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

**F. Participant Rights.Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

**G. Participant Safeguards.Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

**H. Quality Improvement Strategy.Appendix H** contains the Quality Improvement Strategy for this waiver.

**I. Financial Accountability.Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

**J. Cost-Neutrality Demonstration.Appendix J** contains the State's demonstration that the waiver is cost-neutral.

## 4. Waiver(s) Requested

**A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

**B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- (●) **Not Applicable**

- **No**
- **Yes**

**C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- **No**
- **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

- **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
  *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*
- **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
  *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

**In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:**

**A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

**B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

**C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

**D.** Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

**E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

**F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

**G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

**H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

**I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

**J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

***Note: Item 6-I must be completed.***

**A. Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

**B. Inpatients**. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

**C. Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

**D. Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

**E. Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

**F. FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

**G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

**H. Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

**I. Public Input.** Describe how the State secures public input into the development of the waiver:
The Aged and Disabled Waiver's Quality Improvement (QI) Advisory Council meets quarterly to develop and monitor the implementation of Waiver quality improvement strategies. A portion of each meeting is set aside to hear public comment and feedback concerning the implementation of the Waiver. The Council, with its broad-base of stakeholder representation, is the primary conduit for public input. The Bureau for Medical Services and the operating agency along with members of the QI Advisory Council, conducted four (4) regional forums in the Spring of 2009 specifically to solicit input regarding the Waiver renewal directly from participants, providers, advocates, family members and other interested parties.

The draft renewal application was posted for a 30-day public period on April 15, 2010.

**J. Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

**A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:** Nisbet

**First Name:** Patricia

**Title:** Director of Office of Home and Community-Based Services

**Agency:** Bureau for Medical Services, Department of Health and Human Resources

**Address:**

350 Capitol Street, Room 251

**Address 2:**

**City:** Charleston, WV

**State:** **West Virginia**

**Zip:** 25301

**Phone:** (304) 356-4904 **Ext:** ☐ **TTY**

**Fax:** (304) 558-4398

**E-mail:** Patricia.S.Nisbet@wv.gov

**B.** If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:** Wright

**First Name:** Linda

**Title:** Acting Director, Medicaid Program Operations

**Agency:** WV Bureau of Senior Services

**Address:** 1900 Kanawha Blvd., E

**Address 2:**

**City:** Charleston

**State:** **West Virginia**

**Zip:** 25305

**Phone:** (304) 558-3317 **Ext:** ☐ **TTY**

**Fax:** (304) 558-6647

**E-mail:** Julie.L.Shelton@wv.gov

## 8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

**Signature:** Stacie Haynes-Legg

State Medicaid Director or Designee

**Submission Date:** Oct 22, 2014

**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

**Last Name:** Haynes-Legg

**First Name:** Stacie

**Title:** Director, Budget & Accounting Services

**Agency:** West Virginia Department of Health and Human Resources, Bureau for Medical Services

**Address:** 350 Capitol Street, Rm 251

**Address 2:**

**City:** Charleston

**State:** **West Virginia**

**Zip:** 25301

**Phone:** (304) 356-4879 **Ext:** ☐ **TTY**

**Fax:** (304) 558-4398

**E-mail:** stacie.l.haynes-legg@wv.gov

## Attachments

**Attachment #1: Transition Plan**

Specify the transition plan for the waiver:

**Attachment #2: Home and Community-Based Settings Waiver Transition Plan**
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*
*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*
*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*
*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

Based upon the State's assessment of the HCBS settings in the Aged and Disabled waiver, the state confirms that services in this waiver are rendered in a home and community setting. This waiver does not include residential or non-residential serivces, only homemaker services. A survey completed by the operating agency for the ADW, the WV Bureau of Medical Services, that included all sixty (60) Independent Case Management agencies and all one hundred and two (102) Homemaker agencies revealed only one member possibly receiving services in a congregate setting. Waiver participants reside in private home dwellings located in the community. This waiver does not provide services in either congregate living facilities, institutional settings or adjacent to or on the grounds of institutions. No further transition plan is necessary other than investigating the one questionable response. This setting will be reviewed by 10/15/14 and a report made back to CMS regarding the findings and possible remedial action that may need to be taken.
The state provided a 30-day public notice and comment period regarding the transition plan. The notice was publicized in the state's largest newspaper, The Charleston Gazette/Daily Mail on Saturday, July 26, 2014. The notice was also posted on the Bureau for Medical Services website as well as at the Bureau of Senior Services, all of the senior centers and all the ADW providers. Additionally all members of the ADW Quality Improvement Councils and 3 advocacy groups received a copy.
A public hearing was held on July 31, 2014 from 1 pm to 3 pm at the Bureau of Senior Services. One person attended. A teleconference utilizing a toll-free number was held at the same time with an operator recording all comments. Five comments were received, four of which were related to individuals residing in nursing homes who were not ADW recipients. Additionally, the email of the ADW Program Manager was made available to receive comments for thirty days, from July 31, 2014 to August 31, 2014. No comments were received. One question was received related to how WV planned to operationalize person-centered planning requirements and we will address this outside the HCBS Transition Plan.
Copies of the survey completed by the Case Management and Homemaker agencies, the newspaper advertisement, the comments received during the public hearing as well as the comment received via email are available on the BMS website: http://www.dhhr.wv.gov/bms/hcbs/ADW/ADWTP/Pages/default.aspx

This amendment was posted for an additional 30 days of public comment on the Bureau for Medical Services from 9/5/14 to 10/5/14 and no comments were received.

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

## Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ○ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   *(Do not complete item A-2)*

   ○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

   *(Complete item A-2-a).*

   ◉ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:
   **The Bureau of Senior Services (BoSS)**

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

## Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   **As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   The Aged and Disabled Waiver (ADW) is operated by a separate agency of the State under the supervision and guidance of the West Virginia Bureau for Medical Services (BMS). BMS provides administrative oversight and issues policies, rules and regulations related to the operation of the ADW. A copy of the interagency agreement between BMS and the operating agency outlining specific activities, functions, and responsibilities is on file. The administrative functions delegated to the operating agency include:

   - Participant waiver enrollment

- Qualified provider enrollment
- Review of member Service Plans (participant-direction)
- Quality assurance and quality improvement activities

Per the interagency agreement with BMS, the operating agency will:

- Perform on-site visits to prospective ADW providers to evaluate certification requirements

- Refer potential service providers for enrollment as ADW providers

- Enroll new ADW members and maintain a master list of all current members

- Monitor provider compliance with Program policies and certification criteria

- Monitor the delivery of ADW services for appropriateness and effectiveness

- Provide monthly reports on all provider monitoring activities.

- Maintain ADW provider files, information, and reports necessary to determine compliance with established program standards

- Represent BMS's interests in all ADW member Fair Hearings

- Provide ADW providers with appropriate Medicaid regulations and policies

- Confer with BMS staff on training and providing technical assistance to ADW providers

- Respond to all referrals, legislative and other requests (except for fiscal issues) in writing, and be present upon request of the legislature to answer any inquiries about the ADW program

- Establish and maintain secure Email capacity that complies with HIPAA regulations.

- Provide the necessary appropriated state funds to match with federal administrative matching funds for ADW services and certify in writing, on a quarterly basis, the availability of such funds

- Invoice the Bureau for Medical Services for allowable administrative costs

- Repay any administrative funds that are disallowed as a result of federal and/or state audits.

Quality Improvement

- Maintain an ongoing and effective Quality Improvement system for the ADW

- Maintain and support an ADW Quality Improvement (QI) Advisory Council

- Ensure the ongoing development of the QI Advisory Council with appropriate information and training

- Develop and monitor the implementation of an annual Quality Management Plan for the ADW

- Participate in the quarterly Quality Management Team meetings with BMS staff.

- Develop and distribute the Quarterly Quality Management Report to the QI Advisory Council and BMS.

- Develop and maintain an Incident Management System and complaint line for the ADW

- Maintain minutes of the monthly operational meeting with BMS.

- Conduct quality reviews of all ADW providers and prepare review reports. (Final reports must be approved by BMS prior to any distribution or action.)

The methods BMS employs to provide oversight and guidance related to the implementation of the agreement include:

- Monthly contract meetings with BMS and operating agency staff
- Monthly written reports prepared for and submitted to BMS and operating agency management staff
- Quarterly Quality Management Reports submitted to BMS and operating agency management staff
- Quarterly QI Advisory Council meetings

## Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

(●) **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
BMS contracts with the following entities to perform operational and administrative functions as follows:

1. Operating Agency:
- Participant waiver enrollment
- Qualified Provider enrollment
- Quality assurance and quality improvement activities
- Review of member Service Plans (participant-direction)

2. Administrative Services Organization (ASO):
- Level of Care evaluation
- Prior authorization of Waiver services

3. Claims Processing Entity:
- Utilization management

4. Fiscal Employer/Agent (FE/A):
- Waiver expenditures managed against approved levels
- Utilization management
- Qualified Provider enrollment
- Execution of provider agreements

( ) **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

(●) **Not applicable**

( ) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

[ ] **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

*Specify the nature of these agencies and complete items A-5 and A-6:*

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Specify the nature of these entities and complete items A-5 and A-6:*

## Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.**Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The Bureau for Medical Services (BMS) is responsible for assessing the performance of contracted entities with delegated Waiver operations and administrative functions.

## Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The Bureau for Medical Services (BMS) conducts monthly contract meetings with the operating agency, the FE/A, and the Administrative Services Organization (ASO). These meetings cover all delegated functions performed by the contracting entities. In addition, the operating agency provides a monthly program report and a quarterly Quality Management Report to BMS that cover delegated functions. The ASO provides BMS a monthly activity report and a monthly tracking report that details the disposition of all referrals for medical eligibility. These reports cover delegated functions. The FE/A provides a monthly program report and other regularly scheduled reports and ad hoc reports as requested. These reports cover delegated functions. The claims processing entity provides a number of regular and ad hoc reports on claims data that cover delegated functions. All reports are reviewed by management staff at BMS and discussed at regularly scheduled contract meetings as warranted.

## Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.**In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

| Function | Medicaid Agency | Other State Operating Agency | Contracted Entity |
|---|---|---|---|
| **Participant waiver enrollment** | ☑ | ☑ | ☐ |
| **Waiver enrollment managed against approved limits** | ☑ | ☐ | ☐ |
| **Waiver expenditures managed against approved levels** | ☑ | ☐ | ☑ |
| **Level of care evaluation** | ☑ | ☐ | ☑ |
| **Review of Participant service plans** | ☑ | ☑ | ☐ |
| **Prior authorization of waiver services** | ☑ | ☐ | ☑ |
| **Utilization management** | ☑ | ☐ | ☑ |

| Function | Medicaid Agency | Other State Operating Agency | Contracted Entity |
|---|---|---|---|
| Qualified provider enrollment | ☑ | ☑ | ☐ |
| Execution of Medicaid provider agreements | ☑ | ☐ | ☑ |
| Establishment of a statewide rate methodology | ☑ | ☐ | ☐ |
| Rules, policies, procedures and information development governing the waiver program | ☑ | ☐ | ☐ |
| Quality assurance and quality improvement activities | ☑ | ☑ | ☐ |

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Administrative Authority**
***The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.***

**i. Performance Measures**

***For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application.*** *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

***Where possible, include numerator/denominator.***

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of Medicaid oversight meetings where Waiver functions are discussed.**
**(Numerator = # of Medicaid oversight meetings where Waiver functions are discussed**
**Denominator = # of Waiver meetings).**

**Data Source** (Select one):
**Meeting minutes**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |

| | | |
|---|---|---|
| | | |
| ☑ **Other**<br>Specify:<br>Administrative Services Organization (ASO) and FE/A | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>ASO and FE/A | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of annual nursing home level of care re-evaluations that were completed in the time specified in the agreement with the ASO. (Numerator = # of annual nursing home level of care re-evaluations completed by ASO in specified time frame Denominator = # of requests for re-evaluations received in a timely manner per policy).**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| | | |

| | | |
|---|---|---|
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval =<br> |
| ☑ **Other**<br>Specify:<br>ASO | ☐ **Annually** | ☐ **Stratified**<br>Describe Group:<br> |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify:<br> |
| | ☐ **Other**<br>Specify:<br> | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>ASO | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify:<br> |

**Performance Measure:**
**Number and percent of initial nursing home level of care determinations that were completed in the time frame specified in the agreement with the ASO. (Numerator = # of determinations completed by ASO in specified time frame Denominator = # of requests for initial evaluation)**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |

| | | |
|---|---|---|
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval =<br> |
| ☑ **Other**<br>Specify:<br>ASO | ☐ **Annually** | ☐ **Stratified**<br>Describe Group:<br> |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify:<br> |
| | ☐ **Other**<br>Specify:<br> | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>ASO | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify:<br> |

**Performance Measure:**
**Number and percent of service level change requests that were processed by the ASO in the specified time frame per policy. (Numerator = # of service level change requests that were processed by the ASO in the specified time frame per policy Denominator = # of service level change requests).**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Report to State Medicaid Agency**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| | | |

| | | |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>ASO | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other**<br>Specify:<br>ASO | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percentage of members enrolled by the operating agency who meet all eligibility criteria. (Numerator = # of members enrolled by the operating agency who meet all eligibility criteria Denominator = # of members enrolled by the operating agency).**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|

| | | |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of prior authorizations conducted by the ASO with enrollment confirmed by the operating agency. (Numerator = # of prior authorizations conducted by the ASO with enrollment confirmed by the operating agency Denominator - # of prior authorizations conducted by the ASO).**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| Responsible Party for data collection/generation *(check each that applies):* | Frequency of data collection/generation *(check each that applies):* | Sampling Approach *(check each that applies):* |
|---|---|---|
| ☐ State Medicaid Agency | ☐ Weekly | ☑ 100% Review |
| ☐ Operating Agency | ☐ Monthly | ☐ Less than 100% Review |
| ☐ Sub-State Entity | ☐ Quarterly | ☐ Representative Sample<br>Confidence Interval =<br>[ ] |
| ☑ Other<br>Specify:<br>ASO | ☐ Annually | ☐ Stratified<br>Describe Group:<br>[ ] |
| | ☑ Continuously and Ongoing | ☐ Other<br>Specify:<br>[ ] |
| | ☐ Other<br>Specify:<br>[ ] | |

