

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 section 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 purpose of this application is to renew WV's IDDW 5-year application. Listed below are the changes that can be found:
- The West Virginia Department of Health and Human Resources (WV DHHR) has been changed to West Virginia Department of Human Services (WV DoHS) throughout the application. The name change follows the re-organization of the Department into three separate departments, effective January 1, 2024, pursuant to House Bill 2006.
- B.1.b, B.6.b "Autism" changed to "Autism Level 3" for clarification purposes. This change will not impact any currently enrolled members or future applicants of the IDDW and is based solely on the update of the DSM diagnosis terminology.
- B-3-a: Table updated for Year 1
- B.6.h: Clarification regarding the required credentials for staff conducting initial and annual medical eligibility assessments.
- QI-b-I (Appendices A, B, C, D, G & I) revised to comply with CMS revision to describe how both individual and systemic deficiencies are identified and remedied.
- Section B-8: updated percentage of English proficiency per 2020 census. (decrease to 97.5%)
- C.a (Nursing): Additional description of the RN's role in supervising AMAP
- C.a (Case Management): Clarifying responsibility for CM to increase in-person contacts depending on individual need
- C1/C3:
- Case Management: updated service definition to include description of case management training regarding the HCBS settings rule and person-centered planning practices. Specified members living in a Natural Family setting will have quarterly case management in-person visits. Visits occurring in all other months may be conducted in-person or via secure electronic means. Individuals receiving services in a 24-hour residential setting will continue to receive monthly in person case management visits. Allowing for CMs to be hired with five years of experience in the WV IDD Waiver field in lieu of a four-year degree in the human services field with supervisory requirements.
- Telehealth: updated service descriptions to reflect current practices regarding the provision of Case Management, RN Services, Behavioral Health Supports, Day Habilitation, PT, OT, Speech and Dietary via telehealth when necessary and appropriate to meet the needs of the individual.
- Licensed Group Home PCS and Unlicensed Group Home PCS have been expanded to include qualifications for the provision of AMAP services.
- Added a new service - Skilled Nursing Medication Administration.
- Removed requirement for monthly OIG checks for all services in Section C. West Virginia recently implemented a comprehensive background check database, WV CARES, that includes a "rap back" system. The "rap back" system will alert providers if there is a change in an employee's criminal background and includes the monthly OIG check.
- C-2-b: Updated narrative to include description of current practices to ensure continuity of care in the event that a service provider is substantiated for abuse, neglect, exploitation or in response to a critical incident.
- C-2-d: Updated to reflect safeguards in place to ensure that Legal Authorized Representative (LAR) uses substituted judgment on behalf of the individual served.
- C-2-d: Updated Base Budget Rates and "add-on" amounts to reflect current budget ranges.
- C-2-e: Updated to reflect safeguards in place to ensure that LAR uses substituted judgment on behalf of the individual served. Revised language also includes reference to relevant WV Code Chapter 44a-1-5. Additional clarification regarding the limitations on the provision of services by guardians and family members.
- C-2-g: Updated to reflect current practices described in Chapter 513, IDDW Policy Manual, to allow for provision of direct support services in acute care hospital settings.
- C-3-L: Electronic Monitoring: updated service description to be consistent with current practices described in Chapter 513, IDDW Policy Manual (e.g., placement of cameras, ability of individual to turn system on and off, individual training on system functionality).
- C-3: Occupational Therapy: Updated to describe provision of waiver services authorized beyond EPSDT medical necessity.
- C-3: Physical Therapy: Updated to describe provision of waiver services authorized beyond EPSDT medical necessity.
- C-3: Speech Therapy: Updated to describe provision of waiver services authorized beyond EPSDT medical necessity.
- C-3 Dietary Services: Updated to describe provision of waiver services authorized beyond EPSDT medical necessity.
- C-5: Home and Community-Based Settings: Service description updated to reflect current policies and practices regarding identification and remediation of settings found to be out of compliance with the HCBS settings rule. Further clarification regarding BMS designation of provider-owned/controlled settings.
- D-1-a: Revised to describe case manager's role in the development of the service plan, including importance of person-centered planning and training on the HCBS settings criteria.
- D-1-a: Updating language around IPP timelines. 30 days updated to calendar month. 90 days updated to three calendar months. 180 days updated to six calendar months.
- D-1-b: Description of service plan development safeguards revised to reflect that in the event case management agency is also responsible for service delivery, that agency is the only willing and qualified provider in a given geographic area. In addition, no agency can furnish both case management and provider service without authorization from the state agency.
- D-1-d-i: Service Plan Development Process description revised to reflect that the 7-Day IDT plan is limited to an effective duration of 60, unless otherwise authorized by BMS.
- D-1-g: New language included to limit the effective duration of the 7-Day IDT plan to 60 days without state agency

authorization.

- D-2-b: Removed language referring to personal attendant (PA) services and replaced with "other waiver services."
- I.1: Description of current post-payment review processes, how BMS verifies claims, and the scope, methods, and frequency of post-payment reviews.
- I.2.a: Updated description of process and entity responsible for rate determination.
- J.2.c.i: Clarification regarding recent rate increases and calculation of Factor D
- J.2.c.ii: Updated description of how Factor D is calculated
- J.2.c.iii: Clarified process for calculation of Factor G
- J-2-d: Updated rates and added three new services for AMAPs in unlicensed residential homes and four new services for AMAPS in licensed group homes and an additional new service for Skilled Nursing Medication Administration.
- J-2-d: Added a new component for Behavior Support Professional (BSP) service - BSP I IPP Planning

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 section 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*):

Intellectual/Developmental Disability 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

Original Base Waiver Number: WV.0133

Waiver Number: WV.0133.R08.00

Draft ID: WV.007.08.00

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

Regular Waiver

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

07/01/25

Approved Effective Date: 07/01/25

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 in 42 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 section 1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under section 1915(b) of the Act.

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

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

section 1915(b)(1) (mandated enrollment to managed care)

section 1915(b)(2) (central broker)

section 1915(b)(3) (employ cost savings to furnish additional services)

section 1915(b)(4) (selective contracting/limit number of providers)

A program operated under section 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 section 1915(i) of the Act.

A program authorized under section 1915(j) of the Act.

A program authorized under section 1115 of the Act.

Specify the program:

H. Dual Eligibility 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 purpose of the Intellectual/Developmental Disability Waiver (IDDW) is to offer a comprehensive scope of services and supports to eligible individuals within each member's individualized budget to avoid or delay institutionalization.

Services are provided in community settings of the member's choice and may include living with their family, in their own home, in foster care settings for individuals with intellectual and/or developmental disabilities, or in smaller settings (1-3 person homes) leased by the individual or in larger congregate settings of 4 or more (licensed group homes). Any site owned or leased by an IDDW provider or having more than 3 people living together must be licensed by the Office of Health Facility Licensure and Certification and meet all of the characteristics of an integrated setting as defined by the Centers for Medicare and Medicaid. The goal of the IDDW program is to provide services through which qualifying individuals may receive person-centered services and supports in the least restrictive manner in the community. All individuals are assessed annually and assigned an individualized budget. All services purchased must be within the individualized assigned budget.

The objective is to provide needed services to individuals with intellectual and/or developmental disabilities and to increase enrollment capacity in a systematic manner in order to reduce waiting lists for these services.

The organizational structure for this waiver includes the West Virginia Department of Human Services' Bureau for Medical Services as the Single State Medical Agency and a Utilization Management Contractor (UMC). BMS retains final authority over the waiver, its administration and operation.

The IDDW offers both traditional and self-directed service options. The traditional method of service delivery is provided by qualified, enrolled IDDW providers, both profit and not-for-profit. The self-directed method of service delivery is provided by one Government/Subagent which provides Financial Management Services (FMS) and Information and Referral (Resource Consulting).

12 slots are reserved each wavier year per the Benjamin H. court order, 6 of those slots are reserved for adults who are on the managed enrollment list and have resided in a state-owned mental institutions for over one year and 6 slots are reserved for children under the age of 21 who are on the managed enrollment list and have resided in out-of-state facilities for over one year.

Additional limits in the waiver include the individualized budget methodology and are as follows: (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 an IDDW member'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 member 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.

In the case of a member with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act. After December 31, 2019 (or other date as required by law), spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of members with a community spouse for the special home and community-based waiver group. In the case of a member with a community spouse, the state elects to use spousal post-eligibility rules.

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 section 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 section 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. Statewide. Indicate whether the state requests a waiver of the statewide requirements in section 1902(a)(1) of the Act (*select one*):

No

Yes

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

Geographic Limitation. A waiver of statewide requirements 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 statewide requirements 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 section 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 inpatients 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 section 1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR Part 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. 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 Part 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:

BMS posted a notice on the BMS website and DoHS Social Media platforms announcing the 30-day public comment period and sent a copy of the notice to all the IDDW providers directing them to display it in a prominent location in their offices. IDDW providers were instructed to direct all of their case managers to call the members on their caseloads and advise them of the 30-day public comment period.

The public comment period for this draft renewal was from February 21, 2025, through March 22, 2025. The document that lists the comments made and the responses indicating whether a change was made or not can be found here: <https://dhhr.wv.gov/bms/CMS/Pages/Waiver-Approvals.aspx>

IDDW received 57 public comments, 14 of which were duplicate comments. A total of 43 unique comments required responses. Sixteen comments resulted in revisions to the waiver application. The following is a summary of the public comments received:

Seven comments addressed Case Management (CM) responsibilities. Three of these comments resulted in revisions to the waiver application related to the CM's role in: 1) monitoring restrictions approved by the Human Rights Committee; 2) verifying Environmental Accessibility Adaptations, and 3) compiling results of evaluations for the annual Individual Program Plan (IPP) meeting.

Three comments involved provider qualifications. All three comments resulted in changes to the waiver application to expand the definition of qualified service providers for Home-Based Agency Person-Centered Supports and Family Person-Centered Supports.

Two comments were submitted regarding the frequency of face-to-face visits by the Case Manager. One comment resulted in a change to the waiver application to reduce the frequency of face-to-face visits for individuals who reside in their natural family home.

Two comments were submitted regarding billing procedures. These comments did not result in changes to the waiver application.

Two comments requested the addition of the At-Risk CM services previously included in a now deactivated amendment. While this comment did not result in a change in the current waiver application, BMS responded that the need for this service will continue to be evaluated and may be included in a future waiver amendment.

Additional comments that resulted in waiver application revisions were regarding CM use of EVV, simplification of IPP timelines, eligibility requirements related to a stand-alone Autism diagnosis, waiver slot allocation, an increase in crisis intervention service units, base budget calculations, frequency of Office of Inspector General (OIG) checks and the definition of group homes to include smaller residences serving one to three individuals.

The remaining comments that resulted in no changes to the waiver application addressed the following areas: appreciation for the IDDW, individual choice of CM, eligibility requirements, enrollment targets for traditional and participant-directed models, public reporting of the Statewide Transition Plan, permissible nursing tasks, provider review requirements, accessibility of public comment, engagement of the Quality Improvement Advisory Council, background checks, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), and inclusion of the list of excluded items for Participant-Directed Goods and Services in the waiver application, rather than solely in the IDDW Policy Manual (Chapter 513).

The state of WV does not have any federally-recognized Tribal Governments thus no tribal consultation was required.

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:**

Parsons

First Name:

Cynthia

Title:

Office Director Home and Community Based Services

Agency:

Bureau for Medical Services

Address:

350 Capitol Street, Room 251

Address 2:**City:**

Charleston

State:

West Virginia

Zip:

25301

Phone:

(304) 352-5254

Ext:

TTY

Fax:

(304) 558-4398

E-mail:

cynthia.a.parsons@wv.gov

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

Carpenter

First Name:

Mandy

Title:

Interim Deputy Commissioner of Finance

Agency:

Bureau for Medical Services

Address:

350 Capitol Street. Room 251

Address 2:**City:**

Charleston

State:

West Virginia

Zip:

25301

Phone:

(304) 352-4222

Ext:

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(304) 558-4398

E-mail:

mandy.d.carpenter@wv.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under section 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:

Mandy Carpenter

State Medicaid Director or Designee

Submission Date:

Jun 17, 2025

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

Last Name:

Beane

First Name:

Cynthia

Title:

Commissioner

Agency:

Bureau for Medical Services

Address:

350 Capitol Street, Room 251

Address 2:

City:

Charleston

State:

West Virginia

Zip:

25301

Phone:

Ext:

TTY

Fax:

E-mail:

Attachments**Attachment #1: Transition Plan**

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

“Autism Level 3” is listed in Appendix B.1.b (“Additional Criteria” for the waiver target group) and Appendix B.6.d (“Level of Care Criteria”) as one of several examples of diagnoses or “related conditions” that may reach a threshold of severity and chronicity that can make an individual eligible for the IDDW regardless of associated, adaptive deficits. This change is not expected to lead to any changes in eligibility for individuals currently served in or applying to enroll in the IDDW, nor is it likely to necessitate the transfer of any individual to another waiver. It is merely a clarification that a diagnosis of Autism alone (at any level) does not qualify an individual for the IDDW. The eligibility criteria for initial and continued enrollment have not changed since the waiver was initially approved in 2010 (e.g., diagnosis, functionality, and need for ICF/IID level of care).

BMS routinely monitors application, enrollment, and discharge data, and issues monthly reports to the WV State Legislature’s Joint Committee on Government and Finance and Legislative Oversight Commission on Health and Human Resources Accountability (LOCHHRA). This report is posted each month on the DoHS website. BMS also meets monthly with the Utilization Management Contractor (UMC) vendor who conducts the annual medical eligibility redeterminations to review program data, including the findings of annual reassessments. In the event that data from any source indicates any individual is at risk of losing eligibility due to the updates to the DSM-5-TR diagnostic criteria for Autism or any other diagnosis or related condition, BMS will take immediate action to address any misapplication of the IDDW eligibility criteria in the eligibility determination process. As previously stated, the eligibility criteria have not changed since CMS initially approved the IDDW in 2010, nor has the annual redetermination and standardized assessment process changed.

An individual’s diagnosis is not determined during the annual medical eligibility redetermination process. The annual medical eligibility redetermination process involves a standardized functional assessment that includes a structured interview as well as standardized measures of adaptive behavior in the six major life areas (e.g., Inventory for Client and Agency Planning functional assessment tool). This process does not include a diagnostic determination and does not involve any diagnostic tests or procedures. The UMC staff responsible for performing the annual medical eligibility redetermination are not licensed clinicians and are therefore not qualified to make a new diagnosis or change an individual’s existing diagnosis.

If an individual’s adaptive functioning has improved so significantly that they are no longer medically eligible to participate in the waiver, the individual is notified of the changes to their eligibility and provided with a written Notice of Decision, a Request for Hearing form, and the results of the standardized functional assessment. If the individual chooses to appeal the eligibility determination, IDDW services will continue through the appeals process. This process has been in place for individuals who are found medically ineligible at the annual redetermination since the waiver was initially approved in 2010.

If the eligibility determination is not appealed or if the Fair Hearing results in a finding that the termination of eligibility is valid, BMS policy requires that the individual’s CM takes steps to facilitate the individual’s transition to alternative services and supports, including making referrals to other waiver and non-waiver services, as appropriate. The UMC is also responsible for helping to ensure that the individual is referred to any other 1915 or 1115 waiver or State plan services that may meet their needs, such as the Aging and Disabled Waiver (ADW) or community mental health services. The table below depicts examples of other programs and services an individual may be referred to following termination from IDDW services due to a significant improvement in adaptive functioning:

Waiver Services Example Transitional Services and Supports

Case Management	TCM, LBHC (Ex. Person and Family Centered Treatment Planning)
Day Habilitation	ICF, OAA (Title III-E), Psych Rehab Services, LBHC (Ex. Skills Training and Development)
Employment Services	WV Works, Workforce WV, Regional Workforce Development Boards, Career Centers, ICF/IID
Behavior Supports	LBHC (Ex. Therapeutic Behavioral Services, Behavior Management), CCBHC, ACT, CSED, BH
Outpatient Services, Psychiatric Services	
Crisis Services	9-8-8, LBHC Crisis Services, CCBHC Crisis Services
Specialized Therapies	State Plan, LBHC, CCBHC
EAA	ADW, OAA, WV Community Living Services Program (Center for Independent Living)
Group Home	ICF, Transitional ICF beds (SB 575), CCBHC, LBHC (Ex. Comprehensive Community Support Services)
PCS (Home/Family)	PCS, ICF, Peer Supports, Family Caregiver Supports, CCBHC, LBHC (Ex. Comprehensive Community Support Services, ADW)
Nursing	State Plan, ADW, Home Health, LBHC (Ex. Medication Management, CCBHC (Primary Care Screening and Monitoring)
Respite	OAA, ADW, CSED
Non-Medical Trans.	WV Works, ADW, LBHC Transportation Services

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:

The Bureau for Medical Services (BMS)

(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:

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:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.

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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.:*

UMC Overview and Functions

The UMC assists BMS with the implementation of the IDDW. The UMC provides assessment, individualized budgeting, quality reviews and prior authorization as well as managing enrollment and the Managed Enrollment List (wait list).

The UMC has a well-established process for the annual assessment of each enrolled person's abilities and needs. This face to face assessment with the enrolled person and his/her chosen respondents (parents/family members; paid staff persons, legal representative, case manager and natural supports) includes a Structured Interview during which the enrolled person and respondents are educated about the IDDW program including:

- Participant-directed services;
- The individualized budget process;
- Services available through the program and related policy and restrictions;
- Freedom of choice including the right to choose providers, services, and service options;
- Available service providers including locations and contact information;
- Concepts of person-centered planning and philosophy;
- The process for negotiating the allocated budget amount;
- The process for fair hearings/appealing eligibility and service decisions.

The UMC will be responsible for tracking active enrolled people by performing the following functions in accordance with the waiver policy:

- Processing statements of interest/applications within timeframes established in the waiver manual;
- Ensuring each enrolled person's medical eligibility is initially established and reestablished on an annual basis in coordination with the Medical Eligibility Contract Agent;
- Notifying enrolled people and their chosen Case Management providers of enrollment/reenrollment decisions;
- Maintaining an accurate wait list of certified applicants awaiting an available slot;
- Management of eligibility appeals;

Through the annual assessment of each person receiving services, the UMC compiles comprehensive data pertaining to the enrolled person's abilities, strengths, and support needs. Statistical analysis of this data results in customized algorithms for adults and children. Through the application of these algorithms against each enrolled person's unique assessment data, an individualized budget is determined.

The enrolled person and his/her chosen Case Manager is notified of the budget amount and assessment results a minimum of 45 days prior to the enrolled person's annual team meeting. Following the annual team meeting and subsequent quarterly or critical juncture meetings, services and supports may be requested from funds allocated in the enrolled person's budget.

Through the UMC's web-based application, each person's Case Manager requests services as determined necessary by the enrolled person's team. Upon submission of requested services, the UMC reviews the request to ensure services/supports are within policy and program parameters and that the enrolled person's identified health & safety issues are addressed. Requests for services that exceed the enrolled person's budget allocation are clinically researched, negotiated and the authorized units adjusted as necessary so that the most clinically appropriate amounts of services are authorized.

The UMC's web-based application allows the person's Case Manager to submit documentation and purchase requests resulting from annual, quarterly and critical juncture team meetings. This ensures that changes in the person's needs are addressed.

The UMC performs quality and utilization reviews, both on-site and through desk reviews, of IDDW providers annually and OHFLAC performs on-site reviews biennially as specified in the Quality Management Plan (See Appendix H). The scope of reviews will address CMS quality assurance standards and all quality indicators identified in the Waiver Quality Management Plan.

The UMC develops and conducts training for providers and other stakeholders as necessary to improve systemic and provider-specific quality of care and regulatory compliance issues. Training is available through both face-to-face and web-based venues.

See Main 8-B for the remaining descriptions of contracted entity functions.

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 WV Department of Human Services' 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:

BMS conducts monthly contractual oversight meetings with the UMC, the MECA, OHFLAC and the Government-subagent F/EA (Personal Options). During these monthly meetings performance measures for each contractor are reviewed and any issues/concerns are identified and addressed.

The quality management data collected through discovery methods is compiled using the Quality Management Report Template and reviewed at least monthly by BMS at its contract meetings. The Quality Management Report is also compiled and reviewed quarterly by the IDDW Quality Improvement 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 QIA Council for its review and analysis.

Reports:

BMS management staff will receive and review the following contract reports:

- (1) IDDW Quality Management Report on delegated functions and ad hoc reports as requested.
- (2) Participant-Directed F/EA Vendor Monthly Report on delegated functions and ad hoc reports as requested.
- (4) Claims Processing Vendor routine reports on claims data and ad hoc reports as requested.
- (5) Medical Eligibility Contracted Agent Vendor Monthly Report on delegated functions and ad hoc reports as requested.
- (6) Reports from OHFLAC on quality audits and investigations.

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.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment		
Waiver enrollment managed against approved limits		
Waiver expenditures managed against approved levels		
Level of care waiver eligibility evaluation		
Review of Participant service plans		
Prior authorization of waiver services		
Utilization management		
Qualified provider enrollment		
Execution of Medicaid provider agreements		
Establishment of a statewide rate methodology		
Rules, policies, procedures and information development governing the waiver program		

Function	Medicaid Agency	Contracted Entity
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:

Percent of requests for prior authorization responded to within established timelines.

Numerator-Number of requests for prior authorization responded to within established timelines. Denominator-Number of requests for prior authorization.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

		Interval = <div></div>
Other Specify: <div>UMC</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

Percent of on-site provider reviews conducted within established timelines. Numerator-
Number of on-site provider reviews conducted within established timelines. Denominator-

Number of on-site provider reviews conducted.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Specify: <div> <div>UMC</div> </div>	
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

Percent of providers that submitted the validation review within timeline. Numerator-
Number of providers that submitted the validation review within timeline Denominator-
Number of providers whose validation review was due

Data Source (Select one):**Record reviews, off-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 Confidence Interval = <div></div>
Other Specify: <div> <div>UMC</div> </div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 5px;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 5px;"></div>

Performance Measure:

Percent of required monthly reports provided by the contracted entities to BMS by the due date. Numerator: The number of required monthly reports provided to BMS by the due date Denominator: The number of required monthly reports

Data Source (Select one):**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

		Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="UMC"/> <input type="text" value="MECA"/> <input type="text" value="OHFLAC"/> <input type="text" value="Claims payer"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="UMC"/> <input type="text" value="MECA"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Percent of provider agencies who met continuing certification standards. Numerator-
Number of provider agencies who met continuing certification standards annually.
Denominator-Number of provider agencies.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">UMC</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
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 Specify: <div> <div>UMC</div> <div>OHFLAC</div> </div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

Percent of written complaints followed-up on by the UMC within established timelines.

Numerator-Number of written complaints followed-up on by the UMC within established timelines. Denominator-Number of written complaints submitted to the UMC.

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 = <div></div>
Other Specify: <div> <div>UMC</div> </div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/> UMC	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Percent of satisfaction surveys pertaining to UMC functions rated 80% or higher.

Numerator-Number of satisfaction surveys pertaining to UMC functions rated 80% or higher. Denominator-Number of satisfaction surveys submitted.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="UMC"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text" value="UMC"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- 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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The Operating Agency collects all information related to this assurance through the review of individuals receiving services 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. The Operating Agency must approve all Corrective Action Plans. Services provided that are not documented on the service plan are disallowed, and payment is recouped from the provider agency.

The Bureau for Medical Services (BMS) is responsible for building and maintaining the Intellectual and/or Developmental Disabilities Waiver's (IDDW's) Quality Improvement System (QIS). The IDDW provider and the Personal Options vendor are responsible for participating in all activities related to the QIS. The IDDW's QIS is used by BMS and the Utilization Management Contractor (UMC) as a continuous system that measures system performance, tracks remediation activities, and identifies opportunities for system improvement. Achieving and maintaining program quality is an ongoing process that includes collecting and examining information about program operations and outcomes for members receiving services, and then using the information to identify strengths and weaknesses in program performance. This information is used to form the basis of remediation and improvement strategies. The QIS is designed to collect the data necessary to provide evidence that the CMS Quality Assurances are being met and to ensure the active involvement of interested parties in the quality improvement process.

In addition to the QIS, BMS also engages the Quality Improvement Advisory (QIA) Council to analyze information from individual problems, identify systemic deficiencies, and implement remediation activities. The QIA Council is the focal point of stakeholder input for the IDDW Program and plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies.

The role of the QIA Council is to advise and assist BMS and UMC staff in program planning, development, and evaluation consistent with its stated purpose. In this role, the QIA Council uses IDDW Performance Indicators as a guide to:

- Recommend policy changes;
- Recommend program priorities and quality initiatives;
- Monitor and evaluate policy changes;
- Monitor and evaluate the implementation of Waiver priorities and quality initiatives;
- Serve as a liaison between the Waiver and interested parties; and
- Establish committees and work groups consistent with its purpose and guidelines.

The Council membership is composed of persons who formerly utilized IDDW services of the IDDW Program, members who currently are utilizing IDDW services (or their legal representatives), service providers, advocates, and other allies of people with intellectual and/or developmental disabilities.

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(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<div style="border: 1px solid black; padding: 5px;"> UMC MECA OHFLAC Claims vendor </div>	
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>

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 Sub Group	Minimum Age	Maximum Age			
				Maximum Age Limit		No Maximum Age Limit	
Aged or Disabled, or Both - General							
		Aged					
		Disabled (Physical)					
		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		3			

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Intellectual Disability	3		
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

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

In order to be eligible to receive IDDW Program Services, an applicant must meet the following medical eligibility criteria:

The applicant must be a West Virginia resident, be at least 3 years of age, meet medical eligibility (have a diagnosis of intellectual disability with concurrent substantial deficits manifested prior to age 22 or a related condition which constitutes a severe and chronic disability with concurrent substantial deficits manifested prior to age 22), and meet financial eligibility. Applicants must choose home and community based services over those provided in an institution.

Examples of related conditions which may, if severe and chronic in nature, make an individual eligible for the IDDW program include but are not limited to, the following:

- Autism Level 3;
- Traumatic Brain Injury;
- Cerebral Palsy;
- Spina Bifida; and
- Any condition, other than mental illness, found to be closely related to an intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with an intellectual disability, and requires services similar to those required for persons with intellectual disability.

Additionally, the applicant who has a diagnosis of an intellectual disability or a severe related condition with associated concurrent adaptive deficits must meet the following requirements:

- Likely to continue indefinitely; and,
- Must have the presence of at least 3 substantial deficits out of the 6 identified major life areas listed below:
 - Self-care;
 - Receptive or expressive language (communication);
 - Learning (functional academics);
 - Mobility;
 - Self-direction; and,
 - Capacity for independent living which includes the following 6 sub-domains:
 - home living, social skills, employment, health and safety, community and leisure activities. At a minimum, 3 of these sub-domains must be substantially limited to meet the criteria in this major life area.

Substantial deficits are defined as standardized scores of 3 standard deviations below the mean or less than one percentile when derived from a normative sample that represents the general population of the United States, or the average range or equal to or below the 75 percentile when derived from MR normative populations when intellectual disability has been diagnosed and the scores are derived from a standardized measure of adaptive behavior. The scores submitted must be obtained from using an appropriate standardized test for measuring adaptive behavior that is administered and scored by an individual properly trained and credentialed to administer the test. The presence of substantial deficits must be supported not only by the relevant test scores, but also the narrative descriptions contained in the documentation submitted for review, i.e., psychological report, the IEP, Occupational Therapy evaluation, etc.

Documentation must support that the applicant would benefit from continuous active treatment. Active treatment includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services. Active treatment does not include services to maintain generally independent people who are able to function with little supervision or in the absence of a continuous active treatment program.

Medical Eligibility Criteria: Level of Care

To qualify for ICF/IID level of care, evaluations of the applicant must demonstrate:

- A need for intensive instruction, services, assistance, and supervision in order to learn new skills, maintain current level of skills, and increase independence in activities of daily living,
- A need for the same level of care and services that is provided in an ICF/IID institutional setting. The applicant or legal representative will be informed of the right to choose between ICF/IID services and home and community-based services under the IDDW Program and informed of his/her right to a fair hearing in the event of an adverse decision.

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:

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)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

- 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:

- 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:

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	6165
Year 2	6165
Year 3	6165
Year 4	6165
Year 5	6165

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	
Benjamin H. Slots	

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*):

Benjamin H. Slots

Purpose (*describe*):

The state reserves capacity of 12 slots in years 1, 2, 3, 4 and 5. Six slots are for adults and 6 slots are for children. The 6 adult slots are for adults, 18 years of age and older, who are on the managed enrollment list and have been institutionalized for at least six months. The 6 children's slots are for individuals under age 21 who are on the managed enrollment list and have been institutionalized in an out-of-state facility for at least six months.

Describe how the amount of reserved capacity was determined:

Six individuals who have been institutionalized for one year or more at a state-owned mental institution. 6 children who are on the waitlist and have been institutionalized in out-of-state facilities for over a year per the court order, Benjamin H. v. Joan Ohl, Civ. Action 3:99:0388 dated 7/25/2018.

Year 1: 6 children 6 adults
 Year 2: 6 children 6 adults
 Year 3: 6 children 6 adults
 Year 4: 6 children 6 adults
 Year 5: 6 children 6 adults

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

Waiver Year	Capacity Reserved
Year 1	12
Year 2	12
Year 3	12
Year 4	12
Year 5	12

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 people served by the IDWW program is reached, applicants for the IDWW services are placed on a Managed Enrollment List (MEL). Applicants for entry into the program will be processed on a first-come-first-serve basis based upon the date/time of the determination of medical eligibility as capacity becomes available. When a funded slot becomes available, the applicant must then establish financial eligibility prior to enrollment. The exceptions are the 12 Benjamin H. slots. 6 slots are reserved each year for adults who have been placed in an Institutions for Mental Disease for over a year and 6 slots are reserved each year for children who have been placed out of state for at least one year.

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*):

Section 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)

Parents and Other Caretaker Relatives (42 CFR § 435.110)

Pregnant Women (42 CFR § 435.116)

Infants and Children under Age 19 (42 CFR § 435.118)

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 section 1902(a)(10)(A)(ii)(XIII) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 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 section 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 section 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:

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 spend down 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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), 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 section 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 section 1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 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 period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

Spousal impoverishment rules under section 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 section 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 (Section 1634 State/SSI Criteria 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 section 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 period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules at 42 CFR § 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in ?1924 of the Act. 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

The state provides an allowance for a spouse who does not meet the definition of a community spouse in section 1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (select one):

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 period after September 30, 2027 (or other date as required by law).

- c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).**

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 period after September 30, 2027 (or other date as required by law).

- d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)**

The state uses the post-eligibility rules of section 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 section 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).

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

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 formula:

Other

Specify:

300% of federal SSI Benefit rate.

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR § 435.726 or 42 CFR § 435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

All income is allowed for the personal needs of the waiver participant.

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 or 42 CFR § 435.735:

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 uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through September 30, 2027 (or other date as required by law).**

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- f. Regular Post-Eligibility Treatment of Income: 209(b) State ? January 1, 2014 through September 30, 2027 (or other date as required by law).**

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 (7 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).**

The state uses the post-eligibility rules of section 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 the selections in B-5-d also apply to B-5-g.

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:

The Medical Eligibility Contracted Agent (MECA).

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 MECA, all initial assessments for the determination of medical eligibility for the IDDW program are conducted by licensed psychologists specifically trained to evaluate applicants with intellectual disabilities/developmental disabilities (I/DD) or related conditions (RC).

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.

Every applicant must have an initial Independent Psychological Evaluation (IPE) completed by a member of the Independent Psychologist Network (IPN). The Independent Psychologist (IP) utilizes age-appropriate standardized test(s) which includes but is not limited to: measures of intellect, achievement tests, adaptive behavior scales, measures of autism, and/or developmental profiles to render diagnoses. Documentation must be provided that allows the MECA to make a determination that the diagnosis of I/DD and/or RC with associated concurrent adaptive deficits was manifested prior to age 22 and is likely to continue indefinitely.

DIAGNOSIS

In order to be eligible to receive IDDW Services the following medical eligibility criteria questions must be addressed by the MECA:

- Does the person have a diagnosis of I/DD or RC?
- Does the person require the level of care and services provided by an ICF/IID (Intermediate Care Facility for Individuals with Intellectual Disability)? This is evidenced by required evaluations and corroborated by narrative descriptions of functioning and reported history. An ICF/IID facility provides monitoring, supervision, training and supports.
- Does the person have substantial adaptive deficits in 3 of the 6 major life areas (functionality) due to an I/DD or RC that manifested prior to the age of 22? Does the person have a related developmental condition which constitutes a severe and chronic disability with concurrent substantial deficits that are not primarily due to a mental illness? Related conditions, other than mental illness, found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of intellectually disabled persons and requires services similar to those required for persons with intellectual disabilities can include but are not limited to the following:

- o Autism Level 3
- o Traumatic brain injury
- o Cerebral Palsy
- o Spina Bifida
- o Tuberous Sclerosis

- Is the I/DD or RC likely to continue indefinitely?

FUNCTIONALITY

A deficiency in functionality must be met for IDDW eligibility. Functionality is defined as substantially limited functioning in three (3) or more of the 6 major life areas as evidenced by standardized measures of adaptive behavior scores that are three (3) standard deviations below the mean or less than one (1) percentile when derived from non-ID normative populations or in the average range or equal to or below the seventy fifth (75) percentile rank when derived from ID normative populations. The presence of substantial deficits must be supported not only by the relevant test scores, but also the narrative descriptions contained in the documentation submitted for review, i.e., psychological evaluations, the IEP, Occupational Therapy evaluations, etc.

The six major life areas include:

- Self-care
- Receptive or expressive language (communication)
- Learning (functional academics)
- Mobility
- Self-direction
- Capacity for Independent Living. This major life area is determined to be met by substantial limitations in at least 3 of the following subdomains: home living, social skills, employment, health and safety, community, and leisure activities.

NEED FOR ACTIVE TREATMENT

To qualify for ICF/IID level of care, evaluations of the applicant must demonstrate:

- Need for intensive instruction, services, assistance, and supervision in order to learn new skills, maintain current level of skills, and increase independence in activities of daily living.
- Need for the same level of care and services that is provided in an ICF/IID institutional setting. The applicant or legal representative will be informed of the right to choose between ICF/IID services and home and community based services under the IDDW and informed of his/her right to a fair hearing in the event of an adverse decision.

MEMBER ANNUAL RE-DETERMINATION

Every member must have a re-determination of medical eligibility completed at least annually. The anchor date of the person's annual re-determination is the first day of the first month after the initial medical eligibility was established by

the MECA.

At a minimum, annual re-determination of eligibility will include one annual functional assessment which includes an eligible diagnosis and standardized measures of adaptive behavior in the six major life areas completed by the UMC and the results provided to the MECA. The results of the functional assessment must be provided to the MECA at least 30 days prior to the person's annual anchor date.

For re-determination of eligibility to receive IDDW services the following medical eligibility criteria must be addressed by the MECA:

- The person continues to have a diagnosis of I/DD or a Related Condition that is likely to continue indefinitely.
- The person continues to require the level of care and services provided by an ICF/IID facility.
- The person continues to have a diagnosed condition, other than mental illness, that results in substantially limited functioning in three (3) or more of the six (6) major life areas (self-care, expressive or receptive language, learning, mobility, self-direction and capacity for independent living).
- The person continues to require active treatment to promote the acquisition of skills and/or decrease or prevent regression in skills.
- To be redetermined eligible, a person must continue to display substantial adaptive behavior deficits. People who demonstrate a substantial improvement in adaptive behavior functioning no longer meet eligibility criteria. Substantial improvement is defined as an increase of one standard deviation or more above the initial eligibility criteria on standardized measures of adaptive behavior. A substantial improvement in capacity for independent living is defined as an increase of one standard deviation or more above the initial eligibility criteria on standardized measures of adaptive behavior in all six sub-domains.

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:

A request for medical eligibility is received by the UMC. The UMC contacts the applicant and provides a list of state-wide independent psychologists associated with the Independent Psychologist Network (IPN) and their contact information. The applicant contacts the independent psychologist of their choice and notifies the UMC of the scheduled independent psychological evaluation (IPE). The independent psychologist completes the IPE which includes background information, mental status examination, a measure of intelligence, adaptive behavior and achievement when appropriate. The independent psychologist submits the IPE along with all scores electronically to the UMC. The UMC then submits the IPE and scores electronically to the MECA for final determination. The MECA electronically notifies the UMC of determination of medical eligibility. The UMC notifies the applicant. If the applicant is found not to meet medical eligibility, the UMC also provides the applicant with Medicaid Fair Hearing information which includes the right to request a second medical evaluation by a different member of the IPN.

For annual reevaluation, the UMC submits diagnoses and annual functional assessments within 30 days prior to the anchor "annual date" to the MECA. The MECA reviews the diagnoses and annual assessments and determines eligibility.

Every person must have a re-determination of medical eligibility completed at least annually. The anchor date of the person's annual re-determination is the first day of the month after the initial medical eligibility was established by the MECA.

The UMC employs Service Support Facilitators to conduct re-evaluations for program members. Qualifications include: A Bachelor's Degree in a human service field and at least 1 year experience with the disability population. Staff goes through a rigorous training protocol which includes trainer-led instruction, shadowing seasoned staff and periodic evaluation of their work.

- 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:

Working with the individual's Case Manager, UMC schedules the re-determination annual functional assessment. The UMC is responsible for ensuring that annual re-determination functional assessments are completed within 45 days prior to the person's annual anchor date.

The annual redetermination of medical eligibility is completed by the Utilization Management Contractor and includes, at a minimum, one standardized functional assessment consisting of a structured interview and standardized measures of adaptive behavior in six major life areas. The UMC utilized licensed Registered Nurses (RN) to complete the annual redetermination. The UMC submits the annual redetermination findings to the UMC for review and approval.

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To be a member of the IPN, the individual performing the assessment must be a West Virginia licensed psychologist, a West Virginia Medicaid provider who performs comprehensive psychological evaluations independent of IDDW providers and is a member of the Independent Psychologist Network (IPN) trained by the Medical Eligibility Contracted Agent (MECA).

Service Support Facilitators are employed by the UMC and must have a Bachelor's Degree, be a Qualified Mental Health Professional and have at least 2 years of experience with the IDDW population and possess knowledge of I/DD Waiver program policies and procedures as well as other programs/services available to program members.

- 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*):

Working with the Case Manager, the UMC schedules the annual assessment. The UMC is responsible for ensuring that annual redetermination functional assessments are completed within 45 days prior to the anchor "annual date".

- 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 reevaluations of medical eligibility determinations are maintained for a minimum of five years by the MECA and the UMC.

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:

Percent of applicants who received medical eligibility determinations within 90 days of receipt of the Independent Psychological Network response form by the UMC.

Numerator= Number of initial medical eligibility determinations completed within established timelines. Denominator = Number of applicants for whom medical eligibility determinations are due within the reporting month.

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 = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; padding: 2px;"> UMC MECA </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> UMC MECA </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>

- 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.

- 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:

Percent of secondary reviews of eligibility determinations that are consistent with the

initial eligibility determinations Numerator: Number of secondary review eligibility decisions that were consistent with the initial determinations **Denominator:** Number of secondary reviews completed

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 = <div>95%</div>
Other Specify: <div>UMC MECA</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

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 Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> UMC MECA </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>

- 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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The Operating Agency collects all information related to this assurance through the review of individuals receiving services 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. The Operating Agency must approve all Corrective Action Plans. Services provided that are not documented on the service plan are disallowed, and payment is recouped from the provider agency.

The Bureau for Medical Services (BMS) is responsible for building and maintaining the Intellectual and/or Developmental Disabilities Waiver's (IDDW's) Quality Improvement System (QIS). The IDDW provider and the Personal Options vendor are responsible for participating in all activities related to the QIS. The IDDW's QIS is used by BMS and the Utilization Management Contractor (UMC) as a continuous system that measures system performance, tracks remediation activities, and identifies opportunities for system improvement. Achieving and maintaining program quality is an ongoing process that includes collecting and examining information about program operations and outcomes for members receiving services, and then using the information to identify strengths and weaknesses in program performance. This information is used to form the basis of remediation and improvement strategies. The QIS is designed to collect the data necessary to provide evidence that the CMS Quality Assurances are being met and to ensure the active involvement of interested parties in the quality improvement process.

In addition to the QIS, BMS also engages the Quality Improvement Advisory (QIA) Council to analyze information from individual problems, identify systemic deficiencies, and implement remediation activities. The QIA Council is the focal point of stakeholder input for the IDDW Program and plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies.

The role of the QIA Council is to advise and assist BMS and UMC staff in program planning, development, and evaluation consistent with its stated purpose. In this role, the QIA Council uses IDDW Performance Indicators as a guide to:

- Recommend policy changes;
- Recommend program priorities and quality initiatives;

- Monitor and evaluate policy changes;
- Monitor and evaluate the implementation of Waiver priorities and quality initiatives;
- Serve as a liaison between the Waiver and interested parties; and
- Establish committees and work groups consistent with its purpose and guidelines.

The Council membership is composed of persons who formerly utilized IDDW services of the IDDW Program, members who currently are utilizing IDDW services (or their legal representatives), service providers, advocates, and other allies of people with intellectual and/or developmental disabilities.

ii. Remediation Data Aggregation

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

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: MECA UMC	Annually
	Continuously and Ongoing
	Other 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:

- informed of any feasible alternatives under the waiver; and
- 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 an applicant is informed that a funded slot is available, the UMC meets with the applicant and their legal representative (if applicable) prior to the date the funded slot will become available. The UMC provides the Freedom of Choice Form at this meeting to the applicant and their legal representative (if applicable) in order to choose between Home and Community Based Services and ICF/IID services. This form also allows the applicant to choose from case management agencies that serve the county where the applicant resides. This form also allows the applicant to choose a program options: Traditional Option or the Self-Direction Option (Personal Options). This same function is performed by the UMC during the annual functional assessment.

When the legal representative does not attend the annual functional assessment (and cannot sign the Freedom of Choice form), the Case Manager is responsible to follow-up with the LR to ensure completion no later than the annual individualized program plan meeting.

- 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.

The Freedom of Choice forms (consent, case management choice and service delivery model selection form) are maintained electronically for a minimum of five years by the UMC.

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 Census 2020, 97.5% percent of West Virginians speak only English. Due to this high percentage, the IDDW addresses any needs or requests for alternative materials 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		
Statutory Service	Facility-Based Day Habilitation		
Statutory Service	Home-Based Agency Person-Centered Support		
Statutory Service	In-Home Respite		
Statutory Service	Prevocational Services		
Statutory Service	Supported Employment		
Supports for Participant Direction	Participant-Directed Goods and Services		
Other Service	Behavior Support Professional		
Other Service	Crisis Intervention		
Other Service	Crisis Site Person-Centered Support		
Other Service	Dietary Therapy		
Other Service	Electronic Monitoring		
Other Service	Environmental Accessibility Adaptations		
Other Service	Family Person-Centered Support		
Other Service	Job Development		

Service Type	Service		
Other Service	Licensed Group Home Person-Centered Support		
Other Service	Non-Medical Transportation		
Other Service	Occupational Therapy		
Other Service	Out-of-Home Respite		
Other Service	Physical Therapy		
Other Service	Skilled Nursing by a Licensed Practical Nurse		
Other Service	Skilled Nursing by a Registered Nurse		
Other Service	Speech Therapy		
Other Service	Unlicensed Residential Person-Centered Support		

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:

01 Case Management

Sub-Category 1:

01010 case management

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):

Case Management services establish, along with the person who receives services, a life-long, person-centered, goal-oriented process for coordinating the supports (both natural and paid), range of services, instruction, supervision and

assistance needed by persons with developmental disabilities. It is designed to ensure accessibility, accountability, and continuity of support and services. This service also ensures that the maximum potential and productivity of a person who receives services is utilized in making meaningful choices with regard to their life and their inclusion in the community.