**Data Aggregation and Analysis:**

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis *(check each that applies):* |
|---|---|
| ☑ State Medicaid Agency | ☐ Weekly |
| ☐ Operating Agency | ☐ Monthly |
| ☐ Sub-State Entity | ☑ Quarterly |
| ☑ Other<br>Specify:<br>ASO | ☐ Annually |
| | ☐ Continuously and Ongoing |
| | ☐ Other<br>Specify:<br>[ ] |

**Performance Measure:**
**Number and percent of provider initial certifications conducted by the operating agency in compliance with provider certification standards. (Numerator = # of provider initial certifications conducted by the operating agency in compliance with certification standards Denominator = # of provider initial certifications conducted by the operating agency).**

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of member chart reviews conducted annually by the operating agency as specified in the agreement with BMS. (Numerator = # of member chart reviews conducted**

**annually by the operating agency as specified in the agreement with BMS. Denominator = Representative sample established by BMS).**

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**

**Number and percent of annual provider re-certifications conducted by the operating agency as specified in the agreement with BMS. (Numerator = # of annual provider re-certifications conducted by the operating agency as specified in the agreement with BMS Denominator = # of providers due an annual recertification).**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis *(check each that applies):* |
|---|---|
| | |

**Performance Measure:**
**Number and percent of Quality Improvement Council meetings held quarterly by the operating agency as specified in the agreement with BMS. (Numerator = # of Quality Improvement Council meetings held quarterly by the operating agency as specified in the agreement with BMS Denominator = # of required meetings).**

**Data Source** (Select one):
**Meeting minutes**
If 'Other' is selected, specify:

| Responsible Party for data collection/generation*(check each that applies):* | Frequency of data collection/generation*(check each that applies):* | Sampling Approach*(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval =<br> |
| ☐ **Other**<br>Specify:<br> | ☐ **Annually** | ☐ **Stratified**<br>Describe Group:<br> |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify:<br> |
| | ☐ **Other**<br>Specify:<br> | |

**Data Aggregation and Analysis:**

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| | |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of Quality Management Reports developed by the operating agency per agreement with BMS that are reviewed and discussed at contract meetings with BMS. (Numerator = # of Quality Management Reports reviewed and discussed at contract meetings with BMS Denominator = # of Quality Management Reports developed by the operating agency).**

**Data Source** (Select one):
**Meeting minutes**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval =<br> |
| ☐ **Other**<br>Specify:<br> | ☐ **Annually** | ☐ **Stratified**<br>Describe Group:<br> |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify:<br> |
| | ☐ **Other**<br>Specify:<br> | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| | |

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The operating agency and the ASO are required to submit a number of regular reports to the Bureau for Medical Services (BMS). BMS utilizes these reports to monitor delegated administrative functions. Any individual issues or concerns that are identified via these reports are addressed directly with individual contractors during monthly contract oversight meetings. Strategies to remedy specific identified issues are developed with the contractors and monitored through these meetings. Documentation is maintained with detailed contract meeting minutes.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| Responsible Party*(check each that applies):* | Frequency of data aggregation and analysis *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other**<br>Specify:<br>ASO | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-1: Specification of the Waiver Target Group(s)

**a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

| Target Group | Included | Target SubGroup | Minimum Age | Maximum Age | |
|---|---|---|---|---|---|
| | | | | Maximum Age Limit | No Maximum Age Limit |
| ☑ **Aged or Disabled, or Both - General** | | | | | |
| | ☑ | **Aged** | 65 | | ☑ |
| | ☑ | **Disabled (Physical)** | 18 | 64 | |
| | ☐ | **Disabled (Other)** | | | |
| ☐ **Aged or Disabled, or Both - Specific Recognized Subgroups** | | | | | |
| | ☐ | **Brain Injury** | | | ☐ |
| | ☐ | **HIV/AIDS** | | | ☐ |
| | ☐ | **Medically Fragile** | | | ☐ |
| | ☐ | **Technology Dependent** | | | ☐ |
| ☐ **Intellectual Disability or Developmental Disability, or Both** | | | | | |
| | ☐ | **Autism** | | | ☐ |
| | ☐ | **Developmental Disability** | | | ☐ |
| | ☐ | **Intellectual Disability** | | | ☐ |
| ☐ **Mental Illness** | | | | | |
| | ☐ | **Mental Illness** | | | |
| | ☐ | **Serious Emotional Disturbance** | | | |

**b. Additional Criteria.** The State further specifies its target group(s) as follows:

**c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- ( ) **Not applicable. There is no maximum age limit**

**The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

There is no need for a transition procedure - essentially these individuals continue to be on the program under the minimum age requirements for the aged population as specified above.

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (1 of 2)

**a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

**No Cost Limit.**The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c*.

**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c*.

**The limit specified by the State is** *(select one)*

**A level higher than 100% of the institutional average.**

Specify the percentage:

**Other**

*Specify:*

**Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

**Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

*Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*

**The cost limit specified by the State is** *(select one)*:

**The following dollar amount:**

Specify dollar amount:

**The dollar amount** *(select one)*

**Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

**May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

**The following percentage that is less than 100% of the institutional average:**

Specify percent:

**Other:**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (2 of 2)

**b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The needs of Aged and Disabled Waiver members are addressed in the member's Service Plan (SP), which is developed by an ADW Case Manager in the Traditional Model and by the member with the assistance of the F/EA (if requested) in the Participant-Directed Model. The SP includes Waiver services, non-Waiver services, informal supports, and emergency backup planning. The SP must address all identified needs, including risks to member health and safety.

**c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

**The participant is referred to another waiver that can accommodate the individual's needs.**

**Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

**Other safeguard(s)**

Specify:

A key Case Management function is to oversee the implementation of ADW member services as outlined on the member's Service Plan. At a minimum, Case Managers must contact members monthly to review the implementation of the SP and address any identified issues or concerns. If an ADW member experiences a change in condition or circumstances (e.g., a family caregiver no longer is available or is temporarily unavailable to support the individual) that places the member's health and welfare at risk and cannot be adequately addressed with Waiver services, the Case Manager must make appropriate referrals to other available resources in the community. As a last resort, if a member's health and welfare cannot be assured by utilizing Waiver and/or other available community resources, the member will be referred for institutional services.

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (1 of 4)

**a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

**Table: B-3-a**

| Waiver Year | Unduplicated Number of Participants |
|---|---|
| **Year 1** | 8165 |
| **Year 2** | 8620 |
| **Year 3** | 7210 |
| **Year 4** | 6409 |
| **Year 5** | 6199 |

**b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- (●) **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

**Table: B-3-b**

| Waiver Year | Maximum Number of Participants Served At Any Point During the Year |
|---|---|
| **Year 1** | |
| **Year 2** | |
| **Year 3** | |
| **Year 4** | |
| **Year 5** | |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**c. Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ( ) **Not applicable. The state does not reserve capacity.**
- (●) **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

| Purposes | |
|---|---|
| **MFP Participants** | |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**Purpose** *(provide a title or short description to use for lookup):*

MFP Participants

**Purpose** *(describe):*

The State may reserve a portion of the participant capacity for individuals who are enrolled in the MFP initiative. These are individuals who are medically and financially eligible for the Aged and Disabled Waiver program, and choose to transition to the community. The amount of capacity reserved is based on the number of transitions projected for the State's Money Follows the Person initiative.

The State will reserve capacity in Waiver Year 3 for 100 individuals. The number of unduplicated participants who are served in Waiver Year 3 is 7210.

The State will reserve capacity in Waiver Year 4 for 48 individuals and the maximum number of unduplicated participants who are served in Waiver Year 4 is 6409 (increasing from 6275 to 6409).

The state will reserve the capacity in Wavier Year 5 for 70 individuals and the maximum number of unduplicated participants who are served in Wavier Year 5 is 6199 (decreasing from 6409 to 6199).

If the MFP program does not enroll 70 members in Year 5, then the Aged and Disabled Waiver Program Manager will re-assign those slots to the Aged and Disabled Waiver Program (not to exceed 6199 slots combined ADW and MFP participants).

**Describe how the amount of reserved capacity was determined:**

The amount of capacity reserved is based on the nnumber of transitions projected for the State's Money Follows The Person initiative during Waiver Year 3, Waiver Year 4 and Waiver Year 5.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | |
| Year 2 | |
| Year 3 | 100 |
| Year 4 | 48 |
| Year 5 | 70 |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (3 of 4)

**d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

**e. Allocation of Waiver Capacity.**

*Select one*:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

**f. Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

When the capacity for members served by the Aged and Disabled Waiver (ADW) program is reached, applicants for ADW services are placed on a Managed Enrollment List. Applications for entry to the program will be processed based on the date/time of their request for medical eligibility determination as capacity becomes available.

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served - Attachment #1 (4 of 4)

**Answers provided in Appendix B-3-d indicate that you do not need to complete this section.**

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

**a.**

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (●) **No**
   - ( ) **Yes**

**b. Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

***Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)***

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

*Select one*:

- ( ) **100% of the Federal poverty level (FPL)**
- ( ) **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902 (a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

*Specify:*

***Special home and community-based waiver group under 42 CFR §435.217)*** *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ( ) **No.The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- (•) **Yes.The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

*Select one and complete Appendix B-5.*

- ( ) **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- (•) **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

*Check each that applies*:

- [x] **A special income level equal to:**

*Select one*:

- (•) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount:

- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- [ ] **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- [ ] **Aged and disabled individuals who have income at:**

*Select one*:

- ( ) **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 7)

*In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.*

**a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

*Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

☐ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).*

○ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

○ **Use spousal post-eligibility rules under §1924 of the Act.**
*(Complete Item B-5-b (SSI State) and Item B-5-d)*

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

◉ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**b. Regular Post-Eligibility Treatment of Income: SSI State.**

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

**i. Allowance for the needs of the waiver participant** (*select one*):

- **The following standard included under the State plan**

  *Select one*:

  - **SSI standard**
  - **Optional State supplement standard**
  - **Medically needy income standard**
  - **The special income level for institutionalized persons**

    (*select one*):

    - **300% of the SSI Federal Benefit Rate (FBR)**
    - **A percentage of the FBR, which is less than 300%**

      Specify the percentage:
    - **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - **A percentage of the Federal poverty level**

    Specify percentage:
  - **Other standard included under the State Plan**

    *Specify:*
- **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- **The following formula is used to determine the needs allowance:**

  *Specify:*
- **Other**

  *Specify:*

**ii. Allowance for the spouse only** (*select one*):

- **Not Applicable (see instructions)**
- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.
- **The amount is determined using the following formula:**

*Specify:*

**iii. Allowance for the family** (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- **The amount is determined using the following formula:**

  *Specify:*
- **Other**

  *Specify:*

**iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

  *Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (3 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**c. Regular Post-Eligibility Treatment of Income: 209(B) State.**

**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (4 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (5 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.**

**Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (6 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.**

**Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (7 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.**

# Appendix B: Participant Access and Eligibility

## B-6: Evaluation/Reevaluation of Level of Care

*As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.*

a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

   i. **Minimum number of services.**

   The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

   ii. **Frequency of services.** The State requires (select one):

   - (●) **The provision of waiver services at least monthly**
   - ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

   *If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- (●) **By an entity under contract with the Medicaid agency.**

  *Specify the entity:*

  Administrative Services Organization (ASO)

- ( ) **Other**
  *Specify:*

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Per contract with the ASO, all initial assessments for the determination of medical eligibility for the ADW are conducted by registered nurses.

d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Medical Eligibility Criteria:

Initial medical necessity is based on information provided to a RN of the ASO, which is documented on the Pre-Admission Screening (PAS). An applicant must have at least five (5) deficits to qualify medically for the ADW Program. These deficits are derived from a combination of the following assessment elements on the PAS.

1. Decubitus( Stage 3 or 4 )
2. In the event of an emergency, the applicant is mentally or physically unable to vacate a building
3. Functional abilities of individual in the home
Eating (needs physical assistance to get nourishment)
Bathing (needs physical assistance or more)
Dressing (needs physical assistance or more)
Grooming (needs physical assistance or more)
Continence(must be incontinent)
Orientation (must be totally disoriented, comatose)
Transfer (requires one-person or two-person assistance)
Walking (requires assistance)
Wheeling (must require assistance with walking in the home)

4. Individual has skilled needs in one or more of the following areas:
Suctioning
Tracheostomy
Ventilator
Parenteral fluids
Sterile dressings
Irrigations

5. Individual is not capable of administering his/her own medications.

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. **Process for Level of Care Evaluation/Reevaluation:**Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The ASO currently has eighteen (18) full time registered nurses located across the state who conduct assessments of medical eligibility for the Aged and Disabled Waiver Program (ADW). The process detailed below applies to both initial assessments of medical eligibility as well as annual re-evaluations except where otherwise noted:

1. The ASO accepts Medical Necessity Evaluation Request Forms (referrals) by fax or mail. Incomplete referrals are returned to the referring entity. If the referral is for an initial assessment, a letter is also sent to the applicant informing them of additional information needed.

2. The ASO returns all referrals to the referring entity if it was not signed by the applicant's (initial assessments)/member's (re-evaluation assessments) treating physician within sixty (60) days of receipt.

3. The ASO enters the information from each completed referral into a database and assigns it to a registered nurse, who then accesses this information electronically.

4. The ASO attempts to contact the applicant/member (or legal representative) within 48 hours of receipt of the referral.

5. The ASO issues a potential closure letter if the applicant/member (or legal representative) cannot be contacted with three exhaustive episodes.

6. The ASO mails the potential closure letter to the applicant/member (or legal representative) and also faxes or mails it to the referring entity. The letter includes a toll-free number for the applicant/member (or legal representative) to call to schedule the evaluation.

7. The ASO closes the referral if they do not receive a call within four days of the date of the potential closure letter. If the applicant/member decides to have the evaluation after the referral is closed, a new referral is required.

8. Upon contacting the applicant/member (or legal representative), the ASO schedules the evaluation visit, allowing at least two weeks advance notice.

9. During the scheduling contact, the ASO also:
- Obtains directions to the home.
- Determines if the applicant/member requires alternative handouts (i.e., Braille, audio or large print) to be mailed in advance of the appointment.
- Explains that an appointment confirmation and estate recovery information will be mailed to the applicant/member (or legal representative).
- Advises applicants/members (or legal representative) of their right to have someone else present at the visit.
- If the applicant or member has a diagnosis of alzheimer's, dementia, or related condition, the ASO contacts the designated contact or legal representative noted on the referral form. If no such individual is indicated, the referring entity is contacted for further information.