All case managers will be employed by agencies that practice independent conflict-free case management and do not provide any other services to the member without an approved exception by BMS.

The Case Manager must, at a minimum, perform the following activities listed below:

- Assist the person who receives services and/or legal representative with re-determination of financial eligibility as required at the DoHS office in the county where the person who receives services lives.
- Verify financial eligibility during monthly contact.
- Begin the discharge process and provide linkage to services appropriate to the level of need when a person who receives services is found to be ineligible for IDDW services during annual eligibility or financial re-determination.
- Provide oral and written information about the IDDW provider agency's rights and grievance procedures for persons served by the agency.
- Provide an electronic or hard copy of the policy manual upon request to the person/legal representative.
- Assist with procurement of all services that are appropriate and necessary for each person who receives services within and beyond the scope of the IDDW program including annual medical and other evaluations as applicable to the person who receives services.
- Act as an advocate for the person who receives services.
- Promote a valuable and meaningful social role for the person who receives services in the community while recognizing the person's unique cultural and personal value system.
- Interface with the UMC on behalf of the person who receives services in regard to the assessment process, authorization of services, and the budgeting process. Activities may include linkage, negotiation of services, submission of information, coordination of choice of appropriate assessment respondents on behalf of the person who receives services, education, and coordination of the most appropriate assessment setting that best meets the needs of the person who receives services.
- Communicate with other service providers on the IDT to allow for continuity of services and payment of services.
- Coordinate necessary evaluations to be utilized as a basis of need and recommendation for services in the development of the IPP.
- Notify IDT members 30 days in advance of meeting.
- Support the person who receives services as necessary to convene and conduct IDT meetings. The case manager, individual, and their legal representative must attend the IPP meeting in person. The LAR may participate by teleconference only in extenuating circumstances.
- Coordinate the development of IPPs.
- Assist the member in accessing the necessary resources detailed in the IPP, make referrals to qualified service providers and resources, and monitor that service providers implement the instructional, behavioral, and service objectives of the IPP.
- Disseminate copies of all IPPs to the IDT members and Self-Directed Service Delivery Model provider (if applicable) within 14 calendar days of the IDT meeting.
- Upload the IPP and signature page into the UMC web portal within 14 calendar days of the IDT meeting. IDDW services will not be reviewed for authorization until the required documentation is attached in the UMC's web portal.
- Upload into the UMC web portal any additional documentation requested by BMS or the UMC.
- Disseminate copies of the budget sheet from the IDDW UM web portal, once finalized.
- Monitor to ensure that the health and safety needs of the person who receives services are addressed.
- Comply with reporting requirements of the WV IMS for persons on their caseload.
- Personally, meet monthly with members living in a 24 hour setting and/or Specialized Family Care setting, and their paid or natural supports that are present with the member the time of the visit, at the member's residence to verify that services are being delivered in a safe environment, in accordance with the IPP and appropriately documented. The purpose of these visits is to determine progress toward obtaining services and resources, assess achievement of training objectives, and identification of unmet needs. The visit is documented on the case manager Home/Day Visit Form (WV-BMS-IDD-03).
- Meet quarterly in-person and electronically all other months with members living in a natural family setting, and their paid or natural supports that are present with the member the time of the visit, at the member's residence to verify that services are being delivered in a safe environment, in accordance with the IPP and appropriately documented. Case Managers may meet more frequently with the individual due to changes in circumstances and/or the individual or family's needs and preferences. If there is a change in the individual member's needs, CMs must increase the frequency of contacts necessary to address and/or monitor until the area of concern is satisfactorily resolved.
- The purpose of these visits is to determine progress toward obtaining services and resources, assess achievement of training objectives, and identification of unmet needs. The visit is documented on the case manager Home/Day Visit Form (WV-BMS-IDD-03).

- Personally meet at least quarterly with the member and their support staff at the member's facility-based day program or vocational skills development center (if applicable). The purpose of these visits is to determine progress toward obtaining services and resources, assess achievement of training objectives, and identification of unmet needs. The visit is documented on the case manager Home/Day Visit Form (WV-BMS-IDD-03).
 - Visits to Supported Employment sites should occur only as necessary, such as to remedy a problem identified at the site. CMs should avoid disrupting a person's ability to work in an integrated setting as much as possible.
 - Verify financial eligibility during monthly contacts
 - Responds to and is available to provide planning and coordination before, during, and after crises.
 - Notifies the UMC if a person who receives services is admitted to a crisis site or state institution within 72 hours of admission.
 - Process Freedom of Choice forms in the UMC web portal within 2 business days any time a person who receives services requests a change of Service Delivery Model.
 - Coordinate Transfer/Discharge meetings to ensure the linkage to a new service provider or Service Delivery Model and access to services when transferring services from 1 provider agency to another or to another type of Service Delivery Model. Coordination efforts must continue until the transfer of services is finalized.
 - Travel as necessary to complete Case Management activities related to the IPP.
 - Provide information and assistance regarding the Self-Directed Service Delivery Model during annual IPP meetings and upon request by the person who receives services or legal representative.
 - Inform the person who receives services of their rights at least annually.
 - Attend and participate in the annual functional assessment for eligibility conducted by UMC.
 - Present proposed restrictive measures to the IDDW provider agency's Human Rights Committee (HRC) if no other professional is presenting the same information.
 - Monitor any restrictive measures approved by the HRC to ensure the measures are implemented properly, are reviewed at least every 6 months by the HRC, and reviewed by the IDT at every planned juncture.
- NOTE: Restrictive measures must be addressed by the IDT at Critical Junctures if relevant and applicable.
- Attend and contribute to Futures Planning sessions, including PATHs and MAPs.

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

1 Unit Per Month - Reimbursed at a monthly rate.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	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*):

Agency must have either a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure and Certification (OHFLAC) or a certification as a Case Management Agency by the Bureau for Medical Services.

Certificate (*specify*):

Agency must be an approved IDWW Provider and an enrolled WV Medicaid Provider.

Other Standard (*specify*):

Agency staff must have:

- 1) Current CPR and First Aid cards
- 2) Have acceptable state and federal fingerprint-based checks
- 3) Acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check
- 4) Be over the age of 18
- 5) Be able to perform the tasks; and,
- 6) Meet training requirements as mandated by Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

All case managers must meet one of the following requirements listed below:

- 1) Four-year degree in a human service field and one or more years' experience in the IDD field.
- 2) Four-year degree in a human service field and less than one year of experience in the IDD field. (Restrictions)
- 3) Four-year degree in a non-human service field and one year experience in the IDD field. (Restrictions)
- 4) No degree or two-year degree and is a licensed social worker (LSW) grandfathered in by the West Virginia Board of Social Worker Examiners due to experience in the IDD field.
- 5) RN with a two-year RN degree employed prior to December 1, 2015.
- 6) Two year degree and three years of experience in the IDD field. (Restrictions)
- 7) Five years of experience in the IDD field in lieu of a degree. (Restrictions)

All case managers, except licensed social workers, counselors, and/or registered nurses, must also complete and obtain certification in the on-line case management training developed by BMS.

*Restrictions - must be under the supervision of the case manager supervisor. Clinical supervision involves review of clinical activities, review of case notes, and review of treatment plans for six months. This must be verified by supervisory documentation once per month.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Agency is verified by the Office of Health Facility Licensure and Certification or certified by the Bureau for Medical Service or certified by the Bureau for Medical Services.

Agency staff is verified by the provider and the UMC.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially by the Office of Health Facility Licensure and Certification.

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

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:

Day Habilitation

Alternate Service Title (if any):

Facility-Based Day Habilitation

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04020 day habilitation

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):

Facility-Based Day Habilitation activities in the plan must be developed exclusively to address the habilitation and support needs of the person who receives services. Activities must consist of programs of instruction/training, supervision and assistance, specialist services, and evaluations provided by or under the direct supervision of a qualified staff (training programs must be developed by a BSP).

Facility-Based Day Habilitation activities must be based at the licensed site, but the person who receives services may access community services and activities from the licensed site.

Meals provided as part of this service shall not constitute a full nutritional regimen of 3 meals per day.

Facility-Based Day Habilitation Program services include, but are not limited to:

- Development of self-care skills;
- Use of community services and businesses;
- Emergency skills training;
- Mobility skills training;
- Nutritional skills training;
- Social skills training;
- Communication and speech instruction (prescribed by a Speech Language Pathologist);
- Therapy objectives (prescribed by Physical Therapist, Occupational Therapist, etc.);
- Interpersonal skills instruction;
- Functional academic training such as recognizing emergency and other public signs, independent money management skills, etc.;

- Citizenship, rights and responsibilities, self-advocacy, and voting training;
- Self-administration of medication training;
- Independent living skills training;
- Training the individual to follow directions and carry out assigned duties;

Facility-Based Day Habilitation Direct Support Professionals may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the UMC if requested by the person who receives services or their legal representative (if applicable).

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

The maximum annual units of Facility-Based Day Habilitation cannot exceed 6,240 units/1,560 hours (average 6 hours/weekday), in combination with all day habilitation services, per the person's IPP year.

The amount of service is limited by the individualized budget of the person who receives services.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Licensed Behavioral Health Center IDWW Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Facility-Based Day Habilitation

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center IDWW Provider

Provider Qualifications

License (*specify*):

Agency must have a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure and Certification (OHFLAC). The site must be listed on the agency's Behavioral Health License from OHFLAC.

Certificate (*specify*):

Agency must be an approved IDWW Provider and an enrolled WV Medicaid Provider.

Other Standard (*specify*):

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the Office of Health Facility Licensure and Certification.

Agency staff is verified by the Licensed Behavioral Health Provider and the UMC.
The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a “rap back” system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

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:

Habilitation

Alternate Service Title (if any):

Home-Based Agency Person-Centered Support

HCBS Taxonomy:**Category 1:**

08 Home-Based Services

Sub-Category 1:

08010 home-based habilitation

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):

Service Description and Purpose: Home-Based Agency Person-Centered Support services consist of individually tailored training and/or support activities enabling the member to live and inclusively participate in the most integrated community setting appropriate to their needs.

The activities and environments are designed to assist with obtaining goal outcomes, increase the acquisition of skills and appropriate behavior necessary for the member to have greater independence and personal choice, and to allow for maximum inclusion into their community.

Home-Based Agency PCS services may be used to assist with the acquisition, retention, and/or improvement of the following areas of functionality:

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for Independent Living.

Staff persons administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent General Education Development (GED).

Home-Based Agency PCS services must be assessment based and outlined on the IPP. Activities must allow the person who receives services to reside and participate in the most integrated setting appropriate to their needs.

Home-based Agency PCS services may include training specific to the person who receives services. Attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the UMC is permitted if requested by the person who receives services or their legal representative.

Home-based Agency PCS Direct Support Professionals may compile data collected in daily documentation during their shift for later review by the BSP, as long as safety/health and oversight of the person who receives services are not compromised.

Home-based Agency PCS Direct Support Professionals may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the UMC if requested by the person who receives services or their legal representative. Home-based Agency PCS Direct Support Professionals will be subject to usage of the EVV utilization and all corresponding requirements.

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

The maximum annual units of Home-Based Agency PCS services for a child under the age of 18 living in a natural family/Specialized Family Care home settings cannot exceed 7,320 15-minute units per IPP year. This is in combination with the following direct support services: All other PCS and Crisis Intervention services. Persons under the age of 18 may not access Facility-Based Day Habilitation, Job Development, Pre-Vocational Training or Supported Employment services, thus a combination limit with these services does not apply.

The maximum annual units of Home-Based PCS services for an adult over age 18 living in a natural family/Specialized Family Care home setting cannot exceed 11,680 15-minute units per IPP year. This is in combination with the following direct support services: All other types of PCS, LPN, Crisis Intervention and Electronic Monitoring. All direct care services cannot exceed an average of 12 hours/day on days when Facility-Based Day Habilitation, Job Development, Pre-Vocational, and/or Supported Employment services are provided.

The amount of service is limited by the individualized budget of the person who receives services.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Licensed Behavioral Health Center IDDW Provider
Individual	Personal Options

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Home-Based Agency Person-Centered Support****Provider Category:**

Agency

Provider Type:

Licensed Behavioral Health Center IDDW Provider

Provider Qualifications**License (specify):**

Agency must have a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure and Certification (OHFLAC).

Certificate (specify):

Agency must be an approved IDDW Provider and an enrolled WV Medicaid Provider.

Other Standard (specify):

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Agency is verified by the Office of Health Facility Licensure and Certification.

Agency staff is verified by the Licensed Behavioral Health Provider and the UMC.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a “rap back” system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Home-Based Agency Person-Centered Support****Provider Category:**

Individual

Provider Type:

Personal Options

Provider Qualifications

License (specify):

Not applicable as the Personal Options self-directing individual/Employer of Record is not required to have a Behavioral Health License or be an enrolled IDWW Provider.

Certificate (specify):

Not applicable.

Other Standard (specify):

The Personal Options employee must have current CPR and First Aid cards, acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, have the ability to perform the tasks and be currently trained on all training requirements listed in the Personal Options section of the IDWW Policy Manual.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The person/Employer Record utilizing the Personal Options Model is responsible for ensuring all of their employees meet all qualifications.

The Personal Options vendor is responsible for verifying the employee's credentials.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

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:

Respite

Alternate Service Title (if any):

In-Home Respite

HCBS Taxonomy:**Category 1:**

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

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):

In-Home Respite services provided in the person's natural family home or Specialized Family Care Home where the person receiving services resides by awake and alert Direct Support Professionals are specifically designed to provide temporary substitute care normally provided by a family member or a Specialized Family Care Provider. The services are to be used for relief of the primary care-giver(s) to help prevent the breakdown of the primary care-giver(s) due to the physical burden and emotional stress of providing continuous support and care to the dependent person who receives services. In-Home Respite services consist of temporary care services for a person who cannot provide for all of their own needs. Persons providing Respite services may participate in person-centered planning.

In-Home Respite services may be used to:

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

Direct Support Professionals providing In-Home Respite services may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by UMC if requested by the person who receives services or their legal representative. In-home Respite Direct Support Professionals will be subject to usage of the EVV utilization and all corresponding requirements.

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

The maximum annual units of In-Home Respite service may not exceed 3,650 units/912 hours per IPP year for persons who live in a natural family home or Specialized Family Care Home. This is in combination with all other types of Respite Services.

Biological and adoptive parents and step-parents may never provide this service to their child (even if the child is now an adult).

The amount of service is limited by the individualized budget of the person who receives services. If a person is self-directing this service, then the amount of respite services that can be self-directed is limited by the participant-directed budget of the person receiving services.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Personal Options
Agency	Licensed Behavioral Health Center IDDW Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: In-Home Respite

Provider Category:

Individual

Provider Type:

Personal Options

Provider Qualifications

License (specify):

Not applicable as the Personal Options self-directing individual/Employer of Record is not required to have a Behavioral Health License or be an enrolled IDDW Provider.

Certificate (specify):

Not applicable.

Other Standard (specify):

The Personal Options employee must have current CPR and First Aid cards, acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, have the ability to perform the tasks and be currently trained on all training requirements listed in the Personal Options section of the IDDW Policy Manual.

Verification of Provider Qualifications

Entity Responsible for Verification:

The person/Employer Record utilizing the Personal Options Model is responsible for ensuring all of their employees meet all qualifications.

The Personal Options vendor is responsible for verifying the employee's credentials.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: In-Home Respite

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center IDDW Provider

Provider Qualifications

License (specify):

Agency must have a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure and Certification (OHFLAC).

Certificate (specify):

Agency must be an approved IDWW Provider and an enrolled WV Medicaid Provider.

Other Standard (specify):

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Agency is verified by the Office of Health Facility Licensure and Certification.
 Agency staff is verified by the Licensed Behavioral Health Provider and the UMC.
 The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially by the Office of Health Facility Licensure and Certification.

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

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:

Prevocational Services

Alternate Service Title (if any):**HCBS Taxonomy:****Category 1:**

04 Day Services

Sub-Category 1:

04010 prevocational services

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):

Prevocational services are designed to create a path to integrated community-based employment for which a person is compensated at or above the minimum wage, but no less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. These services should enable each person who receives services to attain the highest level of work in a setting matched to the person's strengths, interests, priorities, and abilities. Meals provided as part of this service shall not constitute a full nutritional regimen of 3 meals per day.

Pre-vocational Services include, but are not limited to, such concepts as:

- Attendance;
- Task completion;
- Problem solving;
- Interpersonal relations;
- Safety;
- Appropriate attitudes and work habits, such as socially appropriate behaviors on the worksite;
- Adjusting to production and performance standards of the workplace;
- Following directions;
- Compliance in workplace rules or procedures;
- Appropriate use of work-related facilities, such as restrooms, cafeterias/lunchrooms, and break areas; and
-

Persons receiving pre-vocational services must have employment-related goals on the IPP and general habilitation activities must be designed to support such employment goals.

Pre-vocational Direct Support Professionals may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the UMC if requested by the person who receives services or their legal representative.

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

The maximum annual units of Pre-Vocational Services cannot exceed 6,240 units/1,560 hours (average 6 hours/weekday), in combination with other day habilitation services, per the person's IPP year.

Pre-Vocational services may not be accessed by anyone under the age of 18 or who is enrolled in a public school setting.

The amount of service is limited by the individualized budget of the person who receives services.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Licensed Behavioral Health Center IDDW Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center IDDW Provider

Provider Qualifications

License (specify):

Agency must have a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure and Certification (OHFLAC). The site must be listed on the agency's Behavioral Health License from OHFLAC.

Certificate (specify):

Agency must be an approved IDDW Provider and an enrolled WV Medicaid Provider.

Other Standard (specify):

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the Office of Health Facility Licensure and Certification.

Agency staff is verified by the Licensed Behavioral Health Provider and the UMC.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

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:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

03 Supported Employment

Sub-Category 1:

03021 ongoing supported employment, individual

Category 2:

03 Supported Employment

Sub-Category 2:

03022 ongoing supported employment, group

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):

Supported Employment Services provided by awake and alert Direct Support Professionals are services that enable people to engage in paid, competitive employment in integrated community settings. The services are for people who have barriers to obtaining employment due to the nature and complexity of their disabilities. The services are designed to assist people for whom competitive employment at or above the minimum wage is unlikely without such support and services and need ongoing support based upon the level of need of the person who receives services.

Supported Employment services include, but are not limited to:

- Vocational counseling (Example: Discussion of on-the-job work activities);
- Job development and placement for a specific person who receives IDD services with the person present;
- On-the-job training in work and work-related skills;
- Accommodation of work performance tasks;
- Supervision and monitoring by a job coach;
- Intervention to replace inappropriate work behaviors with adaptive work skills and behaviors;
- Retraining as jobs change or job tasks change;
- Training in skills essential to obtain and retain employment, such as the effective use of community resources; and
- Transportation to and from job sites when other forms of transportation are unavailable or inaccessible.

Natural work setting supports are to be considered prior to the utilization of Supported Employment.

Supported Employment Services must be supervised by a Behavior Support Professional. In addition to the standard training requirements, Direct Support Professionals providing Supported Employment services must have documented training or experience in implementation of Supported Employment plans of instruction.

Supported Employment Direct Support Professionals may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC if requested by the person who receives services or their legal representative (if applicable).

Documentation is maintained in the file of each person who receives Supported Employment IDD services that a referral was made to a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) before this service was provided.

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

The maximum annual units of Supported Employment Services cannot exceed 8,320 units/2,080 hours (average 8 hours/5 days per week) the person's IPP year. Supported Employment services may not be accessed by anyone under the age of 18

or who is enrolled in a public school setting.

The amount of service is limited by the individualized budget of the person who receives services.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Licensed Behavioral Health Center IDDW Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center IDDW Provider

Provider Qualifications

License (*specify*):

Agency must have a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure and Certification (OHFLAC).

Certificate (*specify*):

Agency must be an approved IDDW Provider and an enrolled WV Medicaid Provider.

Other Standard (*specify*):

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the Office of Health Facility Licensure and Certification.

Agency staff is verified by the Licensed Behavioral Health Provider and the UMC.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

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:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Participant-Directed Goods and Services

HCBS Taxonomy:
Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

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):

Participant-Directed Goods and Services (PDGS) are services, equipment, or supplies not otherwise provided through this Waiver program or through the Medicaid State Plan that address an identified need in the IPP and meet all of the following requirements:

- An item or service that would decrease the need for other Medicaid services and/or promote full membership in the community and/or increase safety in the home environment and local public community and/or assist the individual is self-directing his or her services.
- The person who receives services does not have the funds to purchase the item or service or the item or service is not available through another source.
- This service cannot be accessed as a means of reimbursement for items or services that have already been obtained and not been pre-approved by the UMC.
- Participant-directed Goods and Services are deducted from the participant-directed budget.
- The need for PDGS must be supported by an assessed need documented in the IPP.
- PDGS must be pre-approved by the UMC and purchase must be documented by receipts or other documentation of the

goods or services from the established business or otherwise qualified entity or individual.

- The need must be documented on the Annual IPP unless it is a new need which must be documented on a Critical Juncture IPP.

o NOTE: All services must be based on assessed need and within the individualized budget of the person who receives services.

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

- The amount of service is limited by the individualized participant-directed budget and spending plan.
- 1000 units (\$1,000) per IPP year in combination with Traditional and Self-Directed Environmental Accessibility Adaptations- Vehicle and Home.
- The Personal Options provider must not pay PDGS funds to the person who receives services, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the PDGS service.
- To access Participant-Directed Goods and Services the person who receives services must also access at least 1 other type of participant-directed service during the budget year—i.e. PCS, Respite and/or Transportation.
- The following represents non-permissible Goods and Services:
 - o Goods, services or supports covered or exhausted by the State Plan, Medicare, other third- parties, including education, home-based schooling and vocational services (must have a denial letter or be on the exclusionary lists from other funding sources);
 - o Goods, services and supports available through another source;
 - o Goods, services or supports provided to or benefiting persons other than the person who receives services;
 - o Room and board;
 - o Personal items and services not related to the qualifying disability;
 - o Gifts for workers/family/friends, payments to someone to serve as a representative,
 - o Clothing, food(including nutritional supplements) and beverages;
 - o Appliances that are not adapted/modified;
 - o Air purifiers, humidifiers or air conditioners unless individual has a documented respiratory/allergy condition or diagnosis;
 - o Electronic entertainment equipment;
 - o Utility payments;
 - o Generators unless used for medical equipment only (cannot be for the entire house);
 - o Swimming pools, hot tubs and spas or any accessories, repairs or supplies for these items;
 - o Railings for decks and porches;
 - o Outdoor recreational equipment unless specifically adapted for the individual's needs;
 - o Costs associated with travel;
 - o Household furnishings such as comforters, linens, drapes and furniture;
 - o Furniture unless it is a lift chair for someone with mobility issues;
 - o Vehicle expenses including running boards, routine maintenance and repairs, insurance and gas money;
 - o Medications, vitamins and herbal supplements;
 - o Illegal drugs or alcohol;
 - o Experimental or investigational treatments;
 - o Computers, monitors;
 - o Communication devices/tablets for children under the age of 21;
 - o Communication devices/tablets for adults over the age of 21 unless specifically recommended by a licensed speech therapist;
 - o Computer software;
 - o Fax machines;
 - o Copiers;
 - o Scanners;
 - o Printers or ink cartridges;
 - o Landline telephones or cell phones;
 - o Car seats and strollers that do not require modifications;
 - o Monthly internet service;
 - o Yard work;
 - o Household cleaning supplies;
 - o Home maintenance including paint and replacement of flooring, appliances, doors, furnaces, hot water tank, roof and windows (unless the item needs modified such as a window that is large enough for an adult to use to exit in case of a fire);
 - o Fences, gates, half-doors;
 - o Driveway or walk way repairs or supplies unless specifically to exit or enter home to and from vehicle ;
 - o Covered awnings;
 - o Pet/Pet care including service animals, veterinary bills, food and training;

- o Respite and/or Direct Care Services (Person-Centered Support, LPN, Supported Employment, Facility-based Day Habilitation, etc.) services;
- o Spa services;
- o Public Education or items needed for public educational purposes;
- o Personal hygiene items;
- o Summer Camps;
- o Day care; and
- o Discretionary cash.
- o PDGS is not intended to replace the responsibility of the person who receives services, their family, or their landlord for routine maintenance and upkeep of the home. These include but are not limited to cleaning, painting, repair/replacement of roof, windows or flooring, structural repairs, air conditioning and heating, plumbing and electrical maintenance, fences, security systems, adaptations that add to the square footage of the home except when necessary to complete an approved adaptation, (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

The amount of service is limited by the individualized budget of the program member. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Personal Options

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction

Service Name: Participant-Directed Goods and Services

Provider Category:

Individual

Provider Type:

Personal Options

Provider Qualifications

License (*specify*):

The Personal Options Vendor will only pay for work performed by a vendor that has a Business License and/or relevant skills for work to be performed.

Certificate (*specify*):

Not applicable.

Other Standard (*specify*):

Verification of Provider Qualifications**Entity Responsible for Verification:**

Individuals or legal representative (if applicable) who direct their services are responsible for ensuring that providers of PDGS meet qualification standards with assistance from the F/EA or their Case Manager.
 The Personal Options vendor is responsible for validating vendor qualifications prior to processing invoices.
 The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

The Personal Options vendor verifies prior to each purchase. The UMC verifies the item is not on the exclusion list.

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:

Behavior Support Professional

HCBS Taxonomy:**Category 1:**

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10040 behavior support

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):

Behavior Support Professional (BSP) services are provided to persons with assessed need for adaptive skills training. For persons who require adaptive skills training, the BSP performs the following activities:

- Develops training plans that include person-specific aspects and methods of intervention or instruction;
- Provides training to staff persons who will implement the training plans on aspects and methods of intervention (i.e., family, Person-Centered Support, Facility-Based Day Habilitation, Supported Employment, and Crisis Direct Support Professionals);
- Provides training for Direct Support Professionals who provide Respite services if applicable for respite-relevant training objectives or health/safety training objectives only;
- Evaluates/monitors the effectiveness of the training plans through analysis of programming results that occurs at least monthly;
- Follows-up once training plans have been implemented to observe progress/regression; and
- Revises training plans as needed.

In addition, this service may also be utilized to address assessed and identified maladaptive behaviors that require informal or formal intervention. For persons who require Positive Behavior Support in order to address maladaptive behaviors, the BSP performs the following activities:

- Completes a Functional Assessment to identify targeted maladaptive behaviors;
- Creates Positive Behavior Support Plans to meet Association for Positive Behavior Support standards of practice;
- Provides training to staff persons who will implement the Plan (i.e. family, Person-Centered Support, Facility-Based Day Habilitation, Pre-vocational, Job Development Supported Employment, Crisis, and Respite Direct Support Professionals);
- Evaluates/monitors the effectiveness of the Positive Behavior Support plan through analysis of programming results that occurs at least monthly;
- Follows-up once Plan has been implemented to observe progress/regression; and
- Revises the Plan as needed.

The BSP may also perform the following functions:

- Develop the task analysis portion of the IHP/ISP and person-specific strategy or methodology for development of habilitation plans; Develop Interactive Guidelines or Behavior Protocols for people who do not require a formal Positive Behavior Support Plan; Collaborate with BSP(s) from other agency(s) to ensure that Positive Behavior Support strategies are consistently applied across all environments;
- Facilitate person-centered planning as a component of the Positive Behavior Support plan;
- Present proposed restrictive measures to the IDDW provider's Human Rights Committee if no other professional is presenting the same information regarding the person;
- Attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO if requested by the person who receives services or their legal representative;
- Evaluate environment(s) for implementation of the ISP which creates the optimal environment for habilitation plans, when clinically indicated and beneficial to the person who receives services;
- Assist persons who receive services in selecting the most suitable environment for their habilitation needs;
- Provide on-site training to the support staff in behavior/crisis situations;
- Consult via telephone during behavioral crisis situations only;
- Developing/update the behavioral crisis section of the crisis plan;
- Verify data compiled by Direct Support Professionals for accuracy; and
- Attend and contribute to Futures Planning sessions, including Planning Alternative Tomorrows with Hope (PATHs) and Making Action Plans (MAPs).

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

- The amount of service is limited by the individualized budget of the person who receives services.
- The maximum annual units of BSP services cannot exceed 768 units/192 hours per IPP year.
- Staff persons providing BSP services may not live in the home of the person who receives services.
- The amount of service must be identified on the IPP.
- If the assigned BSP is unavailable due to an emergency or illness another BSP may provide services in their absence.
- Direct Support Professional services provided by the BSP must be billed utilizing the appropriate Direct Support Professional service code.
- BSP services may not be billed for traveling to complete BSP activities.
- BSP services cannot be billed for completing administrative activities to include these listed below.
 - o Human Resources activities such as staff supervision, monitoring, and scheduling.
 - o Routine review of a file for quality assurance purposes.
 - o Staff meetings for groups or individuals.
 - o Monitoring of group home (fire drills, hot water heater temperature checks, etc.).

- o Filing, collating, writing notes to staff.
- o Phone calls to staff.
- o Observing staff while training individuals without a clinical reason.
- o Administering assessments not warranted or requested by the person who receives services or their legal representative.
- o Making plans for a parent for a weekend visit.
- o Working in the home while providing Direct Support Professional services.
- o Sitting in the waiting room for a doctor or medical appointment.
- o Conducting home visits without justification — only Case Managers are required to make monthly home visits.

The amount of service is limited by the individualized budget of the person who receives services.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Licensed Behavioral Health Center IDDW Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavior Support Professional

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center IDDW Provider

Provider Qualifications

License (*specify*):

Agency must have a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure and Certification (OHFLAC).

Certificate (*specify*):

Agency must be an approved IDDW Provider and an enrolled WV Medicaid Provider.

Other Standard (*specify*):

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

Additionally, the BSP I must meet the following standard:

- Four year degree in a human service field or a Board of Regents degree, completion of the WVAPBS facilitated 3 hour Overview of Positive Behavior Support or the WVUCED Positive Behavior Support Direct Care Overview, completion of an approved WVAPBS curriculum and one year of professional experience in the I/DD field.

Exception: Those meeting all the above requirements except the one year experience requirement will be considered qualified ONLY IF:

Operating under the clinical supervision of a Behavior Support Professional. Clinical supervision involves review of clinical activities, review of case notes and review of habilitation programming for 6 months. This must be verified by supervisory documentation once per month.

Note: New hires of individual agencies must complete an approved WVAPBS curriculum within the first 6 months of employment and also be under ongoing clinical supervision of Behavior Support Professional.

A BSP II must meet one of the following standards:

- Be a Board Certified Behavior Analyst (BCBA) - Master's degree or Board Certified Behavior Analyst Doctoral level (BCBA-D)- Doctoral degree and completion of the WVAPBS facilitated Overview of Positive Behavior Support or the WVUCED Positive Behavior Support Direct Care Overview and 3 years professional experience; or
- Have a Master of Arts (MA) or Master of Science (MS) degree, completion of an approved WVAPBS curriculum and the facilitated WVAPBS Overview of Positive Behavior Support or the WVUCED Positive Behavior Support Direct Care Overview, 3 years professional experience and have a PBS Endorsement by a recognized APBS Network or PBS Board of Review; or
- Have a Bachelor of Arts (BA), Bachelor of Science (BS) degree, Board of Regents degree or BCaBA credential and completion of the WVAPBS facilitated Overview of PBS or WVUCED Positive Behavior Support Direct Care Overview, completion of an approved WVAPBS curriculum, 3 years post curriculum experience and have a PBS Endorsement by a recognized APBS Network or PBS Board of Review.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the Office of Health Facility Licensure and Certification.

Agency staff is verified by the Licensed Behavioral Health Provider and the UMC.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

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:

Crisis Intervention

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10030 crisis intervention

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):

The goal of this service is to respond to a crisis immediately, and to assess and stabilize the situation as quickly as possible. Crisis Services provided by awake and alert Direct Support Professionals are to be used if there is an extraordinary circumstance requiring a short-term, acute service that utilizes Positive Behavior Support planning, interventions, strategies, and direct support. Except in emergent situations, this service requires prior authorization. This service has a 2:1 ratio (staff person to person who receives services). The additional staff person is available for assurance of health and safety in the respective setting. Crisis Services include formal training, informal training, and Positive Behavior Support.

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

The maximum annual units of Crisis Intervention Services cannot exceed 17,280 15-minute units (4320 hours) per individual's IPP year.

The amount of service is limited by the individualized budget of the person who receives services.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Licensed Behavioral Health Center IDDW Provider

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service**Service Name: Crisis Intervention****Provider Category:**

Agency

Provider Type:

Licensed Behavioral Health Center IDW Provider

Provider Qualifications**License (specify):**

Agency must have a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure and Certification (OHFLAC).

Certificate (specify):

Agency must be an approved IDW Provider and an enrolled WV Medicaid Provider.

Other Standard (specify):

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Agency is verified by the Office of Health Facility Licensure and Certification.

Agency staff is verified by the Licensed Behavioral Health Provider and the UMC.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

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:

Crisis Site Person-Centered Support

HCBS Taxonomy:**Category 1:**

02 Round-the-Clock Services

Sub-Category 1:

02011 group living, residential habilitation

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):

Crisis Site Person-Centered Support (PCS) is provided in a site licensed by the Office of Health Facility Licensure and Certification by awake and alert Direct Support Professionals. Sites must be either adult or child (no combination), and must serve only persons approved for IDDW. This service is specifically designed to provide temporary substitute care for a person who is in need of an alternative residential setting due to behavioral needs or lack of supports. Training programs on the IPP may be implemented by Direct Support Professionals while the person who receives services is at the Crisis Site.

The services are to be utilized only in OHFLAC licensed crisis sites and used on a short-term basis not to exceed a maximum stay of 30 days per admission without prior authorization from the UMC.

Crisis Site PCS services usually occur after a critical juncture in treatment and must be approved by the IDT. If Crisis Site PCS services are utilized due to an emergent need there must be a plan to transition the member back into the community developed at the time of admission by the Case Manager.

Crisis Sites are listed on the IDDW Provider Reference Guide. Case Managers must contact individual sites to determine availability for admission.

The referral packet to the Crisis Site must include the IPP that identifies the services to be provided and assessments as appropriate. The Case Manager must submit form I/DD-12 to the UMC within 72 hours of the initial admission and again if the stay will exceed the dates of the initial admission.

Direct Support Professionals may compile data collected in daily documentation during their shift for later review by the BSP, as long as safety/health and oversight of the person who receives services are not compromised.

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

Crisis Site PCS services may only be authorized for 30 days (2,880 units, a unit is 15 minutes) at a time. Additional units may be authorized after approval from UMC, however, a crisis site is not a permanent living situation for any person in the IDDW and it is the responsibility of the Case Management Agency to have a discharge plan in place before placement may occur at a Crisis Site. The discharge plan must include a placement option for the person within 30 days of admission to the Crisis Site. All types of PCS, LPN, Pre-Vocational, Facility-Based Day Habilitation, Job Development, Supported Employment, Respite and Electronic Monitoring may not be provided while the member is in a Crisis site.

All LPN services provided must be within the scope of practice for licensed nurses. If a LPN is providing a service that is not within the scope of practice for licensed nurses (such as taking vital signs, providing personal hygiene, comfort, nutrition, ambulation and environmental safety and protection) that service must be billed as a Crisis PCS service and not an LPN service. All requests for more than 12 hours of 1:1 service must be approved by BMS and have extenuating circumstances.

Crisis site PCS for adults may only be provided at sites licensed by OHFLAC and approved to provide only IDDW services.

Crisis site PCS for children may only be provided at sites licensed by the Bureau for Children and Families and approved to

provide only IDWW services.

The amount of service is limited by the individualized budget of the program member.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Licensed Behavioral Health Center IDWW Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Crisis Site Person-Centered Support

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center IDWW Provider

Provider Qualifications

License (*specify*):

Agency must have a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure and Certification (OHFLAC). The residential site must be listed on the Agency's OHFLAC license.

Certificate (*specify*):

Agency must be an approved IDWW Provider and an enrolled WV Medicaid Provider.

Other Standard (*specify*):

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the Office of Health Facility Licensure and Certification.

Agency staff is verified by the Licensed Behavioral Health Provider and the UMC.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

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:

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:

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):

Dietary Services are provided directly to the person who receives services by a staff person who is a WV-licensed and registered dietitian and may include:

- Nutritional assessment and therapy for diseases that have a nutrition component;
- Preventive health and diet assessment;
- Weight management therapy;
- Design of menus;
- Screening;
- Assessments;
- Planning and reporting;
- Direct therapeutic intervention; and
- Consultation or demonstration of techniques with other service providers and family members.

The scope and nature of these services differ from dietary therapy services furnished under the State Plan. Dietary Therapy services provided under the Waiver are for chronic conditions and maintenance, while the dietary therapy services furnished under the State Plan are short term and restorative in nature. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Any similar services provided in a school setting may also be eligible for reimbursement under the waiver when Medicaid

program requirements are met.

The Dietary Therapist may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by the UM if requested by the person who receives services or their legal representative (if applicable).

The maximum annual units of Dietary Therapy services may not exceed 416 units/104 hours per IPP year. This is in combination with the following services: Traditional and Self-Directed Physical Therapy and Occupational Therapy. A unit is 15 minutes. This service occurs in the office of the Dietary Therapist or in the member's home. The amount of service is limited by the individualized budget of the program member. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Person-Centered or Home-Based Person-Centered Support and In-Home or Out-of-Home Respite and Non- Medical Transportation.

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

The maximum annual units of Dietary Therapy services may not exceed 416 units/104 hours per IPP year. This is in combination with the following services: Traditional and Self-Directed Physical Therapy and Occupational Therapy. A unit is 15 minutes.

This service occurs in the office of the Dietary Therapist or in the member's home.

The amount of service is limited by the individualized budget of the program member. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Person-Centered or Home-Based Person-Centered Support and In-Home or Out-of-Home Respite and Non- Medical Transportation.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Licensed Behavioral Health Center IDW Provider
Individual	Personal Options

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Dietary Therapy

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center IDW Provider

Provider Qualifications

License (specify):

Agency must have a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure and Certification (OHFLAC).

Agency staff or Contracted staff must be a WV Licensed Dietitian.

Certificate (specify):

Agency must be an approved IDWW Provider and an enrolled WV Medicaid Provider.

Other Standard (specify):

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the Office of Health Facility Licensure and Certification.
Agency staff is verified by the Licensed Behavioral Health Provider and the UMC.
The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Dietary Therapy

Provider Category:

Individual

Provider Type:

Personal Options

Provider Qualifications

License (specify):

Provider must be a WV licensed Dietician.

Certificate (specify):

Provider must be an enrolled WV Medicaid Provider.

Other Standard (specify):

Provider must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by the WV Board of Licensed Dieticians.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider credentials are verified by the F/EA prior to processing invoices.
The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

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:

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:

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):

Electronic monitoring services include the provision of oversight and monitoring within the residential setting through off-site electronic surveillance. Also included is the provision of designated IDDW agency standby intervention staff prepared for prompt engagement with the member(s) and/or immediate deployment to the residential setting. The use of this service must be designed and implemented to ensure the need for independence and privacy of the member in their own home/apartment. All of the following requirements must be met.

- This service is only to be utilized when there are no paid staff in the member's home.
- This service may be installed in any area of the residential settings in which residing adult members, their legal representatives (if applicable), and their IDT teams request such surveillance and monitoring in place of paid staff. The IDT and the Human Rights Committee (HRC) will evaluate the appropriateness of placement of electronic monitoring devices in areas such as bathrooms and bedrooms on an individual basis.
- All electronic monitoring systems or companies used or contracted by the IDDW provider meet the standards set by the BMS and must be pre-approved by the BMS before providing any services and approved annually thereafter.
- The IDDW provider must have written policies and procedures approved by BMS that define emergency situations and detail how remote and standby staff respond to each. Examples are fire, prolonged power outage, medical crisis, stranger in

the home, violence between members, any situation that appears to threaten the health and welfare of the member.

- The electronic monitoring system or company must receive notification of smoke/heat activation at each member's home.
- The electronic monitoring system or company must have two-way (at minimum, full duplex) audio communication capabilities. This allows monitoring base staff to effectively interact with and address the needs of the members in each home, including emergency situations when the participant may not be able to use the telephone.
- The electronic monitoring system or company must allow the monitoring base staff to have visual (video) oversight of areas in the member's home deemed necessary by the IDT.
- At the time of monitoring, the monitoring base staff may not have duties other than the oversight and support of members at the remote living site.
- The monitoring base staff will assess any urgent situation at a member's living site and call 911 emergency personnel first if that is deemed necessary, then call the standby staff.
- The monitoring base staff will stay engaged with the participant(s) at the living site during an urgent situation until the standby staff or emergency personnel arrive.
- Any member wishing to access this service must first be assessed using the identified Risk Assessment and approved by the IDDW provider's HRC to ensure that the member's health and welfare would not be harmed by accessing this service. The approval of the HRC must be documented and attached to the member's IPP.
- After HRC approval of the HRC is obtained, the member and their legal representative (if applicable) and the IDT must give informed consent and document the approval of such support in place of on-site staff or natural supports on the member's IPP. The member is permitted to turn the remote monitoring system on and off and is instructed by the provider regarding this functionality. The member, their legal representative, and all IDT members are made aware of both the benefits and the risks of the operating parameters and limitations. Benefits may include increased independence and privacy, and risks may include not having on-site staff in case of an emergency. All members who receive the electronic monitoring service are informed of their ability to turn the monitoring system on and off and instructed on how to use this function.
- The Case Manager conducts a home visit that includes a programmatic review of the system as well as a drill at 7 days of implementation, again at 14 days, and at least quarterly thereafter. The drill will consist of testing the equipment and response time;
- The Case Manager reviews the continued usage of this service at every home visit and during every IPP and makes the IDT aware of any problems or concerns encountered with the use of this system, all of which is documented on the IPP;
- The number of program members served by one stand-by intervention staff for on-site response is determined by the IDT and based upon the assessed needs of the member being served in specifically identified locations; and
- The IDDW provider has stand-by intervention staff who meet the following standards:
 - o Responds by being at the residential living site of the person who receives services: within 20 minutes or less from the time an incident is identified by the remote staff and the stand-by staff acknowledges receipt of the notification by the remote staff. The IDT has the authority to set a shorter response time based on the individual need of the person who receives services;
 - o Assists the member in the home as needed to ensure the urgent need/issue that generated a response has been resolved;
 - o Each time an emergency response is generated, an incident report must be submitted to the West Virginia Incident Management System by the IDDW provider.

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

The maximum units of Electronic Monitoring Service available for people living in Unlicensed Residential settings cannot exceed 23,360 units/5,840 hours (average 16 hours per day) per individual's IPP year.

The maximum units of Electronic Monitoring Service available for adults living in natural family/Specialized Family Care Homes are 11,680 units (8 hours per day).

This service is in combination with the following types of direct care services: All other PCS, Crisis Intervention, LPN, Facility-Based Day Habilitation, Pre-Vocational, Job Development and Supported Employment Services.