10. The ASO provides a toll-free number for the applicant/member (or legal representative) to call to reschedule appointments if necessary, or to ask further questions. The agreed upon timeframe for visits is a two hour window (e.g., 10:00 am-12:00 pm).

11. The ASO mails an appointment confirmation letter to the applicant/member (or legal representative) once the visit is scheduled and faxes a copy to the referring entity.

12. A RN of the ASO distributes informational handouts to the applicant/member (or legal representative). The RN explains the reason for the visit and offers to read any of the information distributed.

13. During initial assessments of medical eligibility, the RN obtains consent, using the BMS approved Consent Form. The RN offers to read/explain the form, if necessary. The applicant/member (or legal representative) must sign and date the consent form for the evaluation to proceed.

14. The RN verifies the applicant/member's information from the referral form. The RN also verifies the Medicaid identification number, if applicable, by asking to see the card.

15. The RN then offers to answer any questions the applicant/member (or legal representative) may have.

16. The RN collects the data for the PAS Assessment Form by asking questions and requesting that the applicant/member demonstrate abilities, e.g., walking, transferring, raising arms.

17. The RN reviews the assessment documentation with those present at the visit once the evaluation is complete and allows time for any questions or discussions surrounding the documentation.

18. The RN submits the evaluation electronically within seven days of the assessment. During the time between the assessment and submission of the evaluation, the RN attempts to clarify any outstanding issues with the applicant/member's treating physician. Such issues may include additional diagnoses.

19. The RN mails and faxes the signed Consent Form to the ASO central office.

20. The ASO runs the medical eligibility assessment data through a computerized algorithm that is based on current BMS policy.

21. If the applicant/member has five or more deficits, the computerized algorithm will calculate the individual's service level, consistent with BMS policy.

22. If the applicant has five or more deficits, the ASO issues a medical eligibility determination letter. If there is capacity to

add new members, the notification also includes the service level, appeal rights information and a copy of the completed evaluation. The packet also includes a Hearing Request Form with instructions for completion. A copy is also sent to the referring entity.

23. For initial referrals, the ASO informs the operating agency if the applicant fails to select a Case Management and Personal Assistance/Homemaker Agency.

24. The ASO issues a potential denial letter if the applicant/member has less than five deficits allowing the applicant/member (or legal representative) 2 weeks to submit additional clinical information. The letter includes a copy of the completed evaluation. In addition, a copy is also faxed or mailed to the referring entity.

25. The ASO mails a final denial letter to the applicant/member (or legal representative) with appeal rights information and a copy of the evaluation if no additional information is submitted within two weeks. A copy is also faxed or mailed to the referring entity.

26. If additional information is submitted within this two week time period, the additional information is sent to a RN of the ASO to review. The RN documents the additional information, as well as any changes that he/she is making, and submits the final evaluation within seven days following the 2 week time period from the potential denial.

27. The ASO runs data ascertained from the medical necessity assessment through the computerized algorithm (as described above) once the final evaluation information is received.

28. A final denial letter is issued with a copy to the referring entity, along with a copy of the final assessment form and appeal rights if the applicant/member has fewer than five deficits. Also enclosed is a hearing request form with instructions for its completion.

29. A service level is calculated using the computerized algorithm, (following the same process as noted above) if the applicant/member has five or more deficits.

30. If the applicant/member (or legal representative) requests a Fair Hearing regarding denial of services, or service level determination, the ASO RN who completed the assessment attends the hearing either by conference call or in person. The RN testifies as to the information gathered, either at the assessment or within two weeks of the denial.

31. All packets for medical approvals/denials include a Medical Records Release Form for the applicant/member (or legal representative). When submitted, a copy of the requested documents is provided to the member or his/her designees free of charge.

32. The ASO conducts annual re-evaluations prior to expiration of the current PAS.

33. The completion of referrals for initial or re-evaluation will take no longer than 30 working days from receipt of the referral by the ASO.

34. The ASO notifies BMS of any extenuating circumstances that may affect its ability to meet turn around times.

**g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  *Specify the other schedule:*

**h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

**The qualifications are different.**
*Specify the qualifications:*

i. **Procedures to Ensure Timely Reevaluations.**Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

Per the ADW Policy Manual, it is the responsibility of Case Management Agencies to ensure that each member's annual request for medical evaluation is submitted in a timely manner. ADW case managers must submit the Medical Necessity Re-Evaluation Request Form to the ASO no later than 45 days prior to the annual re-evaluation due date. Per contract, the ASO is responsible for completing all annual re-evaluations prior to the due date. Members who participate in participant-direction are responsible for submitting the Medical Necessity Re-Evaluation Request Form with the assistance of the FE/A or case manager (if applicable). The FE/A mails a reminder notification to participant-directed members at least ninety (90) days prior to the medical re-evaluation due date. Resource Consultants with the FE/A then track and verify that the Medical Necessity Re-Evaluation Request Form was received and accepted by the ASO.

j. **Maintenance of Evaluation/Reevaluation Records.**Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All initial assessments and annual re-evaluations of medical eligibility determinations are maintained for a minimum of 3 years by the ASO.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**

***The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.***

i. **Sub-Assurances:**

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of new enrollees whose medical eligibility assessment indicated nursing home level of care was conducted prior to receipt of Waiver services.**
**(Numerator = # of new enrollees whose medical eligibility assessment indicated nursing home level of care was conducted prior to receipt of Waiver services Denominator = Total # of enrollees).**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**b.** ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of participants who received an annual re-determination of eligibility within 12 months of their last loc evaluation. (Numerator = # of participants who received an annual re-determination of eligibility within 12 months of their last loc evaluation Denominator = Total # of participants due an annual re-determination).**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☑ **Other** Specify: Administrative Services Organization | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☑ **Other** Specify: Report generated monthly. | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>ASO | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of members who have a current Pre-Admission Screening(WV Level of Care Assessment Tool) in member's chart. (Numerator = # of members who have a current Pre-Admission Screening in member's chart Denominator = # of member charts reviewed).**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% |
| ☐ **Other** | ☐ **Annually** | ☐ **Stratified** |

| | | |
|---|---|---|
| Specify: | | Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☑ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of Pre-Admission Screenings signed by an Administrative Services Organization RN. (Numerator = # of Pre-Admission Screenings signed by an Administrative Services Organization RN Denominator = # of charts reviewed).**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** |

| | | |
|---|---|---|
| | | Confidence Interval = 95% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of initial nursing home LOC determinations made where appropriate criteria was accurately applied. (Numerator = # of initial nursing home LOC determinations made where appropriate criteria was accurately applied Denominator = # of initial nursing home level of care determinations reviewed).**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| | | |

| | | |
|---|---|---|
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>Administrative Services Organization (ASO) | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☑ **Other**<br>Specify:<br>Reviews conducted for internal quality check. Review sample may not be representative. |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other**<br>Specify:<br>ASO | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Information regarding compliance with the Level of Care assurance is reported to the Bureau for Medical Services by the operating agency and the ASO. These reports are reviewed by BMS with the contractors. Any individual problems that are identified via these reports are addressed immediately and discussed during regularly scheduled contract meetings with the operating agency and the ASO. Remediation strategies including completion timeframes and responsible party (ies) are developed and monitored. Documentation is maintained in contract meeting minutes.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other**<br>Specify:<br>ASO | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

***Freedom of Choice.*** *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

*i. informed of any feasible alternatives under the waiver; and*
*ii. given the choice of either institutional or home and community-based services.*

**a. Procedures.**Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

When the Administrative Services Organization (ASO) conducts the initial medical eligibility assessment, applicants (or legal representative) are provided an ADW Program Brochure that details services available to eligible individuals. Applicants (or

legal representative) are asked to sign a Consent Form indicating their choice of waiver services vs. institutional care. If determined medically eligible, applicants (or legal representative) receive a Service Delivery Model Selection Form which provides information on the two service model options - the Traditional Model and the Participant-Directed Model.

b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

   Freedom of choice forms (Consent Forms and Service Delivery Model Selection Forms) are maintained electronically for a minimum of three years by the ASO.

## Appendix B: Participant Access and Eligibility

### B-8: Access to Services by Limited English Proficiency Persons

**Access to Services by Limited English Proficient Persons.** Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
Per the Census 2000, 97.25% of West Virginian's speak only English. Due to this high percentage, the ADW program addresses any needs or requests for alternative material on an individual basis. All materials are currently available in alternate formats for individuals who cannot access standard print material. These formats include large print, audio and Braille. In addition, BMS and all contract staff are available to read printed materials upon request.

## Appendix C: Participant Services

### C-1: Summary of Services Covered (1 of 2)

a. **Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

| Service Type | Service | | |
|---|---|---|---|
| Statutory Service | Case Management | | |
| Other Service | Participant-Directed Goods and Services | | |
| Other Service | Personal Assistance/Homemaker Service | | |

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Case Management

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Services that assist ADW members in gaining access to needed waiver services and other State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.
Case Management responsibilities also include:
- The ongoing monitoring of the provision of services included in the member's service plan and member health and welfare.
- Initiating the process to re-evaluate the individual's medical eligibility and the development of service plans.

All ADW members, whether they choose the Traditional Model or Participant-Directed Model of service delivery, have access to Case Management services from qualified providers. Any Waiver member who chooses to serve as their own Case Manager will be supported by the operating agency in fulfilling the Case Management responsibilities.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

**Service Delivery Method** *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Case Management Agency |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Case Management**

**Provider Category:**

Agency

**Provider Type:**
Case Management Agency
**Provider Qualifications**
**License** *(specify):*
Case management services must be provided by an individual licensed in West Virgninia as a social worker, counselor or registered nurse.
**Certificate** *(specify):*
Operating agency certification (initial and continuing)
**Other Standard** *(specify):*
The operating agency conducts initial and annual certification reviews per BMS policy.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
The operating agency certifies Case Management Agencies prior to the agency enrolling as a Medicaid Waiver provider. The operating agency also conducts continuing certification every 12 months.
**Frequency of Verification:**
Every 12 months

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
**Service Title:**
Participant-Directed Goods and Services

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Equipment or supplies not otherwise provided through the ADW or through the Medicaid State Plan that address an identified need in the Participant-Directed Service Plan (including improving and maintaining the member's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; and/or promote inclusion in the community; and/or increase the member's safety in the home environment; and, the member does not have the funds to purchase the item or service or the item or services is not available through another source. Participant Directed Goods and Services are purchased from the member's budget. Experimental or prohibited treatments are excluded. Participant Directed Goods and Services must be documented in the Participant-Directed Service Plan.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
The following items or services are excluded: Gifts for workers, family or friends, payments to someone to serve as a representative, clothing, food and beverages, electronic entertainment equipment, utility payments, swimming pools and spas, costs associated with travel, comforters, linens, drapes, furniture, vehicle expenses including routine maintenance and repairs, insurance and gas money, medications, vitamins, herbal supplements, monthly internet service, yard work, illegal drugs or alcohol, household cleaning supplies, home maintenance and repair, pet care, respite services, spa services, education, personal hygiene, discretionary cash. Any other good or service that does not address an identified need in the Participant-Directed Service Plan, decrease the need for other Medicaid services, and/or increase the person's safety in the home environment, and/or improve and maintain the member's opportunities for full membership in the community. There is a $1,000 annual limit.

**Service Delivery Method** *(check each that applies)*:

☑ **Participant-directed as specified in Appendix E**
☐ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

☐ **Legally Responsible Person**
☑ **Relative**
☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Qualified Business |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Participant-Directed Goods and Services**

**Provider Category:**
Individual
**Provider Type:**
Qualified Business
**Provider Qualifications**
**License** *(specify):*
Business License and/or relevant skills for work to be performed.
**Certificate** *(specify):*

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Members (or legal representative) who direct their services are responsible for ensuring that providers of PDGS meet qualification standards with assistance from the FE/A or their case manager (if applicable). The FE/A is responsible for validating vendor qualifications prior to processing invoices. The operating agency will monitor compliance during periodic reviews.

**Frequency of Verification:**
Initial – FE/A
Every 12 months – the operating agency

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Personal Assistance/Homemaker Service

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| | |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Personal Assistance/Homemaker services are defined as long-term direct care and support services that are necessary in order to enable an individual to remain at home rather than enter a nursing facility, or to enable an individual to return home from a nursing facility.

The components of the Personal Assistance/Homemaker Service include Personal Assistance/Homemaker, RN

Assessment, Nursing, and Transportation.

Personal Assistance/Homemaker: This component provides ADW members direct-care assistance with Activities of Daily Living (ADLs) such as eating, bathing, grooming, prompting with normally self-administered medications, essential light housekeeping , etc. Personal Assistance/Homemaker staff are also responsible for reporting changes in the member's condition and needs. Only qualified staff employed by certified Personal Assistance/Homemaker Agencies can provide this support.

RN Assessment: The RN Assessment component provides for an annual nursing assessment which is then used in conjunction with the medical eligibility assessment to develop the member's Plan of Care. Unlike the member's Service Plan, which is developed by the Case Manager and incorporates Waiver and non-Waiver services, the Plan of Care only details how Personal Assistance/Homemaker Services will be used to meet direct-care needs of the member. Only a Registered Nurse employed by a certified Personal Assistance/Homemaker Agency can provide this support.

Nursing: This component of the Personal Assistance/Homemaker Service provides for oversight of the implementation of each member's Plan of Care and the training and supervision of direct care staff. Only a Registered Nurse employed by a certified Personal Assistance/Homemaker Agency can provide this support.

Transportation: The Transportation component provides mileage reimbursement for Personal Assistance/Homemaker Agency staff who transport members as they conduct essential errands and participate in community activities as outlined in the member's Plan of Care. Only qualified direct-care staff with a valid driver's license employed by a qualified Personal Assistance/Homemaker Agency can provide this support.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

The following limits apply to Members who utilize the Traditional Agency Model:

Personal Assistance/Homemaker
Service Level D - up to 155 hours per month
Service Level C - up to 124 hours per month
Service Level B - up to 93 hours per month
Service Level A - up to 62 hours per month

The RN Assessment is limited to one (1) event per year.

Nursing is limited to six (6) 15 minute units per month.

The following limits apply to member's who utilize the Participant-Directed Model:

Personal Assistance/Homemaker - cannot exceed the member's monthly budget.

**Service Delivery Method** *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Personal Assistance/Homemaker Agency |
| Individual | Paraprofessional (Direct-care staff) |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Personal Assistance/Homemaker Service**

**Provider Category:**
Agency
**Provider Type:**
Personal Assistance/Homemaker Agency
**Provider Qualifications**
**License** *(specify):*
RN Assessement and Nursing supports must be provided by a Registered Nurse employed by a Personal Assistance/Homemaker Agency. Transportation supports must be provided by Personal Assistance/Homemaker agency staff with a valid driver's license.
**Certificate** *(specify):*
Operating agency certification (initial and continuing certification)
**Other Standard** *(specify):*
The operating agency conducts initial and annual certification reviews per BMS policy.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
The operating agency certifies Personal Assistance/Homemaker Agencies prior to the agency enrolling as a Waiver provider. The operating agency also conducts continuing certification every 12 months.
**Frequency of Verification:**
Every 12 months.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Personal Assistance/Homemaker Service**

**Provider Category:**
Individual
**Provider Type:**
Paraprofessional (Direct-care staff)
**Provider Qualifications**
**License** *(specify):*
Paraprofessional (direct-care staff) providing transportation support for members of the Participant-Directed Model must have a valid driver's license.
**Certificate** *(specify):*
**Other Standard** *(specify):*
Paraprofessionals employed by members in the Participant-Directed Model to provide Personal Assistance/Homemaker supports must meet mandatory training requirements prior to providing services. They must also meet ongoing annual training requirements.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Members (or legal representative if applicable) who direct their services are responsible for ensuring that their employees meet all training requirements. The FE/A is responsible for validating employee qualifications prior to processing payroll for services provided. The operating agency will monitor compliance with annual training requirements.
**Frequency of Verification:**

FE/A - Initial verification of paraprofessional (direct-care staff) qualifications.
Operating Agency - Verification every 12 months of paraprofessional (direct-care staff) qualifications.

## Appendix C: Participant Services

### C-1: Summary of Services Covered (2 of 2)

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

- ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

**a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Traditional Model - Statewide Criminal Investigation Background (CIB) checks are to be conducted by Personal Assistance/Homemaker Agencies for each direct-care staff prior to service delivery. Personal Assistance/Homemaker Agencies are required to provide the operating agency evidence of CIB checks as part of the annual review of provider qualifications.

Participant-Directed Model - Statewide Criminal Investigation Background (CIB) checks are to be conducted by the FE/A for each member employee prior to service delivery. The FE/A is required to provide the operating agency evidence of CIB checks as part of the annual review of provider qualifications.

**b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

WV Code § 15-2C-1. The West Virginia State Police, Criminal Identification Bureau maintains the Central Abuse Registry. Personal Assistance/Homemaker Agencies are required to request a Criminal Background Check (Central Abuse Registry) for all direct-care staff. The Central Abuse Registry shall contain, at a minimum, information relating to: Convictions of a misdemeanor or a felony involving abuse, neglect or misappropriations of property, by an individual performing services for compensation, within the scope of the individual's employment or contract to provide services, in a residential care facility, in a licensed day care center in connection with providing behavioral health services, or in connection with the provision of home care services; information relating to individuals convicted of specific offenses. Compliance is monitored by the operating agency as part of the periodic review of provider qualifications.

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

**c. Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- (●) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ( ) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

## Appendix C: Participant Services

### C-2: General Service Specifications (3 of 3)

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

  Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

  Specify the controls that are employed to ensure that payments are made only for services rendered.

  Relatives may be paid for providing any Aged and Disabled Waiver (ADW) service. Any relative may provide services excluding the member's spouse. Payments cannot be made to legal guardians for ADW services. Under the Participant-Directed Model, spending plans must be approved by the operating agency. The FE/A processes payments based on the approved spending plan. The operating agency conducts an annual review of member charts to monitor compliance and to ensure that services are furnished in the best interest of the member.
- **Other policy.**

  Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The Bureau for Medical Services (BMS) claims processing entity provides entities interested in becoming an Aged and Disabled Waiver (ADW) provider an enrollment packet, including a provider agreement, along with specific requirements and procedures to qualify. Per policy, the BMS claims processing entity has five (5) business days to process the enrollment application.

The applicant must return the provider agreement signed by an authorized applicant representative to BMS. An authorized representative from BMS signs the Provider Agreement and returns a copy to the applicant. BMS forwards a copy of the provider agreement to the BMS claims processing entity. Once this process has been completed, the claims processing entity assigns a provider number and sends a letter informing the agency that it may begin providing services with a copy to the operating agency. Information on the certification and enrollment process is posted on the operating agency's website.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Qualified Providers**

***The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.***

**i. Sub-Assurances:**

**a.** ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of new ADW providers who received certification prior to the provision of Waiver services. Numerator = Number and percent of new ADW providers who received certification prior to the provision of Waiver services Denominator = Total # of new ADW providers.**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| ☑ Operating Agency | ☑ Monthly |
| ☐ Sub-State Entity | ☐ Quarterly |
| ☐ Other<br>Specify: | ☐ Annually |
| | ☐ Continuously and Ongoing |
| | ☐ Other<br>Specify: |

**Performance Measure:**
**Number and percent of ADW providers who continue to meet certification standards.**
**Numerator = # of ADW providers who continue to meet certification standards**
**Denominator = # of ADW enrolled providers.**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| Responsible Party for data collection/generation *(check each that applies):* | Frequency of data collection/generation *(check each that applies):* | Sampling Approach*(check each that applies):* |
|---|---|---|
| ☐ State Medicaid Agency | ☐ Weekly | ☑ 100% Review |
| ☑ Operating Agency | ☐ Monthly | ☐ Less than 100% Review |
| ☐ Sub-State Entity | ☐ Quarterly | ☐ Representative Sample<br>Confidence Interval = |
| ☐ Other<br>Specify: | ☐ Annually | ☐ Stratified<br>Describe Group: |
| | ☑ Continuously and Ongoing | ☐ Other<br>Specify: |
| | ☐ Other<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of direct-care staff for whom a background check is conducted prior to providing services. Numerator = # of direct-care staff for whom a background check is conducted prior to providing services Denominator = Total # of ADW direct-care staff.**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**c.** ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of direct-care staff who meet all mandatory training requirements prior to service delivery. Numerator = # of direct-care staff who meet all mandatory training requirements prior to service delivery Denominator = Total # of personnel files reviewed**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other** Specify: Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of direct-care staff who met all annual training requirements for review period. Numerator = # of direct-care staff who met all annual training requirements for review period Denominator = Total # of personnel files reviewed.**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other** Specify: Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of direct-care staff who met the annual abuse/neglect training requirement. Numerator = # of direct-care staff who met the annual abuse/neglect training requirement Denominator = Total # of personnel files reviewed.**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| Responsible Party for data collection/generation *(check each that applies):* | Frequency of data collection/generation *(check each that applies):* | Sampling Approach*(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of direct-care staff who met CPR certification for the review period. Numerator = # of direct-care staff who met CPR certification for the review period Denominator = Total # of personnel files reviewed.**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| Responsible Party for data collection/generation *(check each that applies):* | Frequency of data collection/generation *(check each that applies):* | Sampling Approach*(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of direct-care staff who met First Aid training for the review period. Numerator = # of direct-care staff who met First Aid training for the review period Denominator = Total # of personnel files reviewed.**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

| | | |
|---|---|---|
| | | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
All evidence relating to this assurance is collected through the review of provider qualifications (Detailed in Appendix H) and reviewed by the Bureau for Medical Services (BMS) and the operating agency. Individual provider qualification issues related to these specific indicators are addressed immediately upon identification by the operating agency. Providers are required to submit corrective action plans addressing identified issues that must be approved by the operating agency.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | |

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
*Furnish the information specified above.*

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
*Furnish the information specified above.*

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
*Furnish the information specified above.*

☐ **Other Type of Limit.** The State employs another type of limit.

*Describe the limit and furnish the information specified above.*

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301 (c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

*Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (1 of 8)

**State Participant-Centered Service Plan Title:**
Service Plan (SP); Participant-Directed Service Plan (PDSP)

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  *Specify qualifications:*

- ☐ **Social Worker**

  *Specify qualifications:*

- ☑ **Other**

  *Specify the individuals and their qualifications:*

  Members choosing the Participant-Directed Model are responsible for development and implementation of the Participant-Directed Service Plan (PDSP). Supports to assist members with this responsibility are provided by the FE/A. Members may also choose to utilize their budget to purchase case management services from a qualified ADW provider to assist with the development and implementation of the PDSP.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (2 of 8)

**b. Service Plan Development Safeguards.***Select one:*

- (●) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (3 of 8)

**c. Supporting the Participant in Service Plan Development.**Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

At the time of the medical eligibility assessment, applicants/members (or legal representative) are provided information regarding their rights to direct and be actively engaged in the Service Plan development process. General information regarding participant-centered planning is also provided. Program information regarding service delivery models (Traditional Model and Participant-Directed Model)is provided as well.

Participant-Centered Planning is the process by which the Case Manager (CM) works in collaboration with the member (or legal representative) to develop the Service Plan (SP). The initial SP is scheduled and developed in collaboration with informal supports as requested by the member (or legal representative). Subsequent annual revisions to the SP are done in collaboration with direct care staff, other service providers and informal supports as requested by the member (or legal representative).

The SP is developed utilizing the medical eligibility assessment, the Case Management Assessment, the RN Assessment and incorporates the preferences and needs identified by the member. By participating in the assessment process and having access to the support of the CM, direct care provider, other professionals and informals, the member has the opportunity and tools to be actively engaged in the Service Plan development process.

Those who choose participant-direction are responsible for the development of the Participant-Directed Service Plan (PDSP). Members may also choose to utilize their budget to purchase case management services from a qualified ADW provider to assist with the development and implementation of the PDSP. In addition to the medical eligibility assessment, a variety of self-assessment tools are made available to assist members in identifying and addressing needs. Staff of the FE/A are available to assist and support members in the development of the Participant-Directed Service Plan if requested by the member.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (4 of 8)

**d. Service Plan Development Process.**In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when

the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) Who develops the plan, who participates in the process and what is the timing of the plan?

Traditional Model: Case Managers (CMs) are responsible for the development of the Service Plan (SP) in collaboration with the member (or legal representative). Participation in the initial Service Plan development is mandatory for the member and Case Manager. The member (or legal representative) may choose to have whomever else they wish to participate in the process. Participation in subsequent reviews and annual SP updates are mandatory for the member, the Case Manager and direct-care service staff of the Personal Assistance/Homemaker Agency. The Case Management Assessment must be completed within seven days of enrollment in the program. The Service Plan, which is scheduled in collaboration with the member, must be completed within fourteen days of this assessment. In order to begin services immediately and address any health and safety concerns, an Interim SP may be developed and implemented upon enrollment. The Interim SP can be in effect up to twenty-one days to allow time for assessments to be completed, the SP meeting to be scheduled and the SP to be developed.

Participant-Directed Model: Under the Participant-Directed Model, members (or legal representative) are responsible for the development of the Participant-Directed Service Plan with the assistance of the FE/A or case manager (if applicable). The member (or legal representative) may choose to have whomever they wish to participate in the process. Members may also choose to utilize their budget to purchase case management services from a qualified ADW provider to assist with the development and implementation of the SP. The Participant-Directed Service Plan must be completed and the monthly Spending Plan approved prior to services being provided.

b)What are the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences, goals and health status?

Traditional Model: There are three primary assessments conducted to support the Service Plan development process. The medical eligibility assessment and RN Assessment (for annual SP reviews and updates) identifies medical issues and functional deficits in Activities of Daily Living. The Case Management Assessment reviews independent living skills, medical and behavioral health status, goals and preferences, formal and informal supports, risks to health and welfare, communication, environmental issues including assistive technology needs, emergency and back-up planning, and socialization and community integration.

Participant-Directed Model - The medical eligibility assessment, which identifies medical issues and functional deficits in Activities of Daily Living, is available to all participant-directed members. Participant-directed members may purchase a RN assessment from their budget allotment which also identifies medical issues and functional deficits of daily living. Participant -directed members also have the option of purchasing Case Management services from a qualified ADW provider which include the Case Management Assessment which reviews independent living skills, medical and behavioral health status, goals and preferences, formal and informal supports, risks to health and welfare, communication, environmental issues including assistive technology needs, emergency and back-up planning, and socialization and community integration. A variety of self-assessment and planning tools are also available to assist participant-directed members with the Service Plan development process.

c) How is the participant informed of the services that are available under the waiver?

All applicants are provided information that includes an overview of the ADW Program and available services at the time of the medical eligibility assessment. If determined medically eligible, applicants receive information explaining both the Traditional Model and the Participant-Directed Model and are given the opportunity to select the model of their choice.

d) How does the plan development process ensure that the service plan addresses the participants goals, needs (including health care needs) and preferences?

Traditional Model - The medical eligibility assessment and the Case Management Assessment must be completed and reviewed with the member prior to the development of the SP. The medical eligibility assessment, the Case Management Assessment and the RN Assessment must be completed and reviewed with the member prior to subsequent reviews and annual SP updates. It is the CM's responsibility to ensure that all assessments are considered in the plan development. The SP document requires that these areas be addressed. As part of the Quality Improvement System (QIS), monitors review files to

ensure that Service Plans address participant goals, needs (including health care needs) and preferences.

Participant-Directed Model: The medical eligibility assessment and all other assessments utilized by the member, are completed prior to the development of the SP. It is the member's responsibility with assistance from the FE/A or case manager (if applicable) to ensure that all assessments are considered in the plan development. The Participant-Directed Service Plan requires that these areas be addressed. As part of the QIS, monitors review files to ensure that Service Plans address participant goals, needs (including health care needs) and preferences.

e) How are waiver and other services coordinated?

Traditional Model - Coordination of services begins with the SP development process. It is the CM's responsibility through collaboration with the member to ensure that all Waiver and other services are identified as part of the plan. The CM is responsible for coordinating the implementation of the plan through case review, referral, monitoring and advocacy. As part of the Quality Improvement System (QIS), operating agency staff review files and conduct Participant Experience Surveys to ensure that services have been delivered as planned.

Participant-Directed Model: Coordination of services begins with the SP development process. It is the member's responsibility with the assistance of the FE/A or case manager (if applicable) to ensure that all Waiver and other services are identified as part of their plan. Members have the option of purchasing Case Management services from a qualified ADW provider to assist them with assessment, planning, case review, referral, monitoring and advocacy. Staff of the FE/A are available to provide information and assistance related to the coordination of services. As part of the QIS, operating agency staff review files and conduct Participant Experience Surveys to ensure that services have been delivered as planned.

f) How does the plan development process provide for the assignment of responsibilities to implement and monitor the plan?