The amount of service is limited by the individualized budget of the program member.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Licensed Behavioral Health Center IDDW Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Electronic Monitoring

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center IDDW Provider

Provider Qualifications

License (specify):

Agency must have a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure and Certification (OHFLAC).

Certificate (specify):

Agency must be an approved IDDW Provider and an enrolled WV Medicaid Provider. Additionally the IDDW Provider must have a current letter of approval from BMS.

Other Standard (specify):

Agency must be an approved WV Medicaid Provider.

Electronic Monitoring providers must be approved by Bureau for Medical Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by Office of Health Facility Licensure and Certification.

IDDW provider must have a current letter of approval from BMS to provide this service.

The UMC will verify BMS approval and appropriate use of Electronic Monitoring during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially by OHFLAC.

BMS provides an annual letter to agency if the agency continues to meet the qualification to provide this 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:

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:

Environmental Accessibility Adaptations

06/26/2025

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

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):

Environmental Accessibility Adaptations-Home (EAA-Home) are physical adaptations to a residence where a member receives services. The adaptation maximizes physical accessibility to the home and within the home. Additionally, these adaptations enable the person who receives services to function with greater independence in the home. This service is used only after all other non-family funding sources have been exhausted.

Environmental Accessibility Adaptations-Vehicle (EAA-Vehicle) are physical adaptations to vehicles that members use to maximize community integration. The purpose of this service is to maximize accessibility to the vehicle only.

All EAA requests must be submitted to the UMC for prior authorization. If authorized, the completion of the adaptation to the residence or vehicle as specified must be verified prior to receiving payment and/or paying contracted vendor(s).

Documentation including dated and itemized receipts of the completed adaptation must be maintained in the member's file.

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

- The amount of service is limited by the individualized budget of the program member
- EAA-Home is not intended to replace the responsibility of the person who receives services, their family, or their landlord for routine maintenance and upkeep of the home. These include but are not limited to:
 - cleaning
 - painting
 - repair/replacement of roof
 - windows (unless a modified window is needed that is large enough for an adult to use to exit in case of fire)
 - flooring
 - structural repairs
 - air purifiers, humidifiers or air conditioners (unless the person has a documented respiratory/allergy condition or diagnosis)
 - heating equipment or furnaces
 - generators unless used for specific medical equipment (cannot be for the entire house),
 - plumbing and electrical maintenance
 - fences, gates or half-doors
 - security systems
 - adaptations that add to the square footage of the home except when necessary to complete an approved adaptation, (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair)
 - Computers, communication devices, tablets, and other technologies

- landline telephones or cell phones
- swimming pools, hot tubs or spas or any accessories, repairs or supplies for these items
- railing for decks or porches
- appliances that are not adapted/modified
- yard work
- household cleaning supplies
- utility payments
- household furnishings such as comforters, linens, drapes, etc.
- furniture unless it is a lift chair for someone with documented mobility issues
- outdoor recreational equipment unless specifically adapted for the person's needs
- driveway or walk way repairs or supplies unless specifically to exit or enter home to and from vehicle
- covered awnings
- Adaptations made to rental residences must be portable.
- \$1000 available per IPP year in combination with Traditional and Self-Directed Environmental Accessibility Adaptations - Vehicle and/or Participant-Directed Goods and Services.

EAA - Vehicle:

- The amount of service is limited by the individualized budget of the person who receives services.
- \$1000 available per IPP year in combination with Traditional and Self-Directed Environmentally Accessibility Adaptations - Home and/or Participant-Directed Goods and Services.
- This service may not be used for adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the person who receives services.
- This service may not be used to purchase or lease a vehicle.
- This service may not be used for regularly scheduled upkeep, maintenance, or repairs of a vehicle except upkeep and maintenance of the modifications.
- This service may not be used for running boards, insurance or gas money.
- Car seats unless specifically adapted/modified for the person.
- The Case Management agency must not pay EAA funds to the person who receives services, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service.

The amount of service is limited by the individualized budget of the program member. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Person-Centered or Home-Based Person-Centered Support and In-Home or Out-of-Home Respite and Non-Medical Transportation.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Personal Options
Agency	Licensed Behavioral Health Center IDDW Provider

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Environmental Accessibility Adaptations****Provider Category:**

Individual

Provider Type:

Personal Options

Provider Qualifications**License (specify):**

The Personal Options Vendor will only pay for work performed by a vendor that has a Business license and/or relevant skills for work to be performed.

Certificate (specify):

Not Applicable.

Other Standard (specify):

N/A

Verification of Provider Qualifications**Entity Responsible for Verification:**

Individuals or legal representatives (if applicable) who self-direct their services are responsible for ensuring that the provider of EAA meets the qualifications/standards with assistance from the F/EA or their Case Manager. The item must not be on the exclusion list or payment will not occur.

The Personal Options vendor is responsible to validating that the item is not on the exclusion list and the vendor qualifications prior to processing invoices.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

The Personal Options vendor verifies prior to each purchase. The UMC also verifies the item is not on the exclusion list.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Environmental Accessibility Adaptations****Provider Category:**

Agency

Provider Type:

Licensed Behavioral Health Center IDW Provider

Provider Qualifications**License (specify):**

Business license and/or relevant skills for work to be performed.

Certificate (specify):

Not applicable.

Other Standard (specify):**Verification of Provider Qualifications****Entity Responsible for Verification:**

The Case Manager is responsible for ensuring that providers of EAA meet qualification standards prior to processing invoices.

The UMC is responsible to review for prior authorization to assure items/services are not on the exclusion list and are indicated on the IPP as a documented need.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

The UMC will monitor compliance during on-site reviews.

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:

Family Person-Centered Support

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02021 shared living, residential habilitation

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):

Family Person-Centered Support (PCS) services can only be provided by family members or Specialized Family Care Providers living in the home with the person who receives services. For the purposes of providing services, family members include: biological/adoptive parents or step-parents, biological/adoptive adult siblings or stepsiblings, biological/adoptive grandparents or step-grandparents, biological/adoptive aunts/uncles or step-aunts/uncles, and Specialized Family Care Providers only. Other relationships may be considered with prior approval by BMS; for example, a non-family member who resides in the home, such as a domestic partner of a member's parent.

Family PCS is provided by awake and alert Direct Support Professionals and consists of individually tailored training and/or

support activities that enable the person who receives services to live and inclusively participate in the community in which the person resides, works, receives their education, accesses healthcare, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the person who receives services to have greater independence and personal choice, and to allow for maximum inclusion into their community.

Family PCS may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for Independent Living

Family PCS services must be assessment based and outlined on the IPP. Activities must allow the person who receives services to reside and participate in the most integrated setting appropriate to their needs.

Family PCS services may include training specific to the person who receives services, attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the UMC.

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

The maximum annual units of Family PCS services for a child under the age of 18 living in a natural family/Specialized Family Care home settings cannot exceed 7,320 15-minute units per IPP year. This is in combination with the following direct support services: All other PCS services and Crisis Intervention. Persons under the age of 18 may not access Facility-Based Day Habilitation, Job Development, Pre-Vocational Training or Supported Employment services, thus a combination limit with these services does not apply.

The maximum annual units of Family PCS services for an adult over age 18 living in a natural family/Specialized Family Care home setting cannot exceed 11,680 15-minute units per IPP year. This is in combination with the following direct support services: All other PCS services, LPN, Crisis Intervention and Electronic Monitoring. All direct care services cannot exceed an average of 12 hours/day on days when Facility-Based Day Habilitation, Job Development, Pre-Vocational, and/or Supported Employment services are provided.

If the person is still attending public school, then the limits of 7,320 15-minute units per IPP year will apply.

The amount of service is limited by the individualized budget of the person who receives services. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the person receiving services.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Personal Options
Agency	Licensed Behavioral Health Center IDDW Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Family Person-Centered Support

Provider Category:

Individual

Provider Type:

Personal Options

Provider Qualifications

License (specify):

Not applicable as the Personal Options self-directing individual/Employer of Record is not required to have a Behavioral Health License or be an enrolled IDWW Provider.

Certificate (specify):

Not applicable.

Other Standard (specify):

The Personal Options employee must have current CPR and First Aid cards, acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, have the ability to perform the tasks and be currently trained on all training requirements listed in the Personal Options section of the IDWW Policy Manual.

Verification of Provider Qualifications

Entity Responsible for Verification:

The person/Employer Record utilizing the Personal Options Model is responsible for ensuring all of their employees meet all qualifications.

The Personal Options vendor is responsible for verifying the employee's credentials.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Family Person-Centered Support

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center IDWW Provider

Provider Qualifications

License (specify):

Agency must have a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure and Certification (OHFLAC).

Certificate (specify):

Agency must be an approved IDWW Provider and an enrolled WV Medicaid Provider.

Other Standard (specify):

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks,

acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the Office of Health Facility Licensure and Certification.
 Agency staff is verified by the Licensed Behavioral Health Provider and the UMC.
 The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a “rap back” system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

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:

Job Development

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04010 prevocational services

Category 2:

03 Supported Employment

Sub-Category 2:

03010 job development

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):

Job Development services are designed for analysis, situational assessments and supports in either acquiring or maintaining competitive employment. These services should enable each person who receives services to attain and maintain employment at the highest level of work in a setting matched to the person's strengths, interests, priorities, and abilities. Services are expected to occur over a two-year period, with attaining and maintaining integrated employment at a competitive wage being the specific outcome. It is expected that on or before two years, transition to Supported Employment will take place and Job Development services will cease.

Meals provided as part of this service shall not constitute a full nutritional regimen of 3 meals per day.

Job Development Services include, but are not limited to, such concepts as:

- Planned visits and meetings with prospective employers to facilitate job acquisition;
- Negotiating job duties and employer expectations;
- Analyzing work duties expected by the employer;
- Creating, modifying, or customizing a community-based job so that it may be successfully performed by the person who receives services;
- Assessment in integrated employment settings to evaluate task management and job skill requirements;
- Assessment of personal interactions with co-workers and the public;
- Supports to assist a person who receives services in developing a business plan and obtaining funding to start his/her own business; and
- Volunteering at integrated work sites to practice the above skills (time limited for not more than one year).

Persons receiving job development services must have employment-related goals on the IPP and general habilitation activities must be designed to support such employment goals.

Job Development Direct Support Professionals may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the UMC if requested by the person who receives services or their legal representative.

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

The maximum annual units of Job Development cannot exceed 6,240 units/1,560 hours (average 6 hours/weekday) per the person's IPP year.

The amount of service is limited by the individualized budget of the person who receives services. Job Development service may not be accessed by anyone under the age of 18 or enrolled in a public school setting.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Licensed Behavioral Health Center IDDW Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Job Development

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center IDDW Provider

Provider Qualifications**License (specify):**

Agency must have a current WV Behavioral Health License issued by the WVDHHR Office of Health Facility Licensure and Certification (OHFLAC).

Certificate (specify):

Agency must be an approved IDDW Provider and an enrolled WV Medicaid Provider.

Other Standard (specify):

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Agency is verified by the Office of Health Facility Licensure and Certification.

Agency staff is verified by the Licensed Behavioral Health Provider and the UMC.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

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:

Licensed Group Home Person-Centered Support

HCBS Taxonomy:**Category 1:**

02 Round-the-Clock Services

Sub-Category 1:

02011 group living, residential habilitation

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):

Licensed Group Home Person-Centered Support (PCS): Agency is provided to adults in a site licensed by the Office of Health Facility Licensure and Certification by awake and alert Direct Support Professionals and consists of individually tailored training and/or support activities that enable the person who receives services to live and inclusively participate in the community in which the person resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the person who receives services to have greater independence and personal choice, and to allow for maximum inclusion into their community.

Licensed Group Home PCS services may be used to assist with the acquisition, retention, and/or improvement of the following areas of functionality:

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for Independent Living.

Staff persons administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent General Education Development (GED).

Licensed Group Home PCS services must be assessment based and outlined on the IPP. Activities must allow the person who receives services to reside and participate in the most integrated setting appropriate to their needs.

Licensed Group Home PCS services may include training specific to the person who receives services. Attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the UMC is permitted if requested by the person who receives services or their legal representative.

Licensed Group Home PCS Direct Support Professionals may compile data collected in daily documentation during their shift for later review by the BSP, as long as safety/health and oversight of the person who receives services are not compromised.

Licensed Group Home Direct Support Professionals may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the UMC if requested by the person who receives services or their legal representative.

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

The maximum annual units of Licensed Group Home PCS services cannot exceed 35,040 units/8,760 hours (based upon 24 hours per day) per IPP year for persons who live in sites licensed by the Office of Health Facility Licensure and Certification. This is in combination with the following types of direct care services: All other PCS, LPN, Crisis Intervention, Facility-Based Day Habilitation, Pre-Vocational, Job Development, Supported Employment Services and Electronic Monitoring. All requests for more than 12 hours of 1:1 service must be approved by BMS and have extenuating circumstances. All current people receiving more than 12 hours of 1:1 service must be evaluated to determine if more than 12 hours of 1:1 service is necessary.

Any person residing in a site serving more than 4 people must have a transition plan created to move to a site that services no more than 4 people within a three year period.

All LPN services provided must be within the scope of practice for licensed nurses. If a LPN is providing a service that is not within the scope of practice for licensed nurses (such as taking vital signs, providing personal hygiene, comfort, nutrition, ambulation and environmental safety and protection) that service must be billed as a PCS service and not an LPN service.

Licensed Group Home PCS services may only be provided to a person over the age 18.

The amount of service is limited by the individualized budget of the person who receives services. budget of the person receiving services.

Current process has allowed individuals to receive 1:1 services up to 35,712 units/year (or 24.46 hours/day – to include time for training outside of regular hours working with the member) based on their personal preference to have 1:1 staff or live in a 1-person residence. New policy will require that anyone wishing to continue or newly receive 1:1 staffing greater than 12 hours/day will submit a request to substantiate they need this level of support. The state will not continue to support 1:1 staffing based solely on personal preference due to cost constraints. Individuals will be given time to transition to other settings. Allowances will be made for those members who can substantiate the need for 1:1 services. Examples of approvable requests would include (but are not limited to): Severe maladaptive behaviors putting the member or others (potential roommates) at risk, severe medical issues (such as the member must limit exposure to others due to immunity issues), social issues, such as the member has purchased a home that will not accommodate roommates. Those subject to a denial of the request will be afforded their right to Medicaid Fair Hearing, where an impartial Hearing Officer will decide the matter.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Licensed Behavioral Health Center IDW Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Licensed Group Home Person-Centered Support

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center IDW Provider

Provider Qualifications

License (*specify*):

Agency must have a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure

and Certification (OHFLAC). The residential site must also be listed on the Agency's license from OHFLAC.

Certificate (*specify*):

Agency must be an approved IDWW Provider and an enrolled WV Medicaid Provider.

Other Standard (*specify*):

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

Any agency staff billing the AMAP code must have current AMAP certification.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the Office of Health Facility Licensure and Certification.

Agency staff is verified by the Licensed Behavioral Health Provider and the UMC.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

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:

Non-Medical Transportation

HCBS Taxonomy:

Category 1:

15 Non-Medical Transportation

Sub-Category 1:

15010 non-medical transportation

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):

Transportation: Miles services are provided to persons who receive IDDW services for trips to and from the home for training purposes, licensed Facility-Based Day Habilitation program or Supported Employment activities, or to the site of a planned activity or service which is addressed on the IPP and based on assessed need.

This service may be billed concurrently with Person-Centered Support, Respite, LPN, RN, Crisis Intervention, Supported Employment, Job Development, Facility-Based Day Habilitation and Pre-vocational services.

Transportation Trips:

Transportation services are provided to persons who receive IDDW services in the IDDW provider's mini-van or mini-bus for trips to and from the home, licensed Facility-Based Day Habilitation program or Supported Employment site or to the site of a planned activity or service which is addressed on the IPP and based on assessed need.

The agency mini-bus or mini-van must have proof of current vehicle insurance and registration inside the vehicle in addition to abiding by local, state and federal laws regarding vehicle licensing, registration, and inspections.

Agency passenger mini-bus or mini-van must have had the original capacity to transport more than 6 passengers but less than 16 passengers.

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

Transportation Miles: The maximum annual units of Transportation: Miles cannot exceed 9,600 miles per IPP year (based on average of 800 miles per month. Trips to training activities must be to the closest location possible that can meet the training goal on the IPP.

- The person who receives services must be present in vehicle if mileage is billed and must be traveling to or from an activity listed on the IPP. If more than one person who receives services is present in the vehicle, the total mileage will be divided between the number of persons who receive services present in vehicle.

- May be utilized up to 30 miles beyond the West Virginia border by members living in a WV county bordering another state.

Transportation Trips:

- The maximum units of Transportation: Trips cannot exceed 2 one-way trips per day.

- The person who receives services must be present in Agency-owned mini-van or mini-bus if trips are billed and the trip must be to or from an activity listed on the IPP.

The amount of service is limited by the individualized budget of the person who receives services. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the person receiving services.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Licensed Behavioral Health Center IDDW Provider
Individual	Personal Options

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Non-Medical Transportation****Provider Category:**

Agency

Provider Type:

Licensed Behavioral Health Center IDDW Provider

Provider Qualifications**License** (*specify*):

Agency must have a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure and Certification (OHFLAC).

Certificate (*specify*):

Agency must be an approved IDDW Provider and an enrolled WV Medicaid Provider.

Other Standard (*specify*):

Transportation Miles: Agency staff must have current CPR and First Aid cards, acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, valid driver's license, proof of current vehicle insurance and registration, have the ability to perform the tasks and meet the training requirements as mandated by the Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

Transportation Trips:

Agency staff must have current CPR and First Aid cards, acceptable fingerprint based National Crime Information Center check, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, valid driver's license, have the ability to perform the tasks and meet the training requirements as mandated by the Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

The agency owned mini-bus or mini-van must have proof of current vehicle insurance and registration,

Verification of Provider Qualifications**Entity Responsible for Verification:**

Agency is verified by the Office of Health Facility Licensure and Certification.

Agency staff is verified by the Licensed Behavioral Health Provider and the UMC.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service**Service Type: Other Service****Service Name: Non-Medical Transportation****Provider Category:**

Individual

Provider Type:

Personal Options

Provider Qualifications**License (specify):**

Not applicable as the Personal Options self-directing person/Employer of Record is not required to have a Behavioral Health License or be an enrolled IDDW Provider.

Certificate (specify):

Not applicable.

Other Standard (specify):

The Personal Options employee must have current CPR and First Aid cards, acceptable state and federal fingerprint-based checks, be over the age of 18, valid driver's license, proof of current vehicle insurance and registration, the ability to perform the tasks and be currently trained on all training requirements listed in the Personal Options section of the IDDW Policy Manual.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The person/Employer Record utilizing the Personal Options Model is responsible for ensuring all of their employees meet all qualifications.

The Personal Options vendor is responsible for verifying the employee's credentials.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

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:

Occupational Therapy

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

11 Other Health and Therapeutic Services

11080 occupational therapy

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):

Occupational Therapy is provided directly to the person who receives services by a staff person who is a licensed/certified occupational therapist and may include:

- Evaluation and training services in the areas of gross and fine motor function;
- Self-care;
- Sensory and perceptual motor function;
- Screening; assessments;
- Planning and reporting;
- Direct therapeutic intervention;
- Design, fabrication, training, and assistance with adaptive aids and devices; and
- Consultation or demonstration of techniques with other service providers and family members.

The scope and nature of these services differ from occupational therapy services furnished under the State Plan.

Occupational Therapy services provided under the Waiver are for chronic conditions and maintenance, while the occupational therapy services furnished under the State Plan are short term and restorative in nature. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Any similar services provided in a school setting may also be eligible for reimbursement under the waiver when Medicaid program requirements are met.

The occupational therapist may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC if requested by the member or their legal representative (if applicable). The maximum annual units of Occupation Therapy services may not exceed 416 units/104 hours per IPP year. This is in combination with the following services: Traditional and Self-Directed Physical Therapy and Dietary Therapy. A unit is 15 minutes. This service is provided in the occupational therapist's office or in the member's home. The amount of service is limited by the individualized budget of the program member. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Person-Centered or Home-Based Person-Centered Support and In-Home or Out-of-Home Respite and Non- Medical Transportation.

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

The maximum annual units of Occupation Therapy services may not exceed 416 units/104 hours per IPP year. This is in combination with the following services: Traditional and Self-Directed Physical Therapy and Dietary Therapy. A unit is 15 minutes.

This service is provided in the Occupational Therapist's office or in the member's home.

The amount of service is limited by the individualized budget of the program member. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Person-Centered or Home-Based Person-Centered Support and In-Home or Out-of-Home Respite and Non- Medical Transportation.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Personal Options
Agency	Licensed Behavioral Health Center IDW Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Occupational Therapy

Provider Category:

Individual

Provider Type:

Personal Options

Provider Qualifications

License (*specify*):

Provider must be a WV Licensed Occupational Therapist.

Certificate (*specify*):

Provider must be an enrolled WV Medicaid Provider.

Other Standard (*specify*):

Provider must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by the WV Board of Occupational Therapy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider credentials are verified by the F/EA prior to processing invoices.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Occupational Therapy****Provider Category:**

Agency

Provider Type:

Licensed Behavioral Health Center IDW Provider

Provider Qualifications**License (specify):**

Agency must have a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure and Certification (OHFLAC).

Agency staff or Contracted Staff must be a WV Licensed Occupational Therapist.

Certificate (specify):

Agency must be an approved IDW Provider and an enrolled WV Medicaid Provider.

Other Standard (specify):

Agency staff or Contracted Staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Agency is verified by the Office of Health Facility Licensure and Certification.