Traditional Model - Specific providers for Waiver and other services are listed on the SP. The CM, via monthly contact, is responsible for monitoring the implementation of the plan to ensure service delivery. As part of the Quality Improvement System (QIS), staff of the operating agency review files and conduct Participant Experience Surveys to ensure that services have been delivered as planned.

Participant-Directed Model: Providers for Waiver and other services are listed on the Participant-Directed Service Plan. The member is responsible with the assistance of the FE/A or case manager (if applicable) for the implementation and monitoring of their plan. As part of the QIS, staff of the operating agency review files and conduct Participant Experience Surveys to ensure that services have been delivered as planned.

g) How and when is the plan updated (including when needs change)?

Traditional Model: CM's are required to have monthly contact with members to monitor plan implementation, identify when members needs change and revise the SP to address changing needs. Additionally, SP's must be reviewed at least every six months and revised at that point as necessary. An annual SP meeting to develop a new plan is required. Case managers are expected to schedule these meetings at times and locations covenient to the member.

Participant-Directed Model: Staff of the FE/A and case manager (if applicable) are required to have monthly contact with members to monitor plan implementation and to assist the member, as needed, to revise the Participant-Directed Service Plan as needs change. Members may also choose to utilize their budget to purchase case management services from a qualified ADW provider to assist with the development, implementation and revision of the SP as needs change. Additionally, they are required to have face-to-face contact with the member at least every six months and assist with Participant-Directed Service Plan revisions if necessary. Participant-Directed Service Plans must be reviewed at least every six months and revised as necessary. The Participant-Directed Service Plan is required, at a minimum, to be developed annually. The FE/A or case manager (if applicable) is expected to schedule these meetings at times and locations covenient to the member.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Traditional Model - Risk assessment is a component of the required Case Management Assessment. Identified risks must be incorporated into the Service Plan (SP) subject to the member's needs and preferences. The SP requires a detailed description of emergency back up plans/arrangements that are to be implemented if a direct-care worker of the Personal Assistance/Homemaker Agency is unable to fulfill their duties. Strategies may include the utilization of an identified back up agency, family members, other informal supports, etc. As part of the Quality Improvement System (QIS), staff of the operating agency review files and conduct Participant Experience Surveys to monitor the effectiveness of risk assessment and backup planning.

Participant-Directed Model - Participant-Directed members (or legal representative) with the assistance of the FE/A or case manager (if applicable) is responsible for identifying risks and the development of mitigation strategies. A variety of tools are made available to assist members with needs assessment and planning. Participant-directed members (or legal representative) also have the option of purchasing case management services from a qualified ADW provider which includes the Case Management Assessment and support with planning. The Participant-Directed Service Plan requires a detailed description of emergency back up plans/arrangements that are to be implemented if a direct-care worker is unable to fulfill their duties. Strategies may include the utilization of an identified back up worker(s), an identified back up agency, family members, other informal supports, etc. As part of the QIS, staff of the operating agency review files and conduct Participant Experience Surveys to monitor the effectiveness of risk assessment and backup planning.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (6 of 8)

**f. Informed Choice of Providers.**Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

At the time of medical eligibility determination and notification that a Waiver slot is available, applicants (or legal representative) are given the opportunity to choose Case Management and Personal Assistance/Homemaker service providers. Selection forms, which list ADW providers by county with contact information are provided to applicants. Information containing helpful tips on selecting providers is also provided. A list of available providers is made available to ADW members on the operating agency's website. Members may also call the operating agency for a list of agencies that provide services in their community.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

**g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.**Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Traditional Model: Responsibility for approving Service Plans is delegated to qualified Case Management Agencies (CMAs). Staff of the operating agency review a representative sample of Service Plans every 12 months as part of the Quality Improvement System (QIS).

Participant-Directed Model: Participant-Directed members are responsible for the development and implementation of the Participant-Directed Service Plan with the assistance of the FE/A or case manager (if applicable). All Spending Plans, which detail how their monthly budget will be utilized, are subject to the approval of the operating agency or the FE/A. Staff of the operating agency review a representative sample of all ADW Service Plans every 12 months as part of the Quality Improvement System (QIS).

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (8 of 8)

**h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- **Every three months or more frequently when necessary**

- **Every six months or more frequently when necessary**
- **Every twelve months or more frequently when necessary**
- **Other schedule**

*Specify the other schedule:*

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- [ ] **Medicaid agency**
- [ ] **Operating agency**
- [x] **Case manager**
- [x] **Other**

*Specify:*

Participant-Directed Service Plans are maintained by the FE/A for a minimum period of 3 years.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.**Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Traditional Model: Case Management Agencies (CMAs) certified by the operating agency are responsible for monitoring the implementation of Service Plans (SPs) for members utilizing the Traditional Model. Case Managers (CMs) are responsible for monthly contacts with members to review the implementation of the SP in order to identify and address any issues and concerns related to the delivery of services. All concerns related to member health and safety must be reported using the West Virginia Incident Management System (IMS) and as appropriate, reported to Adult Protective Services (APS). As part of the Quality Improvement System (QIS), staff of the operating agency reviews a representative sample of Case Management files every 12 months to monitor compliance with this requirement. The operating agency monitoring staff conduct an exit interview to review the results of each provider monitoring. Monitoring staff provide technical assistance as needed to address any identified issues or concerns and require a corrective action plan to ensure that all identified issues are remediated. The operating agency prepares draft monitoring reports which are reviewed for approval by the Bureau for Medical Services management staff prior to issuing the final report to the provider. BMS, the operating agency and the Quality Improvement Advisory Council review monitoring findings annually and develop improvement strategies as indicated. Specific performance indicators are provided in the Service Plan Quality Indicators in this Appendix.

Participant-Directed Model: The implementation and monitoring of Participant-Directed Service Plans are the responsibility of the member (or legal representative)with the assistance of the FE/A if requested or case manager (if applicable). Staff of the FE/A are required to make a monthly telephone contact with each member to review any issues or concerns the member (or legal representative) may have with their services. If requested, staff of the FE/A may assist the member in addressing concerns. They are also required to meet face-to-face with the member every six months. The primary purpose of this meeting is to evaluate health and safety. All identified concerns with member health and safety must be addressed and reported using the IMS, and as appropriate, referred to APS. As part of the QIS, staff of the operating agency review a sample of files every 12 months to monitor compliance with these requirements. Monitoring staff provide technical assistance as needed to address any identified issues or concerns and require a corrective action plan to ensure that all identified issues are remediated. The operating agency prepares draft monitoring reports which are reviewed for approval by the Bureau for Medical Services management staff prior to issuing the final report to the provider.BMS, the operating agency and the Quality Improvement Advisory Council review monitoring findings annually and develop improvement strategies as indicated. Specific performance indicators are provided in the Service Plan Quality Indicators in this Appendix.

b. **Monitoring Safeguards.***Select one:*

- **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Service Plan Assurance/Sub-assurances**

***The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.***

**i. Sub-Assurances:**

**a.** ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of members whose Service Plans are adequate and appropriate to their assessed needs. (Numerator = # of Service Plans that are adequate and appropriate to member's assessed needs Denominator = # of member charts reviewed).**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% |
| ☐ **Other** | ☐ **Annually** | ☐ **Stratified** |

| | | |
|---|---|---|
| Specify: | | Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of members whose Service Plans address identified risks. (Numerator =# of Service Plans that address members identified risks Denominator = # of member charts reviewed).**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** |

| | | |
|---|---|---|
| | | Confidence Interval = 95% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of Service Plans that address member's goals as indicated in the assessment(s). (Numerator = # of Service Plans that address member's goals as indicated in the assessment Denominator = # of member charts reviewed).**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | |

| | | |
|---|---|---|
| | | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other** Specify: Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**b.** ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the*

*method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of members whose initial Service Plans were completed within the required timeframe. (Numerator = # of members whose initial Service Plans were completed within the required timeframe Denominator = # of charts reviewed for members who had an initial Service Plan developed in the review period).**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☑ **Other** Specify: Not all members will have had an initial Service Plan developed during the review period. |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of Service Plans with a member or legal representative signature. (Numerator = # of Service Plans with a member or legal representative signature Denominator = # of member charts reviewed).**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| Responsible Party for data collection/generation *(check each that applies):* | Frequency of data collection/generation *(check each that applies):* | Sampling Approach*(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of members whose Service Plans were developed by a qualified Case Manager. (Numerator = # of members whose Service Plans were developed by a qualified Case Manager Denominator = # of member charts reviewed).**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| Responsible Party for data collection/generation *(check each that applies):* | Frequency of data collection/generation *(check each that applies):* | Sampling Approach*(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of members whose Service Plans were revised as needed. (Numerator = # of members whose Service Plans were revised as needed Denominator = # of charts reviewed for members whose Service Plans need revisions during the review period).**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** |

| | | |
|---|---|---|
| | | Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☑ **Other**<br>Specify:<br>Not all members Service Plans will need revisions during the review period |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of member Service Plans updated at least annually. (Numerator = # of Service Plans updated at least annually Denominator = # of member charts reviewed).**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| | ☐ **Weekly** | ☐ **100% Review** |

| | | |
|---|---|---|
| ☐ **State Medicaid Agency** | | |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other** Specify: Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of members whose Service Plans were updated when service level changed. (Numerator = # of members whose Service Plans were updated when service level changed Denominator = # of charts reviewed for members whose service level changed).**

**Data Source** (Select one):
**Provider performance monitoring**

If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☑ **Other** Specify: Not all members whose charts are reviewed will have had a change in service level during the review period. |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other** Specify: Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| | |

**d.** ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of members who received the types of services specified in the Service Plan. (Numerator = # of members who received the types of services specified in the Service Plan Denominator - # of member charts reviewed).**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| Responsible Party for data collection/generation *(check each that applies):* | Frequency of data collection/generation *(check each that applies):* | Sampling Approach*(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of members who received the scope of services specified in the Service Plan. (Numerator = # of members who received the scope of services specified in the Service Plan Denominator = # of member charts reviewed).**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

| | | |
|---|---|---|
| | | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of members who received the duration of services specified in the Service Plan. (Numerator = # of members who received the duration of services specified in the Service Plan Denominator = # of member charts reviewed).**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of members who received the amount and frequency of services specified in the Service Plan. (Numerator = # of members who received the amount and frequency of services specified in the Service Plan Denominator = # of member charts reviewed).**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other** Specify: Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of member files that contain a consent form showing evidence of choice between waiver services and institutional care. (Numerator = # of member files that contain a consent form showing evidence of choice between waiver services and institutional care Denominator = of of member files reviewed).**

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% |
| ☑ **Other** Specify: Administrative Services Organization (ASO) | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other** Specify: ASO | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**

**Number and percent of member files that contain a Case Management Selection Form. (Numerator = # of member files that contain a Case Management Selection Form Denominator = # of member files reviewed).**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% |
| ☑ **Other** Specify: Administrative Services Organization (ASO) | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other** Specify: ASO | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| | |

**Performance Measure:**
**Number and percent of member files that contain a Personal Assistance/Homemaker Selection Form. (Numerator = # of member files that contain a Personal Assistance/Homemaker Selection Form Denominator = # of member files reviewed).**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| Responsible Party for data collection/generation *(check each that applies):* | Frequency of data collection/generation *(check each that applies):* | Sampling Approach*(check each that applies):* |
|---|---|---|
| ☐ State Medicaid Agency | ☐ Weekly | ☐ 100% Review |
| ☐ Operating Agency | ☐ Monthly | ☑ Less than 100% Review |
| ☐ Sub-State Entity | ☑ Quarterly | ☑ Representative Sample<br>Confidence Interval = 95% |
| ☑ Other<br>Specify:<br>Administrative Services Organization (ASO) | ☐ Annually | ☐ Stratified<br>Describe Group: |
| | ☐ Continuously and Ongoing | ☐ Other<br>Specify: |
| | ☐ Other<br>Specify: | |

**Data Aggregation and Analysis:**

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| ☐ State Medicaid Agency | ☐ Weekly |
| ☐ Operating Agency | ☐ Monthly |
| ☐ Sub-State Entity | ☑ Quarterly |
| ☑ Other<br>Specify: | ☐ Annually |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ASO | |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of member files that contain a Service Delivery Model Selection Form. (Numerator = # of member files that contain a Service Delivery Model Selection Form Denominator = # of member files reviewed).**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% |
| ☑ **Other**<br>Specify:<br>Administrative Services Organization (ASO) | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| | |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other**<br>Specify:<br>ASO | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

All information relating to this assurance is collected by the operating agency through the review of member charts. Individual issues/concerns related to this assurance identified during the chart review process are addressed immediately by the operating agency with providers during an exit interview. Providers are then required to submit Corrective Action Plans addressing identified issues. All Corrective Action Plans must be approved by the operating agency.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix E: Participant Direction of Services

**Applicability***(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** *(select one):*

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

### E-1: Overview (1 of 13)

**a. Description of Participant Direction.**In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

West Virginia was one of twelve states to receive a Robert Wood Johnson Cash & Counseling Grant in October, 2004. West Virginia began enrollment in Personal Options, the Cash & Counseling participant-directed model within the Aged & Disabled Waiver Program (ADW) in May, 2007. Every Aged and Disabled Waiver member (or legal representative) may direct their waiver services by choosing the Participant-Directed Model. Members (or legal representative) may select the Participant-Directed Model at initial medical eligibility assessment, annual re-evaluation assessment, or at any other time by notifying the operating agency.

Services provided through the Traditional Model and the Participant-Directed Model are comparable in description, scope, amount and duration. ADW members can transition from the Participant-Directed Model to the Traditional Model at any time without an interruption of services.

Members choosing the Participant Directed Model are allocated a monthly budget based on their assessed service level. Participant-directed members (or their legal representative) function as the common law employer (employer of record) of workers who provide services. The services directed by members who choose Personal Options include:

- Case Management
- Personal Assistance/Homemaker Services
- Participant-Directed Goods and Services

The Participant-Directed Model uses a Government Fiscal Employer Agent (IRS approved FMS) to support participant-directed members. The Bureau for Medical Services (BMS) subcontracts a FE/A as its sub-agent to perform FMS functions. The support provided by the FE/A is an administrative activity and is reimbursed as such.

The FE/A provides both financial management and resource consulting (assistance and information) services for members. The financial management services provided by the FE/A include:

1) issuing payroll checks to qualified employees of members via approved timesheets

2) executing provider agreements on behalf of BMS

3) assuring the adherence to Federal and State laws and regulations

4) verifying Criminal Investigation Background (CIB) checks of prospective member employees per ADW policy

5) verifying member employee qualifications

6) verifying member employee time records

7) verifying that services are within approved limits(compliance with Participant-Directed Service Plan)

8) monitoring of underpayments and overpayments

9) assisting members to revise spending plans as necessary

10) recognizing and reporting critical incidents

11) verifying member employee's citizenship status

12) providing for payment of member employee benefits where applicable

The FE/A also provides Resource Consulting (information and assistance) services for participant-directed members. This support is an administrative activity and is reimbursed as such. Resource Consulting provides members with the supports needed to self-direct and are available as needed and/or requested by the member. The FE/A employs Resource Consultants at a ratio of 50-60 members per consultant with statewide coverage based on geographic patterns in member enrollment. Resource consulting supports include:

1) Assisting the member as needed and/or requested with information, assistance and referral
2) Explaining and assisting the member with the completion of the employer packet paperwork (i.e. IRS Form 2678, IRS Form 2848, IRS Form 8821, WV State Tax Department Form WV/2848, etc.). The Resource Consultant submits the completed employer packet to the FE/A Financial Operations Unit
3) Providing practical skills training, such as hiring, managing and terminating employees, problem solving, and conflict resolution
4) Assisting the members as needed and/or requested in the recruitment and hiring of employees
5) Maintaining a roster of qualified direct-care workers
6) Maintaining/providing training modules for member employees
7) Verification of required training for all member employees
8) Monitoring quality and health and safety through required monthly calls and face-to-face contact at least every six months. Resource Consultants monitor more frequently as needed based on member needs and/or requests
9) Recognizing and reporting critical incidents (which are then investigated by the FE/A, operating agency, APS, Medicaid Fraud, police, etc. as appropriate). All critical incidents are entered into the Incident Management System (IMS) by the FE/A and the operating agency to analyze for trends
10) Providing information on member employee benefits when applicable
11) Assisting the member as needed and/or requested in the development of the member's Participant-Directed Service Plan
12) Assisting the member as needed and/or requested in the development of the member's Spending Plan
13) Assisting the member as needed and/or requested in revisions to the members Participant-Directed Service Plan and/or Spending Plan
14) Assisting the member as needed and/or requested with the purchase of approved goods and services to address areas of need, increase independence and/or promote health and safety
15) Maintaining a tickler system for member annual medical eligibility re-evaluation
16)Assisting the member as needed and/or requested in completing and submitting the required annual medical re-evaluation request form to the Administrative Services Organization (ASO)

FE/A Resource Consultants do not provide case management. Participant-Directed members (or legal representative) may

choose to purchase case management services from a qualified Case Management Agency certified by the operating agency.

The FE/A also operates a call center for members or member' employees to access needed information about the program. Customer service representatives support the primary role of the Resource Consultant and payroll specialists by performing the following functions:

1) Assisting the member/employer with inquiries related to budgeting, employer responsibilities, paperwork such as tax forms, employee background checks and CPR certification, timesheets and invoices and the status of savings and spending activity
2) Assisting employees and other service providers with issues related to pay periods, the status of timesheeets and invoices, the status of payments, and tax withholdings
3) Place courtesy calls to members and employees regarding incorrect timesheets and invoices, providing additional training and helpful hints to ensure accurate and timely payments
4)Place courtesy calls and mail reminder letters to members in advance of expiration date of employee's CPR certification
5) Mail out timesheets, invoices, forms and training materials as requested by the caller or as directed by the Resource Consultant
6) Maintain an electronic notification system to inform the Resource Consultant of all member inquiries and additional follow -up if necessary

## Appendix E: Participant Direction of Services

### E-1: Overview (2 of 13)

**b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

**c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

  Specify these living arrangements:

## Appendix E: Participant Direction of Services

### E-1: Overview (3 of 13)

**d. Election of Participant Direction.** Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**

- (●) **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ( ) **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

*Specify the criteria*

## Appendix E: Participant Direction of Services

### E-1: Overview (4 of 13)

**e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

At the time of the medical eligibility assessment, the Administrative Services Organization (ASO) provides applicants (or legal representative) a Participant-Directed Model brochure that contains a general overview of the participant-directed opportunity. Applicants that are determined medically eligible will receive more information from the ASO about the service delivery options including a Fact Sheet that gives a comparative description of benefits, responsibilities and liabilities with the Traditional and Participant-Directed Models. Applicants who choose the Participant-Directed Model will then receive detailed instructions on enrolling in the program from the operating agency. Once they are referred to the FE/A members (or legal representative) receive a Quick Start Guide which includes an overview of participant-direction, supports for participant -direction, the enrollment process, developing the Participant-Directed Service Plan, developing the spending plan, selecting, hiring, training and supervising employees and Aged and Disabled Waiver (ADW) program responsibilities.

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

**f. Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- ( ) **The State does not provide for the direction of waiver services by a representative.**
- (●) **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- [x] **Waiver services may be directed by a legal representative of the participant.**
- [x] **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Participant-Directed members may appoint an informal representative to assist them in the direction of their Waiver services. The nature of the assistance is determined by the participant-directed member. Responsibility for developing and implementing the Participant-Directed Service Plan and all employer related responsibilities remain with the member with the assistance of their informal representative and/or staff of the FE/A as requested. FE/A staff are required to make monthly telephone contact directly with the member to review the implementation of their Participant-Directed Service Plan and to address any issues or concerns with their services. A face-to-face contact with the member at least every six months is also required to review the Participant-Directed Service Plan implementation and to identify and address any health and safety concerns. As part of the Quality Improvement System (QIS), staff of the operating agency review files and conduct Participant Experience Surveys.

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

**g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

| Participant-Directed Waiver Service | Employer Authority | Budget Authority |
|---|---|---|
| Personal Assistance/Homemaker Service | ☑ | ☑ |
| Participant-Directed Goods and Services | ☐ | ☑ |
| Case Management | ☐ | ☑ |

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

**h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.***(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☑ **Governmental entities**
☐ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.***Do not complete Item E-1-i.*

## Appendix E: Participant Direction of Services

### E-1: Overview (8 of 13)

**i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

**The waiver service entitled:**

◉ **FMS are provided as an administrative activity.**

**Provide the following information**

**i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

The Government Fiscal Employer/Agent Model is utilized and procured through an RFP and contract process.

**ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

The FE/A is compensated through a Per member/Per Month (PM/PM) fee as specified in the vendor contract.

**iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [ ] **Other**

*Specify:*

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

*Specify:*

Additional functions/activities:

- [x] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

*Specify:*

iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

Bureau for Medical Services (BMS) oversight of the FE/A includes:

1) An initial readiness review

2) Quarterly review of IRS Form 941

3) Quarterly review of FUTA deposit

4) Quarterly review of State withholding and unemployment tax payments

5) Quarterly review of complaints and grievances report

6) Quarterly review of total allocated funds for members and total spent funds

7) Quarterly comparison of bank statements to IRS reports and MMIS billing

8) Monthly contract meetings

9) Monthly review of program activity reports

10) Review of periodic consumer satisfaction survey results

# Appendix E: Participant Direction of Services

## E-1: Overview (9 of 13)

**j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

*Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

☐ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

| Participant-Directed Waiver Service | Information and Assistance Provided through this Waiver Service Coverage |
|---|---|
| Personal Assistance/Homemaker Service | ☐ |
| Participant-Directed Goods and Services | ☐ |
| Case Management | ☐ |

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

*Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

a) Supports for members choosing the Participant-Directed Model are furnished by the FE/A.

b) Supports are procured through an RFP and contract process.

c) Supports are available to:
- provide general information and assistance on the participant-direction opportunity
- assist with the development of the Participant-Directed Service Plan and monthly budget
- provide practical skills training such as hiring, managing and terminating workers, problem solving, and conflict resolution
- maintain and provide required training modules for direct care workers
- maintain a roster of qualified direct-care workers and assist in the verification of qualified employees
- provide information on member employee benefits if applicable
- provide information to assist with the purchase of goods and services
- monitor quality through monthly telephone contact and face-to-face contact with members at least every six months
- assist with required program paperwork

D) Bureau for Medical Services (BMS) oversight of the FE/A includes:
- Monthly contract meetings
- Monthly review of program activity reports
- Review of periodic consumer satisfaction survey results
- Quarterly review of complaints and grievances report

In addition, as part of the Quality Improvement System (QIS), staff of the operating agency review member charts every 12 months and conduct Participant Experience Surveys.

No information and assistance in support of participant direction is provided via the case management service.

## Appendix E: Participant Direction of Services

### E-1: Overview (10 of 13)

**k. Independent Advocacy** *(select one)*.

- (•) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

**l. Voluntary Termination of Participant Direction.**Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Participant-Directed members (or legal representative) can opt to transfer from the Participant-Directed Model to the Traditional Model at any time. Member voluntary termination will ordinarily be effective the first day of the month, except in cases of emergency. The FE/A and operating agency will assist the member to assure a seamless transition.

## Appendix E: Participant Direction of Services

### E-1: Overview (12 of 13)

**m. Involuntary Termination of Participant Direction.**Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Participant-Directed members who demonstrate the inability to self-direct their Aged and Disabled Waiver (ADW) services due to misuse of funds or an on-going health and safety concern, will be required to select a representative to assist them with the responsibilities of participant-direction. If the member refuses to select a representative, they will be required to transfer to the Traditional Model. The FE/A and the operating agency will assist the member to assure a seamless transition.

## Appendix E: Participant Direction of Services

### E-1: Overview (13 of 13)

**n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

**Table E-1-n**

| | Employer Authority Only | Budget Authority Only or Budget Authority in Combination with Employer Authority |
|---|---|---|
| Waiver Year | Number of Participants | Number of Participants |
| Year 1 | | 817 |
| Year 2 | | 725 |
| Year 3 | | 649 |
| Year 4 | | 628 |
| Year 5 | | 586 |

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant Direction (1 of 6)

**a. Participant - Employer Authority** *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

**i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

**ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☑ **Select staff from worker registry**
☑ **Hire staff common law employer**
☑ **Verify staff qualifications**
☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☑ **Determine staff wages and benefits subject to State limits**
☑ **Schedule staff**
☑ **Orient and instruct staff in duties**

- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (2 of 6)

**b. Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (3 of 6)

**b. Participant - Budget Authority**

**ii. Participant-Directed Budget**Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Based on studies by West Virginia of the cost of FMS and I and A, a calculated PMPM was derived. This is claimed as administrative cost before development of individual member budget. The individual member budget is based on assessed needs and monetized based on results of the assessment process. The individual member budget (less the cost of FMS and I and A) is claimed as service match accordingly.

An annual allowance of $1,000 per participant is available for participant directed goods and services (if participant chooses to allocate a portion of their monthly budget to this option; must be included in participant's approved

spending plan). This amount is consistent with funding for environmental adaptations used in other waivers.

The above information is made available to the public by posting this waiver application on the West Virginia Department of Health and Human Resources, Bureau for Medical Services website for a 30 day comment period.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (4 of 6)

**b. Participant - Budget Authority**

**iii. Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Participant-Directed Member's (or legal representative) are notified of their budget in writing by the Administrative Services Organization (ASO) at the point of medical eligibility and slot allocation. Per policy, members (or legal representative) have the opportunity to request an increase in their Service Level at any time. The member's budget would increase accordingly. The request must include clinical documentation sufficient to support the request which may include applicable test results from a member's physician or hospital discharge summary. If approved, the member's Service Level and budget allocation will be adjusted accordingly. If denied, participant-directed members (or legal representative) are offered the opportunity to request a Fair Hearing.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (5 of 6)

**b. Participant - Budget Authority**

**iv. Participant Exercise of Budget Flexibility.***Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (6 of 6)

**b. Participant - Budget Authority**

**v. Expenditure Safeguards.**Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Participant-directed budgets are allocated monthly. Spending plans outlining specific services on how the budget is to be utilized are developed and authorized on a monthly basis by the F/EA to safeguard premature depletion of the participant-directed budget.

The F/EA generates a monthly utilization report to identify member underutilization of budgets. While there are many reasons a member may not use their entire allocated budget (hospitilization, periodic increase of informal

supports, etc.), utilization information is shared with the F/EA Resource Consultants so that they can address potential issues directly and immediately with the participant-directed members and revise Service Plans if necessary.

## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Information on Fair Hearing rights is included in the packet of information sent by the ASO to all members when they are notified that they are medically eligible for the Program and a slot is available.

Aged and Disabled Waiver (ADW) applicants/members (or legal representative) are notified in writing of their Fair Hearing rights when:

1. They do not meet medical eligibility requirements for nursing home level of care (initial assessment and re-evaluation assessment). They are notified by the Administrative Services Organization (ASO). The ASO maintains all records of medical eligibility denials.
2. Their services have been reduced at the time of the annual re-evaluation (e.g., from Service Level D to Service Level C). They are notified by the ASO. The ASO maintains all records of annual re-evaluations.
3. Their request for a Service Level increase is denied. They are notified by the ASO. The ASO maintains all records of requests for Service Level increases and decisions.
4. Their ADW case has been closed (per established policies and procedures). They are notified by the operating agency. The operating agency maintains all records of case closures.

All notifications of Fair Hearing rights includes information that services will continue throughout the Fair Hearing process. Information on available advocacy support is also provided.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

# Appendix F: Participant-Rights

## Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.***Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

**b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

The operating agency.

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Aged and Disabled Waiver (ADW) grievance process is intended to resolve complaints not subject to the Fair Hearing process such as member allegations of provider noncompliance with ADW policy.

The grievance process is not utilized to address decisions regarding medical eligibility, a reduction in service(s) or case closure. Issues related to medical eligibility, a reduction in service(s)or a case closure are not appropriate for the grievance process and are referred to the Medicaid Fair Hearing process.

First Level Grievance

Responsible Party: ADW Provider

1. Member (or legal representative) completes the grievance form and submits it to the provider.
2. Provider has 10 days to hold a meeting with the member (or legal representative) either in person or by telephone.
3. Provider holds the meeting and completes the “Level One” response.
4. Member (or legal representative) and provider sign/date Level One decision.
5. Provider sends a copy of the grievance decision to the member (or legal representative) within three working days.
6. Provider maintains a copy of the grievance in an administrative file.
7. Provider maintains a record of the number of grievances filed, reasons for grievances, dates of grievances, and responses.