Agency staff is verified by the Licensed Behavioral Health Provider and the UMC.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

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:

Out-of-Home Respite

HCBS Taxonomy:**Category 1:**

09 Caregiver Support

Sub-Category 1:

09011 respite, out-of-home

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):

Out-of-Home Respite services are services provided to the person receiving services out of their home and in a certified Specialized Family Care Home by awake and alert Direct Support Professionals are specifically designed to provide temporary substitute care normally provided by a family member or a Specialized Family Care Provider. IDDW agencies may also provide the service in the local public community or at a licensed site. The services are to be used for relief of the primary care-giver(s) to help prevent the breakdown of the primary care-giver(s) due to the physical burden and emotional stress of providing continuous support and care to the dependent person who receives services. Out-of-Home Respite services consist of temporary care services for a person who cannot provide for all of their own needs. Persons providing Respite services may participate in person-centered planning.

Out-of-Home Respite services may be used to:

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

Direct Support Professionals providing Out-of-Home Respite services may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by UMC if requested by the person who receives services or their legal representative. Out-of-Home Respite Direct Support Professionals will be subject to usage of the EVV and NPI number utilization and all corresponding requirements.

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

The maximum annual units of Out-of-Home Respite service may not exceed 3,650 units/912.5 hours per IPP year for persons who live in a Natural Family/Specialized Family Care home. This is in combination with all other types of Respite Services. Any Out-of-Home Respite must be provided in a certified Specialized Family Care Home unless it is provided in the local public community. Parents/step-parents may not provide respite for their own child, even if the parent/step-parents does not have custody of the child.

The amount of service is limited by the individualized budget of the person who receives services. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the person receiving services.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Personal Options
Agency	Licensed Behavioral Health Center IDDW Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Out-of-Home Respite

Provider Category:

Individual

Provider Type:

Personal Options

Provider Qualifications

License (specify):

Not applicable as the Personal Options self-directing individual/Employer of Record is not required to have a Behavioral Health License or be an enrolled IDDW Provider.

Certificate (specify):

The site of this service must be a certified Specialized Family Care Home and the service must be provided by a certified Specialized Family Care Provider.

Other Standard (specify):

The Personal Options employee must have current CPR and First Aid cards, acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, have the ability to perform the tasks and be currently trained on all training requirements listed in the Personal Options section of the IDDW Policy Manual.

Verification of Provider Qualifications

Entity Responsible for Verification:

The person/Employer Record utilizing the Personal Options Model is responsible for ensuring all of their employees meet all qualifications.

The Personal Options vendor is responsible for verifying the employee's credentials.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Out-of-Home Respite

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center IDDW Provider

Provider Qualifications

License (*specify*):

Agency must have a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure and Certification (OHFLAC).

Certificate (*specify*):

Agency must be an approved IDDW Provider and an enrolled WV Medicaid Provider. The site of this service must be a certified Specialized Family Care Home and the service must be provided by a certified Specialized Family Care Provider.

Other Standard (*specify*):

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the Office of Health Facility Licensure and Certification.

Agency staff is verified by the Licensed Behavioral Health Provider and the UMC.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks which are checked every 5 years and the OIG which is checked monthly.

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:

Physical Therapy

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11090 physical therapy

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):

Physical Therapy is provided directly to the person who receives services by a staff person who is a licensed physical therapist and may include:

- Screening and assessments;
- Treatment and training programs designed to preserve and improve abilities for independent functioning, such as gross and fine motor skills, range of motion, strength, muscle tone;
- Activities of daily living;
- Planning and reporting;
- Direct therapeutic intervention;
- Training and assistance with adaptive aids and devices; and
- Consultation or demonstration of techniques with other service providers and family members.

The scope and nature of these services differ from physical therapy services furnished under the State Plan. Physical Therapy services provided under the Waiver are for chronic conditions and maintenance, while the physical therapy services furnished under the State Plan are short term and restorative in nature. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Any similar services provided in a school setting may also be eligible for reimbursement under the waiver when Medicaid program requirements are met.

The physical therapist may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC if requested by the member or their legal representative (if applicable).

The maximum annual units of Physical Therapy services may not exceed 416 units/104 hours per IPP year. This is in combination with the following services: Traditional and Self-Directed Occupational Therapy and Dietary Therapy. A unit is 15 minutes. This service is provided in the physical therapist's office or in the member's home. The amount of service is limited by the individualized budget of the program member. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Person-Centered or Home-Based Person-Centered Support and In-Home or Out-of-Home Respite and Non- Medical Transportation.

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

The maximum annual units of Physical Therapy services may not exceed 416 units/104 hours per IPP year. This is in combination with the following services: Traditional and Self-Directed Occupational Therapy and Dietary Therapy. A unit is 15 minutes.

This service is provided in the Physical Therapist's office or in the member's home.

The amount of service is limited by the individualized budget of the program member. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Person-Centered or Home-Based Person-Centered Support and In-Home or Out-of-Home Respite and Non- Medical Transportation.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Licensed Behavioral Health Center
Individual	Personal Options

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications

License (*specify*):

Agency must have a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure and Certification (OHFLAC).

Agency staff or Contracted Staff must be a WV Licensed Physical Therapist.

Certificate (*specify*):

Agency must be an approved IDWW Provider and an enrolled WV Medicaid Provider.

Other Standard (*specify*):

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the Office of Health Facility Licensure and Certification.

Agency staff or Contracted Staff is verified by the Licensed Behavioral Health Provider and the UMC.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Staff or credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Physical Therapy

Provider Category:

Individual

Provider Type:

Personal Options

Provider Qualifications**License (specify):**

Provider must be a WV Licensed Physical Therapist.

Certificate (specify):

Provider must be an enrolled WV Medicaid Provider.

Other Standard (specify):

Provider must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by the WV Board of Physical Therapy.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Provider credentials are verified by the F/EA prior to processing invoices.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Provider's credentials are verified initially and annually with exception of the state and federal fingerprint-based check which are checked every 5 years and the OIG which is checked monthly.

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:

Skilled Nursing by a Licensed Practical Nurse

HCBS Taxonomy:**Category 1:**

05 Nursing

Sub-Category 1:

05020 skilled nursing

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):

Licensed Practical Nursing (LPN) services listed in the service plan are within the scope of West Virginia's Nurse Practice Act, ordered by a physician, and provided by a LPN under the supervision and monitoring of a RN actively licensed to practice in the State. LPN services are available to individuals who are aged 21 and older, as children with significant medical issues who meet eligibility for this program can access Private Duty Nursing via the Medicaid State Plan. Nursing services that may be provided by an awake and alert LPN include but are not limited to:

- Verifying and documenting physician orders if only RNs or LPNs are administering medication (no AMAPS are administering medications).
- Reviewing and verifying physician orders are current, properly documented, and communicated to Direct Support Professionals and others per IDWW provider policy.
- Direct nursing care including medication/treatment administration.
- Review of Medication Administration Records (MARs), medication storage and documentation (when no AMAPs are administering medication).
- Review of scheduled medical appointments before occurrence and communicate this information to others per IDWW provider policy.
- Facilitating procurement of and monitoring of medical equipment.
- Training persons who receive services on individualized medical and health needs, such as wound-care, medically necessary diets, etc.

A detailed schedule outlining the nursing services that are within the WV Nurse Practice Act must be provided before this service will be approved. Any services that are not within the scope of this practice, must be billed as Person-Centered Support or Respite services.

The LPN may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC at the request of the person who receives services or their legal representative.

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

The maximum annual units of LPN service cannot exceed 11,680 units (8 hours per day average) per the person's IPP year and these units must be deducted from the total direct care services. All LPN services provided must be within the scope of practice for licensed practical nurses. If a LPN is providing a service that is not within the scope of practice for licensed nurses (such as taking vital signs, providing personal hygiene, comfort, nutrition, ambulation and environmental safety and protection) that service must be billed as direct care service and not an LPN service. This service is in combination with the following types of direct care services: All PCS, Crisis Intervention, Facility-Based Day Habilitation, Pre-Vocational, Job Development, Supported Employment Services and Electronic Monitoring.

LPN services are not available to individuals under age 21. Private Duty Nursing services are available to individuals under the age of 21 through state plan services who meet the eligibility standards.

The amount of service is limited by the individualized budget of the person who receives services.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Licensed Behavioral Health Center IDDW Provider

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Skilled Nursing by a Licensed Practical Nurse****Provider Category:**

Agency

Provider Type:

Licensed Behavioral Health Center IDDW Provider

Provider Qualifications**License (specify):**

Agency must have a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure and Certification (OHFLAC).

Agency staff must be a WV Licensed Practical Nurse or WV Licensed Registered Nurse.

Certificate (specify):

Agency must be an approved IDDW Provider and an enrolled WV Medicaid Provider.

Other Standard (specify):

Agency staff must have current CPR and First Aid certifications, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Agency is verified by the Office of Health Facility Licensure and Certification.

Agency staff is verified by the Licensed Behavioral Health Provider and the UMC.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

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:**06/26/2025**

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:

Skilled Nursing by a Registered Nurse

HCBS Taxonomy:**Category 1:**

05 Nursing

Sub-Category 1:

05020 skilled nursing

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):

Registered Nurse (RN) services listed in the service plan are within the scope of the West Virginia Nurse Practice Act, ordered by a physician, and are provided by a licensed RN licensed to practice in the State. RN services are services which only a licensed RN can perform. The service must be provided by a RN under the direction of a physician. The RN may perform clinical supervision of LPN and AMAP staff.

Medication Administration is utilized by a Licensed Practical Nurse and/or Licensed Registered Nurse and provides the administration of medication within the scope of practice under state law and rule. This service is meant to ensure the member's medical needs are met in supplementation to the AMAP program.

Skilled Nursing Medication Administration is designed to support oversight of medication administration by unlicensed direct support providers. Direct support staff are permitted to administer medications under WV's Approved Medication Assistive Personnel (AMAP) program. AMAP staff are trained by OHFLAC approved registered professional nurses and must work under the supervision of an RN. The Skilled Nursing Medication Administration service is reimbursed at a flat, daily rate to help ensure RNs are reimbursed for providing supervision and training to AMAP staff, as needed.

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

The maximum annual units of RN services cannot exceed 480 units/120 hours per individual's IPP year. A unit is 15 minutes. Any RN service provided that is not within the scope of the West Virginia Nurse Practice Act must be billed as a Person-Centered Support service.

The amount of service is limited by the individualized budget of the person who receives services.

Limitations applicable to the Skilled Nursing Medication Administration code modifier:

Events may not exceed 365 per IPP year or 366 per IPP year during leap years (one event per day).

Only available to members living in a 24-hour setting.

The amount of service is limited by the individual's assessed budget

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Licensed Behavioral Health Center IDDW Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Skilled Nursing by a Registered Nurse

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center IDDW Provider

Provider Qualifications

License (*specify*):

Agency must have a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure and Certification (OHFLAC).

Agency staff must be a WV Licensed Registered Nurse.

Certificate (*specify*):

Agency must be an approved IDDW Provider and an enrolled WV Medicaid Provider.

Other Standard (*specify*):

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the Office of Health Facility Licensure and Certification.

Agency staff is verified by the Licensed Behavioral Health Provider and the UMC.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

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:

Speech Therapy

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11100 speech, hearing, and language therapy

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):

Speech Therapy is provided directly to the person who receives services by a staff person who is a licensed speech pathologist and may include:

- Screening and assessments;
- Direct therapeutic intervention and treatment for speech and hearing disabilities such as delayed speech, stuttering, spastic speech, aphasic disorders, injuries, lip reading or signing, or the use of hearing aids;
- Language stimulation and correction of defects in voice, articulation, rate and rhythm;
- Design, fabrication, training and assistance with adaptive aids and devices; and
- Consultation or demonstration of techniques with other service providers and family members.

The scope and nature of these services differ from Speech Therapy services furnished under the State Plan. Speech Therapy services provided under the Waiver are for chronic conditions and maintenance, while the Speech Therapy services furnished under the State Plan are short term and restorative in nature. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Any similar services provided in a school setting may also be eligible for reimbursement under the waiver when Medicaid program requirements are met.

The Speech Therapist may attend and participate in IDT meetings and the annual assessment of functioning eligibility

conducted by the UMC if requested by the member or their legal representative (if applicable). The maximum annual units of service may not exceed 96 units/96 events per IPP year for persons who receive services who are under age 24. A unit is an event. This service is provided in the Speech Therapist's office or in the member's home. The maximum annual units of Speech Therapy services may not exceed 48 units/48 events per IPP year for persons who receive services who are age 24 and over. A unit is an event. This service is in combination with Traditional Speech Therapy. The amount of service is limited by the individualized budget of the program member. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Person-Centered or Home-Based Person-Centered Support and In-Home or Out-of-Home Respite and Non- Medical Transportation.

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

The maximum annual units of service may not exceed 96 units/96 events per IPP year for persons who receive services who are under age 24. A unit is an event.

This service is provided in the Speech Therapist's office or in the member's home.

The maximum annual units of Speech Therapy services may not exceed 48 units/48 events per IPP year for persons who receive services who are age 24 and over. A unit is an event. This services is in combination with Traditional Speech Therapy.

The amount of service is limited by the individualized budget of the program member. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Person-Centered or Home-Based Person-Centered Support and In-Home or Out-of-Home Respite and Non- Medical Transportation.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Personal Options
Agency	Licensed Behavioral Health Center IDDW Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Speech Therapy

Provider Category:

Individual

Provider Type:

Personal Options

Provider Qualifications

License (specify):

Provider must be a WV Licensed Speech Therapist.

Certificate (specify):

Provider must be an enrolled WV Medicaid Provider.

Other Standard (specify):

Provider must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by the WV Board of Speech-Language Pathology and Audiology.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Provider credentials are verified by the F/EA prior to processing invoices.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Speech Therapy

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center IDWW Provider

Provider Qualifications**License (specify):**

Agency must have a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure and Certification (OHFLAC).

Agency staff must be a WV Licensed Speech Therapist.

Certificate (specify):

Agency must be an approved IDWW Provider and an enrolled WV Medicaid Provider.

Other Standard (specify):

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Agency is verified by the Office of Health Facility Licensure and Certification.

Agency staff is verified by the Licensed Behavioral Health Provider and the UMC.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

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:

Unlicensed Residential Person-Centered Support

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02031 in-home residential habilitation

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):

Unlicensed Residential Person-Centered Support services can only be provided by staff persons not living in the home with the person who receives services. This service occurs in Intensively Supported Settings which are typically apartments or homes that are rented or leased by 1, 2 or 3 unrelated individuals (exceptions may be made for siblings). If the setting is owned or leased by an IDDW provider, then the person living there does not qualify for this code. Unlicensed Residential PCS cannot be provided by family members of the person who receives services, including biological/adoptive parents or step-parents, biological/adoptive adult siblings or step-siblings, biological/adoptive grandparents or step-grandparents, and biological/adoptive aunts/uncles or step-aunts/-uncles.

Unlicensed Residential PCS services are provided by awake and alert Direct Support Professionals and consists of individually tailored training and/or support activities that enable the person who receives services to live and inclusively participate in the community in which the person resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the person who receives services to have greater independence and personal choice, and to allow for maximum inclusion into their community.

Unlicensed Residential PCS services may be used to assist with the acquisition, retention, and/or improvement of the

following areas of functionality:

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for Independent Living.

Staff persons who provide this service and are employed by licensed Behavioral Health Center IDWW providers may administer medications per the AMAP program, but must meet all requirements for that program which include having a high school diploma or the equivalent General Education Development (GED).

Unlicensed Residential PCS services must be assessment based and outlined on the IPP. Activities must allow the person who receives services to reside and participate in the most integrated setting appropriate to their needs.

Unlicensed Residential PCS services may include training specific to the person who receives services.

Unlicensed Residential PCS services Direct Support Professionals may compile data collected in daily documentation during their shift for later review by the BSP, as long as safety/health and oversight of the person who receives services are not compromised.

Unlicensed Residential PCS service Direct Support Professionals may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the UMC if requested by the person who receives services or their legal representative.

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

The maximum annual units of Unlicensed Residential PCS services cannot exceed 35,040 units/8,760 hours (based upon average of 24 hours per day) per IPP year for persons who live in sites not licensed by the Office of Health Facility Licensure and Certification. During a leap year, this amount will be a maximum of 35,136 15-minute units. This is in combination with the following types of direct care services: All other PCS, LPN, Crisis Intervention, Facility-Based Day Habilitation, Pre-Vocational, Job Development, Supported Employment Services and Electronic Monitoring. All requests for more than 12 hours of 1:1 service must be approved by BMS and have extenuating circumstances. All current people receiving more than 12 hours of 1:1 service must be evaluated to determine if more than 12 hours of 1:1 service is necessary.

If a LP is providing a service in this setting that is not within the scope of practice for licensed nurses (such as taking vital signs, providing personal hygiene, comfort, nutrition, ambulation and environmental safety and protection) that service must be billed as a PCS service and not an LPN service.

Unlicensed Residential Person-Centered Support services can only be provided to a person over the age 18.

The amount of service is limited by the individualized budget of the person who receives services. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the person receiving services.

Current process has allowed individuals to receive 1:1 services up to 35,712 units/year (or 24.46 hours/day – to include time for training outside of regular hours working with the member) based on their personal preference to have 1:1 staff or live in a 1-person residence. New policy will require that anyone wishing to continue or newly receive 1:1 staffing greater than 12 hours/day will submit a request to substantiate they need this level of support. The state will not continue to support 1:1 staffing based solely on personal preference due to cost constraints. Individuals will be given time to transition to other settings. Allowances will be made for those members who can substantiate the need for 1:1 services. Examples of approvable requests would include (but are not limited to): Severe maladaptive behaviors putting the member or others (potential roommates) at risk, severe medical issues (such as the member must limit exposure to others due to immunity issues), social issues, such as the member has purchased a home that will not accommodate roommates. Those subject to a denial of the request will be afforded their right to Medicaid Fair Hearing, where an impartial Hearing Officer will decide the matter.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Licensed Behavioral Health Center IDW Provider
Individual	Personal Options

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Unlicensed Residential Person-Centered Support

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center IDW Provider

Provider Qualifications

License (specify):

Agency must have a current WV Behavioral Health License issued by the WV DoHS Office of Health Facility Licensure and Certification (OHFLAC).

Certificate (specify):

Agency must be an approved IDW Provider and an enrolled WV Medicaid Provider.

Other Standard (specify):

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification and the Bureau for Medical Services.

Any agency staff billing the AMAP code must have current AMAP certification.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the Office of Health Facility Licensure and Certification.

Agency staff is verified by the Licensed Behavioral Health Provider and the UMC.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Unlicensed Residential Person-Centered Support

Provider Category:

Individual

Provider Type:

Personal Options

Provider Qualifications

License (specify):

Not applicable as the Personal Options self-directing individual/Employer of Record is not required to have a Behavioral Health License or be an enrolled IDWW Provider.

Certificate (specify):

Not applicable.

Other Standard (specify):

The Personal Options employee must have current CPR and First Aid cards, acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, have the ability to perform the tasks and be currently trained on all training requirements listed in the Personal Options section of the IDWW Policy Manual.

Verification of Provider Qualifications

Entity Responsible for Verification:

The person/Employer Record utilizing the Personal Options Model is responsible for ensuring all of their employees meet all qualifications.

The Personal Options vendor is responsible for verifying the employee's credentials.

The UMC will perform certification validation during on-site reviews.

Frequency of Verification:

Staff credentials are verified initially and annually, including state and federal fingerprint-based checks which are checked initially and every 5 years. Monthly OIG checks are no longer required as the WV CARES criminal background check database features a "rap back" system that provides continuous monitoring of criminal histories and issues alert when there is a subsequent change in an individual's criminal history.

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 section 1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.

As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.

As an administrative activity. Complete item C-1-c.

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management). *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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

--

- d. Remote/Telehealth Delivery of Waiver Services.** Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Case Management
Facility-Based Day Habilitation
Prevocational Services
Behavior Support Professional
Electronic Monitoring
Skilled Nursing by a Registered Nurse

1. Will any in-person visits be required?

Yes.

No.

2. By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.

The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. *Explain:*

The remote service will be delivered in a way that respects the privacy of the individual, especially in instances of toileting, dressing, etc. When providing telehealth services, steps will be taken to ensure the individual's privacy. This includes using appropriate camera angles, providing privacy screens, or obtaining consent for video recording. For example, when assisting someone with dressing via telehealth, the camera will be positioned to focus on the face and upper body, avoiding sensitive areas. If a caregiver needs to be present during a telehealth session, their presence and any recording will be discussed and agreed upon beforehand. For remote monitoring, the equipment will have an indicator to show when it is on and recording, and it can only be turned off by the person(s) indicated in the individual service plan.

How the telehealth service delivery will facilitate community integration. *Explain:*

Telehealth will be used to support community integration by enabling individuals to participate in community activities and access services from their own homes or community settings. For example, telehealth for Day Habilitation services will be provided in a community setting (e.g., a library, senior center, or park) to enable the member to interact with others and participate in community activities. This allows individuals to engage with their community without requiring transportation or in-person staff presence for every interaction.

How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual. *Explain:*

For individuals who need hands-on assistance, telehealth will primarily be used in conjunction with in-person support. If in-person support is not possible, telehealth can still be used to provide services but with additional safeguards. This may include providing clear instructions, using visual aids, or having a caregiver present during the telehealth session. For example, when providing telehealth for Nursing services, the nurse will provide clear instructions to the member or their caregiver on how to perform tasks such as taking medication or changing a bandage.

How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service. *Explain:*

The state will provide training and technical assistance to individuals who need support with the technology used for telehealth. This may include training on using the equipment, troubleshooting common issues, and providing adaptive equipment if needed. The support will be tailored to the individual's needs and preferences and may involve their caregivers as well.

How the telehealth will ensure the health and safety of an individual. *Explain:*

Telehealth services will be delivered in a way that prioritizes the individual's health and safety. This may involve monitoring vital signs, providing emergency response protocols, and ensuring a caregiver is present during the session if needed. Additionally, for remote monitoring, the service will only be used to reduce or replace the amount of in-person support if it is safe and appropriate for the individual.