Second Level Grievance (If member (or legal representative) is not satisfied with Level One decision)

Responsible Party: The operating agency

1. The provider sends a copy of the Level One grievance decision to the operating agency and the member (or legal representative) within three working days.
2. The Level One decision and any additional information is reviewed by the operating agency.
3. The operating agency issues a Level Two decision within 10 days of receipt of the grievance request.
4. Notice of the decision is provided in writing to the member (or legal representative), the provider agency and the Bureau for Medical Services (BMS).

# Appendix G: Participant Safeguards

## Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.**Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Aged and Disabled (ADW) Providers must have policies and procedures for thoroughly reviewing, investigating, and tracking all incidents involving the risk or potential risk to the health and safety of the members they serve. Providers are responsible for taking appropriate action on both an individual and systemic basis. All providers are required to report and track incidents using the web-based West Virginia Incident Management System (WV IMS). Providers shall classify all incidents as:

• Allegation of abuse, neglect, or exploitation - must be reported to Adult Protective Services (APS) per W.Va. Code 9-6-1.
• Critical incident - a high likelihood of producing real or potential harm to the health and welfare of the member.
• Simple incident - unusual events occurring to a member that cannot be characterized as a critical incident and does not meet the level of abuse or neglect.

The provider Director or designated staff will immediately review each Incident Report and determine whether the incident warrants a thorough investigation. Investigations must be initiated within twenty-four (24) hours of learning of the incident. An Incident Report must be entered into the WV IMS within fourteen (14) calendar days of the incident.
At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the provider shall immediately notify APS as mandated by State Code. A provider is responsible to investigate all incidents, including those reported to APS.

Providers are required to regularly review and analyze incident reports to identify health and safety trends. Identified health and safety concerns and remediation strategies must be incorporated into the provider's Quality Management Plan.

**c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

A brochure that defines abuse, neglect and exploitation and how to notify the appropriate authorities is provided by the Administrative Services Organization (ASO) to all applicants (or legal representative) at their initial medical assessment as well as to all members (or legal representative) at their annual medical re-evaluation.

**d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

ADW Provider Directors (or designated staff) must immediately review each Incident Report and determine whether the incident warrants a thorough investigation. Investigations are required to be initiated within twenty-four (24) hours of learning of the incident. An Incident Report must be entered into the WV IMS within fourteen (14) calendar days of the incident.

At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the provider shall immediately notify APS as mandated by State Code. Members may request to review APS investigation findings at any time. ADW providers are responsible to investigate all incidents, including those reported to APS. Per policy, when there has been an allegation of abuse, neglect or exploitation, ADW providers must 1) Take immediate necessary steps to ensure the health and safety of the member while investigating the incident 2) Revise the member's Service Plan if necessary to

implement additional member supports, and 3) Implement necesary system's changes including additional staff training that might be helpful in preventing future incidents.

Providers are required to review periodically their incident data to identify and address systemic issues and concerns.

The operating agency monitors provider incidents in real time via the WV IMS. The operating agency generates a monthly report which is reviewed by the Bureau for Medical Services (BMS) and management staff of the operating agency at regular contract meetings. Quarterly reports are also developed to be reviewed by the Quality Improvement Advisory Council.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The operating agency is responsible for overseeing the operation of the WV IMS and is responsible for real time monitoring of provider incident investigations. Every incident submitted into the WV IMS must be reviewed by the Quality Improvement Program Manager at the operating agency who monitors to ensure that appropriate and timely steps are taken by the providers. A report is generated monthly which is reviewed by the BMS and management staff of the operating agency at regular contract meetings to identify and address system issues and concerns and prevent re-occurrences. Quarterly reports are also reviewed by the Quality Improvement Advisory Council.

As part of the Quality Improvement System (QIS), the operating agency reviews a representative sample of member charts annually, including (as applicable) compliance with Incident Management policies.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Providers are mandatory reporters and as such are required to report any incidents of the use of restraints or seclusion directly to Adult Protective Services (APS).
APS is required to investigate these allegations. Providers also have a responsibility per policy to investigate and to report the incident in the WV Incident Management System (IMS).

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

## Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

**b. Use of Restrictive Interventions.** *(Select one)*:

- (●) **The State does not permit or prohibits the use of restrictive interventions**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

  Providers are mandatory reporters and as such are required to report any incidents of the use of restrictive interventions directly to Adult Protective Services (APS).
  APS is required to investigate these allegations. Providers also have a responsibility per policy to investigate and to report the incident in the WV Incident Management System (IMS).

- ( ) **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

  **i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

  **ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

# Appendix G: Participant Safeguards

## Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

**c. Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- ( ) **The State does not permit or prohibits the use of seclusion**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

- ( ) **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

  **i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

  **ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

- **No. This Appendix is not applicable** *(do not complete the remaining items)*
- **Yes. This Appendix applies** *(complete the remaining items)*

**b. Medication Management and Follow-Up**

**i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

**ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

**c. Medication Administration by Waiver Providers**

**Answers provided in G-3-a indicate you do not need to complete this section**

**i. Provider Administration of Medications.** *Select one:*

- **Not applicable.** *(do not complete the remaining items)*
- **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

**ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**iii. Medication Error Reporting.** *Select one of the following:*

**Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
*Complete the following three items:*

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the State:

**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.**Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

a. **Methods for Discovery: Health and Welfare**
***The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.*** *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*
   i. **Sub-Assurances:**

      a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

         **Performance Measures**

         *For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

         *For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of members or legal representative who received information about how to report abuse, neglect, exploitation and other critical incidents. (Numerator = # of members or legal representatives who received information about how to report abuse, neglect, exploitation and other critical incidents Denominator = # of enrolled members).**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Report to State Medicaid Agency**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>ASO | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>ASO | ☑ **Annually** |
| | |

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| | ☐ Continuously and Ongoing |
| | ☐ Other<br>Specify: |

**Performance Measure:**
**Number and percent of members or legal representatives reporting they received information on how to report abuse, neglect, exploitation and other critical incidents. (Numerator = # of members or legal representatives reporting they received information on how to report abuse, neglect, exploitation and other critical incidents Denominator = # of Participant Experience Surveys conducted).**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| Responsible Party for data collection/generation *(check each that applies):* | Frequency of data collection/generation *(check each that applies):* | Sampling Approach*(check each that applies):* |
|---|---|---|
| ☐ State Medicaid Agency | ☐ Weekly | ☐ 100% Review |
| ☑ Operating Agency | ☐ Monthly | ☑ Less than 100% Review |
| ☐ Sub-State Entity | ☐ Quarterly | ☑ Representative Sample<br>Confidence Interval = 95% |
| ☐ Other<br>Specify: | ☐ Annually | ☐ Stratified<br>Describe Group: |
| | ☑ Continuously and Ongoing | ☐ Other<br>Specify: |
| | ☐ Other<br>Specify: | |

**Data Aggregation and Analysis:**

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| ☑ State Medicaid Agency | ☐ Weekly |
| | |

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of abuse, neglect and exploitation allegations reported to the operating agency within required time frames. (Numerator = # of abuse, neglect, and exploitation allegations reported to the operating agency within required time frames Denominator = # of abuse, neglect and exploitation allegations reported).**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| Responsible Party for data collection/generation *(check each that applies):* | Frequency of data collection/generation *(check each that applies):* | Sampling Approach*(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of abuse, neglect, and exploitation allegations reported per required timelines to Adult Protective Services. (Numerator = # of abuse, neglect, and exploitation allegations reported per required timelines to Adult Protective Services Denominator = # of abuse, neglect, and exploitation allegations reported).**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of critical incidents reported to the operating agency within required timeframes. (Numerator = # of critical incidents reported to the operating agency within required timeframes Denominator = # of critical incidents reported).**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other** Specify: Quality Improvement Advisory Council | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of critical incident investigations that were completed within required timeframes. (Numerator = # of critical incident investigations that were completed within required timeframes Denominator = # of critical incident investigations).**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |

| | | |
|---|---|---|
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of members referred for physician examination based on the RN assessment. (Numerator = # of members referred for physician examination based on the RN assessment Denominator = # of member charts reviewed).**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** |

| | | |
|---|---|---|
| | | Confidence Interval = 95% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
All information relating to this assurance is collected and monitored through the WV Incident Management System (IMS)which is monitored by the operating agency. Individual issues/concerns such as failure to meet reporting and/or follow-up requirements are addressed immediately upon identification by the operating agency. Providers may be required to submit Corrective Action Plans addressing identified issues that must be approved by the operating agency.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

**Quality Improvement Strategy: Minimum Components**

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## Appendix H: Quality Improvement Strategy (2 of 2)

### H-1: Systems Improvement

**a. System Improvements**

**i.** Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The operating agency is responsible for monitoring the quality of Waiver services and implementing and evaluating quality improvement strategies. The ADW's Quality Improvement System (QIS) is evidence-driven and incorporates a broad-base of stakeholders in active roles in the process.

Discovery and remediation activities focus on the collection of data necessary to monitor the quality indicators established to provide evidence relating to the six CMS assurances and sub-assurances. Specific data sources include provider monitoring, claims data, incident management reports, contract oversight meetings and reports, Participant Experience Surveys and other stakeholder feedback and input.

The primary mechanism for involving stakeholders in the Waiver's quality improvement initiative is the ADW Quality Improvement (QI) Advisory Council. The fifteen (15) member Council is comprised of at least five (5) current or former members (or legal representatives) of the program, Waiver providers, advocates and other interested stakeholders. The Council serves as a forum for members (or legal representative) and the public to raise and address program issues and concerns affecting the quality of Waiver services.

The Council:
1. Reviews findings from discovery activities.
2. Recommends program priorities and quality initiatives.
3. Recommends policy changes.
4. Monitors and evaluates the implementation of Waiver priorities and quality initiatives.
5. Monitors and evaluates policy changes.
6. Serves as a liaison between the Waiver and its stakeholders.
7. Establishes committees and work groups consistent with its purpose and guidelines.

The Quality Management Report, which incorporates data from discovery and remediation activities, is reviewed and analyzed by the Bureau for Medical Services (BMS) Management staff through regular meetings with contractors. The report is also reviewed quarterly with the QI Advisory Council in order to identify trends and to monitor the effectiveness of quality improvement activities.

Quality improvement priorities are identified through data analysis and stakeholder input and are incorporated in the annual Quality Management Plan. Updates on the goals and objectives of this plan are reviewed at each quarterly meeting and guide the efforts of the Council and staff. The Quality Management Plan is evaluated at the annual QI Advisory Council meeting and is revised if necessary to reflect current quality issues.

**ii. System Improvement Activities**

| **Responsible Party***(check each that applies):* | **Frequency of Monitoring and Analysis***(check each that applies):* |
|---|---|
| | |

| **Responsible Party***(check each that applies):* | **Frequency of Monitoring and Analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Quality Improvement Committee** | ☑ **Annually** |
| ☐ **Other**<br>Specify: | ☐ **Other**<br>Specify: |

**b. System Design Changes**

**i.** Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The ADW Quality Improvement System (QIS) is designed to: 1) Collect the data necessary to provide evidence that the six (6) CMS assurances are being met and 2) ensure the active involvement of stakeholders in the quality improvement process. The primary sources of discovery include provider reviews, incident management reports and member complaints, administrative reports, oversight of delegated administrative functions, and stakeholder input.

Provider Reviews:

The primary means of monitoring the quality of Aged and Disabled Waiver (ADW) services is provider reviews conducted by staff of the operating agency.

Prior to enrolling as an ADW provider, agencies interested in providing ADW services are reviewed by the operating agency to ensure that all Certification standards are met. All new providers are reviewed after the first six (6) months in order to identify and address any issues or concerns.

Providers are required to submit evidence to the operating agency annually to document continuing compliance with all Certification requirements as specified in the ADW Policy Manual. This evidence must be signed by an appropriate official of the provider (e.g., Executive Director, Board Chair, etc.). If appropriate documentation is not provided, a Provisional Certification is issued until appropriate documents are submitted and approved by the operating agency. Providers receiving a Provisional Certification are required to have an on-site review by the operating agency prior to full re-certification. A percentage of providers are randomly selected each year for an on-site review to validate certification documentation. Targeted on-site provider reviews may be conducted based on Incident Management Reports and complaint data.

A statewide representative sample of member charts are reviewed every 12 months. Charts are reviewed by staff of the operating agency using the Personal Assistance/Homemaker Monitoring Tool and the Case Management Monitoring Tool. The West Virginia Participant Experience Survey (PES) is conducted with those members whose charts are selected for review. These tools have been developed to ensure that the critical data necessary to monitor CMS assurances are collected. A proportionate random sample will be identified with the guidance of CMS technical assistance contractors.

West Virginia Incident Management System (WVIMS):

Another key source for monitoring the quality of ADW services is the online West Virginia Incident Management System (WVIMS). Per policy, ADW providers are required to use the online application to report and track all incidents including 1) Simple Incidents, 2) Critical Incidents, and 3) Abuse, Neglect, and Exploitation. The online system gives providers the ability to generate agency specific reports to identify and monitor trends. The WVIMS also provides the operating agency the capability to monitor reported incidents in "real time" in order to ensure that

timely, appropriate steps are taken by providers. The operating agency generates periodic reports to identify and monitor trends statewide.

The operating agency also operates a toll-free hotline allowing members to contact them directly to report and address concerns with there services. Data from these calls are compiled and analyzed for trends.

Reports:

BMS management staff receive and review the following contract reports:
- Operating agency - Monthly Program Report and ad hoc reports as requested.
- FE/A - Monthly Program report and ad hoc reports as requested.
- Administrative Services Organization (ASO) - Monthly Activity Report, weekly Managed Enrollment Report, and various ad hoc reports as requested.
- Claims processing entity - regular claims data reports and ad hoc reports as requested.

Contract Oversight Meetings:

BMS management staff conduct monthly oversight meetings with each of their contractors to monitor performance and address identified issues/concerns.

The quality management data collected through discovery methods is compiled using the Quality Management Report Template and reviewed at least monthly by BMS and the operating agency at its contract meetings. The Quality Management Report is also compiled and reviewed quarterly by the ADW QI Advisory Council. A comprehensive report summarizing the findings of provider reviews is compiled at the end of each review cycle, reviewed and analyzed by Waiver staff and presented to the QI Advisory Council for its review and analysis.

The Quality Improvement (QI) Advisory Council:

The QI Advisory Council is the focal point of stakeholder input for the ADW and plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies. The Council is comprised of 15 members with at least 5 being current or former waiver recipients (or their legal representatives).

The Council provides Waiver staff feedback and guidance regarding quality improvement initiatives. In partnership with Waiver staff, the Council reviews and analyzes data, identifies trends and priorities, and develops the annual Quality Management Plan in which specific quality improvement goals and objectives are established.

The Council frequently establishes work groups consisting of Council members and others wishing to participate in the process to address specific improvement goals and objectives.

**ii.** Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The goals and objectives outlined in the Quality Management Plan are continuously monitored by the ADW QI Advisory Council, with regular updates being provided at each quarterly meeting. An annual planning meeting is held to review progress toward the goals and objectives of the plan and to update the plan as indicated by quality management data.

# Appendix I: Financial Accountability

## I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

A statewide representative sample of member charts are reviewed every 12 months to verify documentation of services billed. Provider reviews are conducted by staff of the operating agency to ensure the integrity of payments that have been made for waiver services.

When provider documentation does not support services billed, providers are required to submit Corrective Action Plans which must be approved by the operating agency. Providers are required to reimburse the Bureau for Medical Services for any services billed without supporting documentation. The Medicaid Program (which would include the Aged and Disabled Waiver) is audited annually under the West Virginia Statewide Single Audit. The State of West Virginia Statewide Single Audit is conducted by Ernst & Young, LLP.

## Appendix I: Financial Accountability

### Quality Improvement: Financial Accountability

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Financial Accountability**
***State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*** *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

**i. Sub-Assurances:**

**a.** ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of processed claims that were denied per MMIS system edits. (Numerator = # of processed claims that were denied per MMIS system edits Denominator = # of processed claims).**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |

| | | |
|---|---|---|
| ☑ **Other**<br>Specify:<br>Claims processing entity | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☑ **Other**<br>Specify:<br>Report generated every 6 months | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Claims processing entity | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Every 6 months |

**Performance Measure:**
**Number and percent of claims paid with appropriate supporting documentation. (Numerator = # of claims paid with appropriate supporting documentation Denominator = # claims paid during review period).**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% |

| | | |
|---|---|---|
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Quality Improvement Advisory Council | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

All information relating to this assurance is collected through the review of member charts by the operating agency and the review and analysis of claims data provided by the claims processing entity. Individual issues/concerns related to appropriate documentation of services billed identified during the review of member charts are addressed immediately by the operating agency with providers during an exit interview. Providers may be required to submit Corrective Action Plans addressing identified issues that must be approved by the operating agency. Evidence collected via claims data is reviewed and analyzed by BMS and the claims processing entity in order to identify any system issues.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>claims processing entity | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (1 of 3)

**a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

West Virginia has a uniform rate determination method based on usual and customary fees that are uniformly and consistently applied to each provider of a waiver service. The basis for the usual and customary fees was an agreed upon rate. The Medicaid agency conducted the original negotiations that resulted in an approved rate, and has consistently applied them to

waiver services and continues to determine rate changes. The rate for Homemaker Services was increased as follows at the direction of Department Administration following negotiations with providers; in October 2008 the rate was increased from $3.05 per 15 minute unit to $3.25; in August 2009 the rate was increased from $3.25 to $3.50 per 15 minute unit. The case management and nursing rates have not changed since the 2005 renewal. Mileage reimbursement is based on the approved mileage rate as published by the West Virginia Division of Purchasing, Travel Management Office. In that rates have not limited access they are deemed to be sufficient to enlist sufficient provider participation and meet the provisions of section 1902(a)30(A) and 42 CFR section 447.200-205. BMS will post payment rates on the Agency website so that waiver participants and providers will be aware of the cost of waiver services. The state of West Virginia does not use a formula to base increases for inflation, and at this time does not anticipate rate increases.

**b. Flow of Billings.**Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billing flows directly from waiver providers to the State's claims processing entity.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (2 of 3)

**c. Certifying Public Expenditures***(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51 (b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (3 of 3)

**d. Billing Validation Process.**Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Each claim is subjected to a series of edits to ensure that the member is eligible on the date of service, that the provider has a valid enrollment status and that the service is eligible for payment. If the claim passes these initial edits, further assurances

are provided through prior authorization of waiver services based on the waiver member's approved service plan. Post-payment review activities are conducted to ensure that services were provided.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

**c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

**d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

## Appendix I: Financial Accountability

### I-3: Payment (5 of 7)

**e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

**Answers provided in Appendix I-3-d indicate that you do not need to complete this section.**

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System.** *Select one:*

- **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

**iii. Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (1 of 3)

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [ ] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [x] **Other State Level Source(s) of Funds.**

  Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

  This waiver program is funded through a lottery appropriation that is transferred from the Bureau of Senior Services to the Bureau for Medical Services, and may also include general revenue appropriation.

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

*Check each that applies:*

- [ ] **Appropriation of Local Government Revenues.**

  Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

  Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (3 of 3)

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

*Check each that applies:*

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings.***Select one:*

- **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:
**Do not complete this item.**

## Appendix I: Financial Accountability

### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

- **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

**a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

***Charges Associated with the Provision of Waiver Services*** *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

*Specify:*

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

**b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.**Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: Nursing Facility**

| Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 | Col. 6 | Col. 7 | Col. 8 |
|---|---|---|---|---|---|---|---|
| Year | Factor D | Factor D' | Total: D+D' | Factor G | Factor G' | Total: G+G' | Difference (Col 7 less Column4) |
| 1 | 13413.26 | 7977.00 | 21390.26 | 43389.00 | 5202.00 | 48591.00 | 27200.74 |
| 2 | 14956.54 | 8275.00 | 23231.54 | 45185.00 | 5418.00 | 50603.00 | 27371.46 |
| 3 | 15681.19 | 8583.00 | 24264.19 | 47055.00 | 5642.00 | 52697.00 | 28432.81 |
| 4 | 18370.65 | 7418.00 | 25788.65 | 46717.00 | 6886.00 | 53603.00 | 27814.35 |
| 5 | 18373.05 | 8053.00 | 26426.05 | 48129.00 | 7352.00 | 55481.00 | 29054.95 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.**Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

| Waiver Year | Total Unduplicated Number of Participants (from Item B-3-a) | Distribution of Unduplicated Participants by Level of Care (if applicable) |
|---|---|---|
| | | Level of Care: |
| | | Nursing Facility |
| Year 1 | 8165 | 8165 |
| Year 2 | 8620 | 8620 |
| Year 3 | 7210 | 7210 |
| Year 4 | 6409 | 6409 |
| Year 5 | 6199 | 6199 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.**Describe the basis of the estimate of the average length of stay on the waiver by participants in item J -2-a.

Estimate for average length of stay is derived from historical claims experience.

The historical claims experience referred to in determining the ALOS for the forecasted future years on the waiver application and amendment uses the same process as the determination of the ALOS for the 372 reports. The data used for the determination of the 280 days submitted in the waiver is from the SFY2011 preliminary data. The SFY2011 data was used (instead of the 319.8 ALOS filed on the SFY2010 372 report) in an effort to provide the most recent data available at the time the forecast was prepared.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimates for Factor D are derived from historical trends of actual claims experience used in preparing the CMS-372 reports adjusted for inflationary increases based on the most recent five year reporting periods. Additional consideration was given to years determined to be outliers and these were excluded for trending purposes. Factor D was estimated using the historical data for: aggregate cost of each service; number of units paid; and number of users of each service. The future years were trended forward for future years by applying the historical data to the estimated number of users based on the projected unduplicated number of participants for each year in the new waiver period.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for Factor D' are derived from historical trends of actual claims experience used in preparing the CMS-372 reports adjusted for inflationary increases based on the most recent five year reporting periods. Additional consideration was given to years determined to be outliers and these were excluded for trending purposes. There are no wrap-around benefits provided to Medicare/Medicaid dual eligibles therefore the only prescription costs included would be for those drugs excluded from the Medicare formulary.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for Factor G are derived from historical trends of actual claims experience used in preparing the CMS-372 reports adjusted for inflationary increases based on the most recent five year reporting periods. Additional consideration was given to years determined to be outliers and these were excluded for trending purposes.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for Factor G' are derived from historical trends of actual claims experience used in preparing the CMS-372 reports adjusted for inflationary increases based on the most recent five year reporting periods. Additional consideration was given to years determined to be outliers and these were excluded for trending purposes.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

| Waiver Services | |
|---|---|
| Case Management | |
| Participant-Directed Goods and Services | |
| Personal Assistance/Homemaker Service | |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (5 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.**Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 1**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | **4554594.90** |
| Participant Directed Case Management | monthly fee | 2 | 12.00 | 71.10 | **1706.40** | |
| Case Management | monthly fee | 7115 | 9.00 | 71.10 | **4552888.50** | |
| **Participant-Directed Goods and Services Total:** | | | | | | **173000.00** |
| Participant-Directed Goods and Services | per event | 173 | 1000.00 | 1.00 | **173000.00** | |
| **Personal Assistance/Homemaker Service Total:** | | | | | | **104791692.47** |
| Participant Directed Personal Assistance/Homemaker Service | 15 minute | 817 | 2608.00 | 3.50 | **7457576.00** | |
| Personal Assistance/Homemaker Service | 15 minute | 7275 | 3522.00 | 3.50 | **89678925.00** | |
| Participant Directed Nursing | 15 minutes | 3 | 91.00 | 13.05 | **3562.65** | |
| Nursing | 15 minutes | 6738 | 20.00 | 13.05 | **1758618.00** | |
| Participant Directed RN Assessment | annual event | 0 | 0.00 | 119.14 | **0.00** | |
| RN Assessment | annual event | 5603 | 1.00 | 119.14 | **667541.42** | |
| Participant Directed Transportation | mile | 130 | 10539.00 | 0.47 | **643932.90** | |
| Transportation | mile | 5890 | 1655.00 | 0.47 | **4581536.50** | |
| | | | | **GRAND TOTAL:** | | **109519287.37** |
| | | | | **Total Estimated Unduplicated Participants:** | | **8165** |
| | | | | **Factor D (Divide total by number of participants):** | | **13413.26** |
| | | | | **Average Length of Stay on the Waiver:** | | 280 |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (6 of 9)

### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.**Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 2**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | **GRAND TOTAL:** | | **128925366.38** |
| | | | | **Total Estimated Unduplicated Participants:** | | **8620** |
| | | | | **Factor D (Divide total by number of participants):** | | **14956.54** |
| | | | | **Average Length of Stay on the Waiver:** | | 280 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | **4808635.20** |
| Participant Directed Case Management | monthly fee | 2 | 12.00 | 71.10 | **1706.40** | |
| Case Management | monthly fee | 7512 | 9.00 | 71.10 | **4806928.80** | |
| **Participant-Directed Goods and Services Total:** | | | | | | **183000.00** |
| Participant-Directed Goods and Services | per event | 183 | 1000.00 | 1.00 | **183000.00** | |
| **Personal Assistance/Homemaker Service Total:** | | | | | | **123933731.18** |
| Participant Directed Personal Assistance/Homemaker Service | 15 minute | 862 | 2736.00 | 3.75 | **8844120.00** | |
| Personal Assistance/Homemaker Service | 15 minute | 7680 | 3703.00 | 3.75 | **106646400.00** | |
| Participant Directed Nursing | 15 minutes | 3 | 96.00 | 13.05 | **3758.40** | |
| Nursing | 15 minutes | 7114 | 21.00 | 13.05 | **1949591.70** | |
| Participant Directed RN Assessment | annual event | 0 | 0.00 | 119.14 | **0.00** | |
| RN Assessment | annual event | 5916 | 1.00 | 119.14 | **704832.24** | |
| Participant Directed Transportation | mile | 137 | 11052.00 | 0.47 | **711638.28** | |
| Transportation | mile | 6218 | 1736.00 | 0.47 | **5073390.56** | |
| | | | | **GRAND TOTAL:** | | **128925366.38** |
| | | | | **Total Estimated Unduplicated Participants:** | | **8620** |
| | | | | **Factor D (Divide total by number of participants):** | | **14956.54** |
| | | | | **Average Length of Stay on the Waiver:** | | 280 |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (7 of 9)

### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.**Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | **GRAND TOTAL:** | | **113061414.27** |
| | | | | **Total Estimated Unduplicated Participants:** | | **7210** |
| | | | | **Factor D (Divide total by number of participants):** | | **15681.19** |
| | | | | **Average Length of Stay on the Waiver:** | | 280 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | **4468066.20** |
| Participant Directed Case Management | monthly fee | 1 | 12.00 | 71.10 | **853.20** | |
| Case Management | monthly fee | 6283 | 10.00 | 71.10 | **4467213.00** | |
| **Participant-Directed Goods and Services Total:** | | | | | | **153000.00** |
| Participant-Directed Goods and Services | per event | 153 | 1000.00 | 1.00 | **153000.00** | |
| **Personal Assistance/Homemaker Service Total:** | | | | | | **108440348.07** |
| Participant Directed Personal Assistance/Homemaker Service | 15 minute | 721 | 2871.00 | 3.75 | **7762466.25** | |
| Personal Assistance/Homemaker Service | 15 minute | 6424 | 3873.00 | 3.75 | **93300570.00** | |
| Participant Directed Nursing | 15 minutes | 3 | 101.00 | 13.05 | **3954.15** | |
| Nursing | 15 minutes | 5951 | 22.00 | 13.05 | **1708532.10** | |
| Participant Directed RN Assessment | annual event | 0 | 0.00 | 119.14 | **0.00** | |
| RN Assessment | annual event | 4948 | 1.00 | 119.14 | **589504.72** | |
| Participant Directed Transportation | mile | 115 | 11589.00 | 0.47 | **626385.45** | |
| Transportation | mile | 5201 | 1820.00 | 0.47 | **4448935.40** | |
| | | | | **GRAND TOTAL:** | | **113061414.27** |
| | | | | **Total Estimated Unduplicated Participants:** | | **7210** |
| | | | | **Factor D (Divide total by number of participants):** | | **15681.19** |
| | | | | **Average Length of Stay on the Waiver:** | | 280 |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (8 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.**Complete the following table