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):

For the Traditional Option:

State and federal fingerprint-based checks are to be conducted by IDDW Provider agencies on all staff having direct contact with persons using IDDW services prior to the Agency staff providing services.

For Personal Options:

The person/Employer Record enrolled in the Personal Options program is responsible for ensuring all of their employees complete state and federal fingerprint-based checks prior to providing services. The Personal Options vendor is responsible for verifying the employee's credentials.

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; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. 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 follows WV Code § 15-2C-1. The West Virginia State Police and Criminal Identification Bureau maintains the Central Abuse Registry. IDDW provider agencies and the Personal Options Employer of Record are required to request a state and federal fingerprint-based checks background check (Central Abuse Registry) for all employees with direct access to people on the IDDW. The Central Abuse Registry shall contain, at a minimum, information relating to the following: 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. UMC monitors compliance as part of the periodic review of provider qualifications. Backup plans are required for each individual service plan, detailing how services will be rendered in the event the provider is unable to deliver services due to a pending investigation of ANE or substantiation of an allegation of ANE. If a participant's service provider is added to the abuse registry, the team will implement the member's backup plan accordingly.

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

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 or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is "*extraordinary care*", exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring 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.*

The legally responsible adult may provide services that have been identified as necessary in the Extraordinary Care Assessment which is completed initially and at the annual reevaluation of eligibility by the UMC. The services they may provide are respite care and family person-centered support services. The method for determining that the amount of personal care or similar services provided by a legally responsible individual is "extraordinary care" is based on the needs of the individual. The "Extraordinary Care Assessment" policies and processes are incorporated into BMS Form I/DD-5, the Individualized Program Plan (IPP), that serves as the person-centered plan of care for the IDDW. The "Extraordinary Care Assessment" section of the plan requires the IDT to document how the team identified the needs most important to the member as areas of focus for the year. The IDT must also document what each area of need looks like for the member, how the individual is impacted by any extraordinary need and what the limitations look like, including the IDT's assessment of whether the individual's needs indicate the provision of services by the LAR is in the best interest of the individual. The IDDW IPP, BMS Form I/DD-5, also includes an integrated settings assessment for individuals who reside in their own home or a natural family home. The assessment documents the IDT's evaluation of the individual's living arrangements, including the individual's right to choose the services and services providers of their choice, including any services delivered by the LAR. Form I/DD-5 also requires the IDT to document the alternative settings and service providers considered in development of the plan, including the availability of other options to meet the service needs provided by the LAR, where appropriate. The state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant are based on the individual's needs and preferences. The state's processes ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgment on behalf of the individual are based on the individual's needs and preferences.

The limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made are based on the individual's needs and preferences. The additional safeguards the state implements when legally responsible individuals provide personal care or similar services are based on the individual's needs and preferences. The procedures used to implement required state oversight, such as ensuring payments are made only for services rendered, are based on the individual's needs and preferences.

The legally responsible adult may only provide services identified as necessary in the Extraordinary Care Assessment, which is completed initially and at the annual reevaluation of eligibility by the UMC. For individuals who self-direct through Personal Options, a program representative cannot serve in the dual role as the program representative and a paid service provider. The rural nature of the state of West Virginia also makes it problematic for behavioral health agencies to recruit appropriate staff, so legal guardians may be paid employees, but someone else will have to serve as the program representative for purposes of self-direction. For children eligible to receive public education services/home schooling/other education alternatives, person-centered support services cannot exceed 7,320 15-minute units per IPP year.

The legal guardian of a person who is not eligible for public education services/home schooling/other educational alternatives is limited to 11,680 15-minute units of person-centered support services. A spouse is not allowed to provide person-centered support services. The IDT must approve all services which are monitored by the Case Manager through at least monthly contacts. If a Behavior Support Professional (BSP) provides services, then the BSP would also be monitoring any training or support services provided by the legally responsible adult. Additionally, all services are prior authorized through the UMC.

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 types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or

legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures 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.*

The legally responsible adult may provide services that have been identified as necessary in the Extraordinary Care Assessment which is completed initially and at the annual reevaluation of eligibility by the UMC. The services they may provide are respite care and family person-centered support services. The method for determining that the amount of personal care or similar services provided by a legally responsible individual is "extraordinary care" is based on the needs of the individual. The state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant are based on the individual's needs and preferences. The state's processes ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgments on behalf of the individual are based on the individual's needs and preferences.

The limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made are based on the individual's needs and preferences. The following additional safeguards are utilized when a parent, guardian, LRI or other relative provide services beyond personal care (ex. Respite):

- a. Existing state policies address concerns related to the provision of services by relatives or family members. In the Traditional model, the provider agency evaluates qualifications, and all providers undergo background checks and training. In the self-directed model, members can hire any qualified individual based on their needs and person-centered care plan, which includes the member's choice of provider. This process is subject to background checks and training, with oversight from a resource consultant. If issues arise, a representative may be required to oversee the relative employee, and the member may need to transition to the Traditional model. The case manager, PA agency, or resource consultant may refer to APS/CPS if there are concerns about abuse, neglect, or exploitation.
- b. Other family members can be paid personal attendants. Under the Traditional Model, they work for an agency. For members who self-direct their services and are employed by the members, there is a case manager and resource consultant with the F/EA to monitor services provided.
- c. Personal attendant services have unique service code(s), unit limits, require prior authorization, and daily billing for EVV where applicable. The personal attendant staff and members sign the personal attendant worksheet; the agency reviews and approves the worksheet, and the UMC reviews personal attendant worksheets during quality reviews. Any duplicative billing is subject to recoupment.
- d. WV State code 44A-1-15 Eligibility of Guardians or Conservators Employed Pursuant to a Department of Health and Human Resources Waiver Program states that a guardian or conservator of a protected person may provide certain personal care services if they are employed by a licensed provider of behavioral health service, the payment for services is made pursuant to a waiver program, the contract or employment agreement is disclosed in writing to the court, and the court finds that the appointment is in the best interests of the protected person.

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.

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:

In order to participate in the IDDW program, provider agencies must meet the following requirements:

- (1) Receive Certificate of Need (CON) approval from the WV Health Care Authority (HCA) as designated in WV Code § 9-5-19. The CON Summary process was put into place to expedite applications for providers that are only providing services through the IDDW so as not to limit people's access and choice of service providers. A IDDW CON committee comprised of the IDDW Program Manager, the State Intellectual/Developmental Disabilities Director and the Behavioral Health Program Manager from the Office of Health Facility Licensure and Certification (OHFLAC). All willing and qualified providers are approved by the IDDW CON committee.
- (2) Following CON Approval, the prospective agency applies to the WV Health Care Authority for approval.
- (3) Following HCA approval, the prospective agency applies for a behavioral health license through the Office of Health Facilities and Licensure and Certification (OHFLAC).
- (4) Following OHFLAC approval, the prospective agency must meet and maintain all Bureau for Medical Services requirements including a valid provider agreement on file that is signed by the provider and the Bureau for Medical Services.
- (5) Workers and vendors providing services under the participant-directed options, must meet established provider qualifications as specified in the service description section. The Personal Options vendor verifies that qualifications are met.

WV approves all willing and qualified providers. All IDDW providers must also be licensed behavioral health centers. The prospective provider may apply through the full Certificate of Need process and be able to provide all behavioral health services or they may apply to just provide IDDW services through the expedited summary review process (WV Code §9-5-18) (See Attachment 5). If the prospective IDDW provider wants to go through the full CON, then the provider must contact the director of the Certificate of Need programs at the WV Healthcare Authority. If the prospective IDDW provider wants to go through the expedited summary review process, then the provider contacts the IDDW Program Manager at BMS and is provided with all of the necessary paperwork. There is an Expedited CON Committee that meets monthly and reviews all applications, completes a check list and makes recommendations. If the recommendation is to approve the provider, then a recommendation is made by the committee to the Commissioner at BMS and if she concurs, then she makes a recommendation to the Secretary of WV DoHS and if concurs, then a recommendation is made to the HealthCare Authority. If the HealthCare Authority also concurs, then the provider applies to the WV Office of Health Facility Licensure and Certification for a behavioral health license. Once approved, then the provider completes a Medicaid agree with our claims payer and is ready to open their doors for business. If the prospective IDDW provider does not meet the minimum standards of the expedited summary review committee, then a letter is sent along with the reasons why the provider did not pass and the provider is invited to re-apply at the earliest opportunity.

Over the past five years, 5 new IDDW providers have been approved through this process.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one:*

No, the state does not choose the option to provide HCBS in acute care hospitals.

Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions. By checking the boxes below, the state assures:

The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;

The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;

The HCBS must be identified in the individual's person-centered service plan; and

The HCBS will be used to ensure smooth transitions between acute care setting and community-based

settings and to preserve the individual's functional abilities.

And specify: (a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.

The state does not make payment for 1915c HCBS when a member is receiving services as an inpatient in an ICF/IID facility, a state institution, a nursing facility, a rehabilitation facility, or a psychiatric facility. The state will make payment for 1915c HCBS when a member is receiving services as an inpatient in a Medicaid-certified hospital if the individual is receiving services in a specialized family care home, an Unlicensed Residential Home, or a Licensed Group Home and is experiencing behavioral issues due to the temporary change in environment.

The state also makes payment for case management services when a member is temporarily in a facility and/or has been placed on hold status in order to facilitate returning to their home/community. The 1915c HCBS will assist the individual in returning to the community by providing the individual with the support they need to remain in the community. The rate for 1915c HCBS provided during a hospitalization is the same as the typically billed rate.

Individuals may receive HCBS from direct support or other support staff (such as behavioral supports) while receiving medical care and treatment in an acute care hospital so long as the following conditions exist:

- 1.the waiver service is accurately documented in the person-centered support plan;
- 2.the waiver service provided meets the need(s) of the individual that are not met through the provision of hospital services; and
- 3.the waiver service is being provided to ensure a smooth transition between the acute care settings and home and community-based setting and preserve the individual's functional abilities.

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:

Percent of agency providers who continue to meet licensure and/or certification standards. Numerator-Number agency providers who continue to meet licensure and/or certification standards. Denominator-Number of active agency providers.

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 Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; padding: 2px;">UMC OHFLAC</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

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 Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> UMC OHFLAC </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>

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:

Percent of agency staff whose Infectious Disease Control training is current.

Numerator-Number of agency staff whose Infectious Disease Control training is current at time of service provision. Denominator-Number of agency staff files reviewed.

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 Confidence Interval = <div>95%</div>
Other Specify: <div>UMC</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> UMC	
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Percent of agency staff whose recognition and reporting of Abuse/Neglect/Exploitation training is current. Numerator-Number of agency staff whose recognition and reporting of Abuse/Neglect/Exploitation training is current at time of service provision. Denominator-Number of agency staff files reviewed.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block;">95%</div>
Other Specify: <div style="border: 1px solid black; padding: 2px; display: inline-block;">UMC</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/> UMC	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Percent of agency staff whose training in Health and Welfare is current Numerator=
Number of agency staff whose training in Health and Welfare training is current
Denominator = Number of agency staff files reviewed

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>UMC</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

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: <div>UMC</div>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):

Performance Measure:

Percent of agency staff whose Direct Care Ethics/Individual Rights training is current. Numerator-Number of agency staff whose Direct Care Ethics/Individual Rights training is current at time of service provision. Denominator-Number of agency staff files reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

Percent of agency staff whose HIPAA/Confidentiality training is current. Numerator-
number of agency staff whose HIPAA/Confidentiality training is current
Denominator-Number agency staff files reviewed.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

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

		Interval = 95%
Other Specify: UMC	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Percent of agency staff whose CPR training is current. Numerator-Number of agency

staff whose CPR training is current at time of service provision. Denominator-
Number of agency staff files reviewed.

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 Confidence Interval = <div>95%</div>
Other Specify: <div>UMC</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Sub-State Entity	Quarterly
Other Specify: <div>UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:**Percent of agency staff whose Person-Centered Support skills training is current****Numerator= Number of agency staff whose Person-Centered skills training is current****Denominator = Number of agency staff files reviewed****Data Source** (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

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

	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; padding: 2px;">UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

Performance Measure:

Percent of agency staff whose First Aid training is current. Numerator-Number of agency staff whose First Aid training is current at time of service provision.
Denominator-Number of agency staff files reviewed.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>UMC</div>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

- 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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The Operating Agency collects all information related to this assurance through the review of individuals receiving services 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. The Operating Agency must approve all Corrective Action Plans. Services provided that are not documented on the service plan are disallowed, and payment is recouped from the provider agency.

The Bureau for Medical Services (BMS) is responsible for building and maintaining the Intellectual and/or Developmental Disabilities Waiver's (IDDW's) Quality Improvement System (QIS). The IDDW provider and the Personal Options vendor are responsible for participating in all activities related to the QIS. The IDDW's QIS is used by BMS and the Utilization Management Contractor (UMC) as a continuous system that measures system performance, tracks remediation activities, and identifies opportunities for system improvement. Achieving and maintaining program quality is an ongoing process that includes collecting and examining information about program operations and outcomes for members receiving services, and then using the information to identify strengths and weaknesses in program performance. This information is used to form the basis of remediation and improvement strategies. The QIS is designed to collect the data necessary to provide evidence that the CMS Quality Assurances are being met and to ensure the active involvement of interested parties in the quality improvement process.

In addition to the QIS, BMS also engages the Quality Improvement Advisory (QIA) Council to analyze information from individual problems, identify systemic deficiencies, and implement remediation activities. The QIA Council is the focal point of stakeholder input for the IDDW Program and plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies.

The role of the QIA Council is to advise and assist BMS and UMC staff in program planning, development, and evaluation consistent with its stated purpose. In this role, the QIA Council uses IDDW Performance Indicators as a guide to:

- Recommend policy changes;
- Recommend program priorities and quality initiatives;
- Monitor and evaluate policy changes;
- Monitor and evaluate the implementation of Waiver priorities and quality initiatives;
- Serve as a liaison between the Waiver and interested parties; and
- Establish committees and work groups consistent with its purpose and guidelines.

The Council membership is composed of persons who formerly utilized IDDW services of the IDDW Program, members who currently are utilizing IDDW services (or their legal representatives), service providers, advocates, and other allies of people with intellectual and/or developmental disabilities.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> UMC and Quality Improvement Advisory Council (analysis only by QIA) </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

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.

The three specialized therapy services, Dietary, Physical and Occupational Therapy services, are grouped separately from daily support services such as family-centered supports and day habilitation. This set of three services is limited to 416 units/104 hours per year in combination with each other. For example, an individual may receive 200 units of Physical Therapy, 100 units of Dietary Therapy and 116 units of Occupational Therapy per year, unless granted an exception through the exception request process described below.

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.

Budget Methodology

Each member is assessed annually to determine their individualized budget. Effective for people with anchor dates starting October 1, 2024, budgets will be calculated pursuant to the methodology described in this Section. Under this methodology, a person's individualized budget is based on two components: 1) a "base" budget range that is determined based on the person's age and setting, and 2) "add-on" funding that is determined based on answers relating to the person's functionality provided to the UMC on the most current ICAP. Any add-on amounts that the person qualifies for will be added to the person's base budget range, resulting in the person's final individualized budget for the IPP year. A person may request services that cost up to the top of their individualized budget range but may not use services costing above their individualized budget range, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in this section. These budget ranges will be updated periodically.

The table below describes the base budget ranges and add-on amounts for individuals receiving services for IPP years beginning October 1, 2024.

I/DD Waiver Base Budgets

Natural Family Home under the age of 18: \$38,138 - \$67,425

Natural Family Home over the age of 18: \$61,417 - \$89,608

1 person ISS Personal Options: \$134,515 - \$143,181

2 person ISS: \$141,608 - \$171,706

3 person ISS: \$124,552 - \$145,274

4 person ISS: \$100,632 - \$121,907

I/DD Waiver Add-Ons Information for all living arrangements EXCEPT 1 PERSON ISS

Variable	Add-On Amount	
Adaptive Behavior: Motor Skills (0-4) (ICAP D1)		
Level	Raw Score	
Motor Skills Level 0	39-54	\$0
Motor Skills Level 1	33-38	\$2,206
Motor Skills Level 2	27-32	\$4,412
Motor Skills Level 3	15-26	\$6,617
Motor Skills Level 4	0-14	\$8,823

Adaptive Behavior: Personal Living Skills (0-4) (ICAP D3)

Level	Raw Score	
Living Skills Level 0	37-63	\$0
Living Skills Level 1	30-36	\$3,272
Living Skills Level 2	23-29	\$6,544
Living Skills Level 3	12-22	\$9,817
Living Skills Level 4	0-11	\$13,089

I/DD Waiver Add-Ons Information for 1 PERSON ISS

Variable	Add-On Amount	
Adaptive Behavior: Motor Skills (0-4) (ICAP D1)		
Level	Raw Score	
Motor Skills Level 0	39-54	\$0
Motor Skills Level 1	33-38	\$2,549
Motor Skills Level 2	27-32	\$5,097
Motor Skills Level 3	15-26	\$7,646
Motor Skills Level 4	0-14	\$10,196

Adaptive Behavior: Personal Living Skills (0-4) (ICAP D3)

Living Skills Level 0	37-63	\$0
Living Skills Level 1	30-36	\$3,782
Living Skills Level 2	23-29	\$7,563
Living Skills Level 3	12-22	\$11,345
Living Skills Level 4	0-11	\$15,127

The person will receive notice of his or her budget calculation, which will include an explanation for how the budget was calculated and instructions for seeking services that cost in excess of the budget. The budget calculation is not a decision about the services the person will be eligible to receive.

The IDT must initially make every effort to purchase services for the person receiving services (“person”) within the budget allocated by the UMC. As part of this effort, the IDT should consider, among other things, substituting less expensive services for more expensive services; accessing Medicaid services offered outside of the IDDW program; and determining whether any services covered by private insurance may be helpful to the person.

Once the person receives his or her budget letter, the IDT team will meet with the person to develop the annual IPP. If the person and/or the IDT team develop an IPP that is within budget and otherwise compliant with DoHS policies (e.g., all services are within the service-specific caps), DoHS or their designated UMC will approve the IPP and authorize services consistent with the IPP.

Redetermination Requests

Within 14 days of receiving a budget, if the person or their legal representative believes that a technical error was made (e.g., a typographical error on the assessment); or there has been a change in circumstances since the assessment that is documented pursuant to a Critical Juncture Meeting, then the member or their legal representative will direct the Case Manager to notify the UMC. The UMC will review the redetermination request to determine if there has been a technical error in the assessment process or a change in circumstances warranting a critical juncture. A decision will be made within 20 business days after a redetermination request. The UMC may communicate with the Case Manager and request additional information from the person, legal representative, or case manager, if necessary. If the UMC determines there was a technical error in the assessment or in applying the budget methodology, or if a Critical Juncture Meeting is warranted the UMC may re-calculate the budget. If the UMC finds in a redetermination that a documented change pursuant to a Critical Juncture Meeting and as a result, the person’s budget should be increased, the UMC should as soon as possible send this finding to BMS with a recommendation for the budget increase. BMS will make the final determination as to whether the person’s individualized budget should be increased.

The UMC does not have authority to change or increase the person’s individualized budget during a redetermination, unless it finds that there was an error in the person’s assessment or in BMS’s application of its budget methodology. Otherwise, authorizing services in excess of the individualized budget can only be done by BMS through the “exceptions process”.

If the UMC determines there was no technical error and no change in circumstances, the first level redetermination will be closed. The UMC will inform the individual or his or her legal guardian in writing that the redetermination has been closed and explain the procedures for receiving services within the person’s budget and for pursuing the “exceptions process” with BMS.

If the IDT continues to believe that the UMC has made an error in the person’s assessment or in applying BMS’s budget methodology, the individual may request a Medicaid Fair Hearing on this limited issue. The individual may not, at this juncture, request a Medicaid Fair Hearing on any other issues, including on the sufficiency of the individualized budget in meeting the member’s needs. Before requesting a Fair Hearing on other issues, the member must first complete the “exceptions process” described below.

Exceptions Process

The IDT has an obligation to make every attempt to purchase services it deems necessary within the individualized budget. If the IDT determines after careful consideration that funds beyond the individualized budget are still necessary to avoid a risk of institutionalization, the person and/or the legal representative (or the Case Manager on their behalf), after consultation with the IDT, may submit a request for services in excess of the budget to BMS through the UMC web portal, along with any supporting documentation.

If the person or his or her legal representative believe services in excess of the budget are necessary, they will fill out an additional section of the IPP that reflects all the additional services that person or his or her legal representative believes the person needs. Even if the IDT believes that services in excess of the budget are necessary, the IDT must complete the primary section of the IPP and specify services that can be purchased within the person's individualized budget. No services for the IPP year will be authorized unless this primary section is completed. The person or their legal representative must sign off on the request for services in excess of the budget. Services requested in excess of the budget, described in the additional section of the IPP, cannot be authorized unless and until an exception is approved through the exceptions process.

An "exceptions process" request for services exceeding the person's individualized budget is clinically researched and reviewed by BMS. Such request may also be negotiated between the person or their legal representative, the Case Manager/IDT and BMS. A panel of three individuals employed by DoHS or its contractor will review the "exceptions" request to determine if any errors were made in the service authorization process, including if any technical errors were made in the assessment, and/or if funds in excess of the budget are needed to purchase clinically appropriate services necessary to prevent a risk of institutionalization. At least one individual on the panel will have medical training. A decision will be made by the Exceptions Panel within 20 business days after the Exceptions Panel has received submission explaining the basis for the exceptions request with any/all supporting documentation.

The individual seeking additional services through the "exceptions process" has the burden of showing that services in excess of the individualized budget are necessary to avoid a risk of institutionalization. To make this showing, the person or his legal representative must provide a clear explanation on the "exceptions process" request as to which additional services are requested and why they are necessary to prevent a risk of institutionalization and may provide documentation to support his or her position. All documentation must be attached/enclosed/provided if the person would like BMS to consider such documents in making its decision during the "exceptions process." Referring to documents on the "exceptions process" form is NOT sufficient; any documents the person would like BMS to consider must be attached to the "exceptions process" form and specific sections highlighted for BMS to review.

In determining whether the person has met his or her burden to receive services in excess of the budget, the three-person panel shall consider, among other things:

- The person's most recent ICAP, Structured Interview, and all IPPs from the current year.
- Any information provided by the person in his or her application for an exception.
- The feasibility of rearranging services within the person's budget.
- The availability of less expensive services that can be substituted for more expensive services.
- The availability of services covered outside the IDDW program by Medicaid or by private insurance.
- The natural supports (if any) available to the person, and limitations on those supports.

If BMS concludes that the person has demonstrated that funds in excess of the individualized budget are necessary to prevent a risk of institutionalization, BMS will authorize funds in excess of the budget to the extent necessary to keep the person safe and healthy and avoid a risk of institutionalization, and the IPP will be finalized. If BMS determines that the person did not demonstrate that funds in excess of the individualized budget are necessary to avoid a risk of institutionalization, BMS will not authorize funds in excess of the budget. If BMS determines that an error was made in the service authorization process, it will take steps necessary to correct the error.

If, during the "exceptions process", BMS determines there was not an error, or that the requested additional services and funding are not warranted, a Letter of Denial will be sent to the person or their legal representative, which will include an explanation as to why the services(s) and funding were denied, how to file for a Medicaid

Fair Hearing and free legal services available. All decisions during the “exceptions process” shall be reviewed and/or issued by BMS.

As is stated in the Letter of Denial, a person will have the ability to appeal the decision made through the Exceptions Process by requesting a Medicaid Fair Hearing. The hearing officer will apply the same standard applied by BMS’s exceptions process panel, i.e., whether the person has met his or her burden of showing that services in excess of the individualized budget are necessary to avoid a risk of institutionalization.

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 in which 1915(c) HCBS are received. *(Specify and describe the types of settings in which waiver services are received.)*

HCBS are received in provider-controlled/owned and member-controlled settings. Member-controlled settings are defined as homes or apartments owned or leased by an HCBS member or by one of their family members. Provider-controlled/ owned settings are settings where a member resides with a paid unrelated caregiver or with an agency provider who provides HCBS services the majority of the day. Any day settings, such as IDDW facility-based Day Habilitation sites, are defined as provider-controlled setting The BMS applies the same methodology to assess and remedy both provider-owned and provider-controlled settings, as described in the February 17, 2023, CMS approved Statewide Transition Plan. The following are considered provider-controlled/owned settings: Residential Settings Licensed by OHFLAC. Specialized Family Care Homes, and any day settings, such as IDDW facility-based Day Habilitation sites, are defined as provider-controlled/owned settings.

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 in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

All waiver agencies will be contacted annually to verify the settings owned, leased, or operated by the provider agency. It is the responsibility of the agency to notify BMS of any change in status (e.g., sites are added or removed). When a new setting is added, BMS, or its designee, must review the site to ascertain the site complies before any HCBS may be billed. All home- and community-based settings must have the following qualities, and such other qualities based on the needs of the individual as indicated on their person-centered plan:

The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community—including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community—to the same degree of access as individuals not receiving Medicaid HCBS. The setting is selected by the individual from among setting options, including non-disability-specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. The setting ensures the individual's rights of privacy, dignity and respect, and freedom from coercion and restraint. The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact. The setting facilitates individual choice regarding services and supports and who provides them.

The Case Management Monthly Contact form prompts the Case Manager to ask if the member has moved to a new home/apartment or if there have been changes to the setting that need to be evaluated.

If it is determined that a setting does not meet requirements, the Case Manager will assist the member to remediate the identified issue(s), including transitioning to a setting that does meet requirements. A member who chooses not to comply with the HCBS settings requirements risks losing their services. Provider-controlled settings include (1) a member residing in a home of a paid unrelated caregiver; (2) a member residing in a home that is owned or managed by a provider agency; and (3) an adult Medical Day Care facility. All provider-controlled settings are evaluated by BMS or its designee and the Utilization Management Contractor (UMC) initially and annually thereafter using the approved Provider-Controlled Setting Assessment to ascertain that the setting meets the HCBS settings requirements. The Case Management Monthly Contact form prompts the Case Manager to ask whether the member has moved to a new home/apartment or if there have been changes to the setting that need to be evaluated. If a provider-controlled setting is determined to be noncompliant with any settings requirements, BMS and/or the UMC will provide technical assistance with remediation to attain compliance. A member or provider agency that chooses not to comply with the HCBS settings requirements risks losing services or enrollment as a provider agency.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. (see Appendix D-I-d-ii)

Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

Facilitates individual choice regarding services and supports, and who provides them.

Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.

Provider-owned or controlled residential settings. (Specify whether the waiver includes provider-owned or controlled settings.)

No, the waiver does not include provider-owned or controlled settings.

Yes, the waiver includes provider-owned or controlled settings. (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

Each individual has privacy in their sleeping or living unit:

Units have entrance doors lockable by the individual.

Only appropriate staff have keys to unit entrance doors.

Individuals sharing units have a choice of roommates in that setting.

Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

Individuals have the freedom and support to control their own schedules and activities.

Individuals have access to food at any time.

Individuals are able to have visitors of their choosing at any time.

The setting is physically accessible to the individual.

Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan (*see Appendix D-1-d-ii of this waiver application*).

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individualized Program Plan

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. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. (*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:

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Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:*

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

a. The OA/UMC notifies members of all available providers and services upon application. The member signs a Freedom of Choice form and identifies their preferred provider, which will be forwarded to the provider of choice. The member is also informed that they may choose to receive services from a different provider of their choosing at any time while receiving services.

b. WV utilizes the following criteria to make determinations regarding geographical exceptions:

(1) The number of conflict-free case managers could not meet the capacity for the number of members in the geographical area.

(2) The number of conflict-free case managers certified by waiver type could not meet the capacity to serve members by waiver type.

(3) Only one provider agency or case management agency serves the geographical area, eliminating the member's opportunity for choice of Case Manager.

(4) There were no other willing and qualified providers of HCBS services or case management services in a geographical area.

Members will be given the opportunity to file a grievance/complaint. OA/UMC oversees grievances/complaints by the members and providers. A member will contact the OA/UMC to dispute the state's assertion that there is not another entity or individual that is not that member's provider to develop the person-centered service plan. The OA/UMC approves applications for exceptions after thorough vetting, including requests for additional information, if needed. Exceptions are awarded for one year, unless another willing and able provider becomes available, to provide agencies with sufficient program operation time before revisiting the continued need for an exception. During the one-year exception period, BMS or its designees have the right to review agency policies and operations.

c. WV will monitor the CFCM process via retro-reviews conducted by the state OA/UMC and may periodically request additional reports from the OA/UMC.

d. WV restricts the entity that develops the person-centered service plan from providing services without the direct approval of the state. The BMS will allow for cultural and geographical exceptions based on the availability of willing and qualified providers in the member's catchment area. If a member disagrees with the BMS regarding the availability of willing and qualified providers, this may be grieved through the OA/UMC.

e. For providers granted an exception to the conflict-free requirements, the State has ensured conflict of interest protections, certifying that case managers employed by that provider remain neutral during the development of the person-centered service plan and including the requirement that the provider separate direct care services and case management into distinct functions, with separate oversight.

(1) Case management agencies must have a policy to ensure there will not be a conflict of interest if an exception has been made.

a. Include a basic description of the duties of the HCBS services supervisor(s) and the case management supervisor(s).

b. Explain how case managers are selected.

c. Explain how members are given a choice of HCBS services and other natural supports or services offered in the community.

d. Explain how the agency ensures that the Case Manager is free from the influence of direct service providers regarding member care plans.

(2) Any Case Manager working for a case management agency that will also be providing personal attendant services will need to sign a CM Conflict of Interest Assurance form.

a. The completed and signed form must be placed in the member file at the CM Agency. Failure to have the form in the file when reviewed will result in sanctions.

(3) Evidence of administrative separation on organizational chart that includes position titles and names of staff.

(4) Attestation/Conflict of Interest Exception Application for Home- and Community-Based Waiver Services by agency owner/administrator of the following:

a. The agency has administrative separation of supervision of case management and HCB services.

b. The attached organization chart shows two separate supervisors, one for case management and one for HCB services.

c. Case management members are offered choice for HCB services between and among available service providers.

d. Case management members are not limited to HCB services provided only by this agency.

e. Case management members are given choice of case managers within the agency.

f. Disputes between case management and HCB services units are resolved.

g. Members are free to choose or deny HCB services without influence from the internal agency case manager and HCB

service staff.

h. Members choose how, when, and where to receive their approved HCB services.

i. Members are free to communicate grievance(s) regarding case management and/or HCB services delivered by the agency.

j. The grievance/complaint procedure is clear and understood by members and legal representatives.

k. Grievances/complaints are resolved in a timely manner.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;

An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;

Direct oversight of the process or periodic evaluation by a state agency;

Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and

Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

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.

(a) The supports and information that are made available to the member and their legal representative (if applicable) to direct and be actively engaged in the service plan development process is provided by the UMC at the time of their initial visit 3 to 6 months prior to receiving a funded slot and annually thereafter. During the visit from the UMC, the member and their legal representative (if applicable) are given education and materials on Person Centered Planning, the Interdisciplinary Team (IDT) membership and the team's role in the development of the IPP and the information is discussed and questions answered. At minimum, the composition of the IDT must consist of the member and their legal representative (if applicable) and their case manager. The member may choose whoever they wish to attend their meeting, but a representative of all agencies/providers who provide services to the person must also attend. The IDT team meeting is a process by which the case manager facilitates the meeting for the person and their legal representative (if applicable); however, the case manager should only lead the meeting if asked to by the member or their legal representative (if applicable). The IDT process is collaborative, with the member and their legal representative. If applicable, other providers who serve the member (as well as other people the member has invited to participate on his/her behalf) to develop a person-centered Individualized Program Plan (IPP).

(b) The member and their legal representative (if applicable) have the authority to determine who is included in the process. The member and their legal representative (if applicable) have the authority to determine the membership of his/her IDT. It is recognized that any agency providing services to the member are a valuable part of planning for services and must be included to ensure that their agencies are represented but of equal importance are people the member wants to attend who are not paid to provide services.

Appendix D: Participant-Centered Planning and Service Delivery

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

- d. **i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. 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. The Service Plan is referred to as the Individual Program Plan (IPP). The IPP is an outline of proposed activities that focus on the establishment of a potentially life-long, person-centered, goal-oriented process for coordinating the range of services, instruction and assistance needed by the member with an intellectual and/or developmental disability. The IDT process is designed to ensure accessibility, accountability, and continuity of support and services. The IDT process also ensures that member with a intellectual and/or developmental disability has opportunities to make meaningful choices with regard to their life and inclusion in the community. The IPP is the critical document that combines all information from the evaluations to guide the service delivery process as well as information from people who know the member outside the service delivery system. The development of the IPP is the process by which the member and their legal representative (if applicable) lead the meeting with the help of a case manager who facilitates the meeting. The member and their legal representative (if applicable) with assistance from other team members will develop a plan based on a person-centered philosophy. The IDT is comprised of the member and their legal representative (if applicable) and his/her "Circle of Support". The circle of support must include the Case Manager and all other agencies that provide paid supports to the member. The circle of support may include other people the member wants to invite. Some suggestions are other professionals, direct care providers, family members, and significant friends and acquaintances in the member's life with and without a vested interest in the member. At minimum, the IDT must consist of the member and their legal representative (if applicable, the member's case manager and any IDDW agencies providing paid support to the member. The content of the IPP must be guided by the member's needs, wishes, desires, and goals. The team which is led by the member and their legal representative (if applicable) with assistance from the member's case manager collaborates in the IPP meeting for the purpose of review of assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support, outline of service options and training goals, and preparation of interventions or strategies necessary to implement a person-centered plan. The case manager assumes the role of Facilitator; however, the team is directed by the member and their legal representative (if applicable) utilizing a person-centered approach to planning. The Individual Program Plan includes the development of the initial IPP, annual IPP and subsequent reviews or revisions of the IPP (to include quarterly reviews as warranted).
- b. The case manager will compile assessment and evaluation results, at least annually, for incorporation into the IPP. The case manager will ensure assessments and evaluations are discussed during IPP meetings to address needs and incorporate recommendations. Evaluations include any significant medical, physical therapy, occupational therapy, speech, nutritional, nursing evaluations, behavior support evaluations/assessments, and/or quality of life assessments, in addition to an annual functional assessment administered by the UMC.
- c. The UMC at the time of the annual assessment provides the member and their legal representative (if applicable) education and materials about the available services under the waiver program and available provider agencies in their geographic area, which would include completion of the Freedom of Choice form. A handbook is also made available to each member that contains the services offered under the waiver program.
- d. The IPP must be based upon person-centered philosophy. The development of the IPP by the IDT must be guided by the member's needs, wishes, desires, and goals as well as address the needs that are identified in assessments and evaluations. The composition of the team must include the member and legal representative (if applicable), the case manager and other IDDW agencies that provide paid supports to the person. People the member wants to include who are not paid to provide services may also be invited by the member. The case manager has the responsibility for ensuring that the member's goals, needs and preferences as well as the needs that are addressed in the assessment and evaluations are addressed. Another safeguard is that the UMC will monitor health and safety as it relates to request for service authorizations and assure that service needs are addressed through individual service requests.
- e. The IPP specifies services requested by the member and the party responsible for securing and/or offering the service designated on the IPP. The IPP is distributed to all members of the IDT within fourteen calendar days. The case manager is responsible for ensuring that service providers implement the content of the IPP.
- f. The IPP format specifically addresses the service, frequency of the service, and the responsible party for delivering the services. The case manager is required to personally, meet monthly with members living in a 24 hour setting and/or Specialized Family Care setting, and their paid or natural supports that are present with the member the time of the visit, at the member's residence to verify that services are being delivered in a safe environment, in accordance with the IPP and appropriately documented. The purpose of these visits is to determine progress toward obtaining services and resources, assess achievement of training objectives, and identification of unmet needs. The visit is documented on the case manager Home/Day Visit Form (WV-BMS-IDD-03).

The CM will meet quarterly in-person and electronically all other months with members living in a natural family setting, and their paid or natural supports that are present with the member the time of the visit, at the member's residence to verify that services are being delivered in a safe environment, in accordance with the IPP and appropriately documented. The purpose of these visits is to determine progress toward obtaining services and resources, assess achievement of training objectives, and identification of unmet needs. The visit is documented on the case manager Home/Day Visit Form (WV-BMS-IDD-03).

The CM will also personally meet at least quarterly with the member and their support staff at the member's facility-based day program or vocational skills development center (if applicable). The purpose of these visits is to determine progress toward obtaining services and resources, assess achievement of training objectives, and identification of unmet needs. The visit is documented on the case manager Home/Day Visit Form (WV-BMS-IDD-03).

CM Visits to Supported Employment sites should occur only as necessary, such as to remedy a problem identified at the site. CMs should avoid disrupting a person's ability to work in an integrated setting as much as possible.

g. The Individual Program Planning includes the development of the initial IPP, annual IPP and subsequent reviews or revisions of the IPP (to include quarterly reviews and critical junctures as warranted). The IPP is to be developed on an annual basis. Minimally, the annual IPP must be reviewed at six-month intervals. IPP reviews may occur more often if needed. The IDT is also required to convene:

Seven Day IDT Meeting

Seven Day IDT Meeting. This meeting is mandatory when a member receives an IDDW slot. This is the initial meeting that occurs within the first seven calendar days of admission/intake by a new provider agency and must include IDDW services as well as other support services a person needs to live successfully in the community. This IPP document must reflect a full range of planned services: Medicaid, non-Medicaid, and natural supports. This meeting must be documented on the Initial IPP (WV-BMS-I/DD-4) by the Case Manager. If services can be finalized at this meeting and a full range of planned services is documented, the Thirty-Day IDT meeting will not be necessary. The IPP developed during the Seven-Day IDT Meeting may not be effective for more than 60 days without approval from BMS.

Thirty Day IDT Meeting

The Initial IPP must be finalized within 30 calendar days. The resulting IPP (WV-BMS-I/DD-5) completed by the case manager identifies the comprehensive array of services necessary to fully support the member who receives IDDW services. This document must be reviewed annually and at least every 6 months.

Transfer/Discharge IDT Meeting

This meeting is held when a member who receives services transfers from one IDDW provider to another, chooses a different Service Delivery Model, or when the person who receives services no longer meets medical or financial eligibility. The transfer-from agency is responsible for coordinating the meeting and documenting the transfer. The member who receives services or their legal representative, as well as the transfer-to agency, must agree to the transfer. The transfer-from agency must send the resulting IPP to the transfer-to agency within 14 calendar days. The transfer-from agency must also send a Transfer/Discharge Form (WV-BMS-I/DD-10) to the UMC within 7 calendar days. If the resulting IPP is found to be not valid because necessary team members did not attend or necessary services were not addressed, the authorizations may be rolled back to the transfer-from agency until a valid IPP is held.

When a member who receives services transfers from one residential provider to another or from one day setting to another, a 7-day IDT meeting must occur to outline the services and supports needed to successfully access the new setting and services. A Thirty Day IDT must occur to finalize these services. The Case Manager must transfer the member who receives services in the UMC web portal by the effective date of the transfer.

A member who receives services may choose to self-direct their services at any time through the Self- Directed Service Delivery Model by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The case manager will enter the information into the UMC web portal within 2 business days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that can be self-directed will be referred to the Personal Options FMS and a self-directed budget will be developed while all Traditional services will remain with the IDDW provider(s).

A member who receives services may choose to stop directing their own services at any time by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The case manager will enter the information into the UMC's web portal within 2 business days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that were self-directed will be referred to the chosen Traditional service agency who will request authorization for necessary services available under the Traditional service delivery model.

Critical Juncture IDT Meeting

This meeting is held as soon as possible when there is a significant change in assessed needs and/or planned services of the person who receives services. A Critical Juncture may be the result of a change in the medical/physical status, behavioral status, or availability of natural supports. The IPP must be updated to include IDT recommendations, minutes, and signatures of all IDT members indicating their attendance and agreement or disagreement. A face-to-face meeting must be held under any of the following circumstances:

- All team members do not agree with services or service mix.
- A new goal will be implemented for the person who receives services.
- The team is discussing implementation of a Positive Behavior Support plan, where one was not previously required.
- The person who receives services changes residential setting (example: moves from Natural Family to ISS);
- The person who receives services and lives in an ISS, group home or Specialized Family Care Home moves to a different location.
- The person who receives services goes into crisis placement,
- The person who receives services has a change in legal representative status, • The primary caregiver changes or passes away,
- The person who receives services elects to change Service Delivery Model, and or,
- A new service not previously received is added.

Annual, Quarterly, and Six-Month IDT Meetings

The IDT must meet in the calendar month prior to the annual anchor date to develop the IPP. The effective date of the annual IPP will remain the annual anchor date even if the IPP was held 30 days earlier. The anchor date sets the clock for scheduling all subsequent IPPs. The IPP must be reviewed and approved by the IDT at least every three months unless otherwise specified in the plan, however the time between reviews shall not exceed six months. The IPP must be reviewed at Critical Juncture meetings. Medley Class Members are required to have IDT meetings every quarter, however, the Medley Advocate may choose to only attend the Annual and Six-Month IDT meetings.

- ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:

A specific and individualized assessed need for the modification.

Positive interventions and supports used prior to any modifications to the person-centered service plan.

Less intrusive methods of meeting the need that have been tried but did not work.

A clear description of the condition that is directly proportionate to the specific assessed need.

Regular collection and review of data to measure the ongoing effectiveness of the modification.

Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

Informed consent of the individual.

An assurance that interventions and supports will cause no harm to the individual.

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.

Risks are assessed at the time of the IPP development utilizing annual functional assessments conducted by the UMC and other assessments completed by providers. The IPP requires a detailed description of the contingency plans that are to be implemented in case of an emergency. Per WV waiver policy, each IPP must have a contingency plan for emergencies - Crisis Plan in the event of unexpected events (i.e. primary caretaker in the family becomes incapacitated, power outages, inclement weather, natural disasters, healthcare epidemics such as the flu). Each member will have a backup plan to address the failure of staff to appear when scheduled to provide necessary services when the absence of the service would present a risk to the person's health and welfare. If an person wishes to access Electronic Monitoring, there is an additional Risk Assessment that must be completed, reviewed and approved by the IDDW provider's Human Rights Committee.

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.

When the applicant is informed that a funded slot is available, the UMC meets with the applicant and their legal representative (if applicable) prior to the date the funded slot will become available. The UMC provides the Freedom of Choice (FOC) Form at this meeting to the applicant and their legal representative (if applicable) in order to choose between Home and Community Based Services and ICF/IID services. This form also allow the applicant to choose a case management agency that serve the county where the applicant resides. The applicant may also choose other agencies to provide all other services, such as Day Services or residential services. This form also allows the applicant to choose a program option: Traditional Option or the self-directed option, Personal Options. This same function is performed by the UMC during the annual functional assessment. The member or their legal representative (if applicable) may initiate a change in the FOC at any time. The Freedom of Choice form and a list of the IDDW providers by county with contact information is available on the UMC and BMS websites. Members may also call the UMC for a list of agencies that provide services in their community. Information related to the Personal Options model is also available to the member/legal representative and is located on the UMC and BMS websites.

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):

It is the responsibility of the Case Manager to upload the IPP into the UMC web portal prior to requesting authorizations for services. The UMC will review the IPP to determine that requested services are listed on the IPP prior to issuing authorizations for payment. No services can be reimbursed by the Claims Payer unless there is a current prior authorization in place for the billed service. As a part of the Quality Improvement System, UMC staff will review a sample of IPPs that is representative of the demographic makeup of the waiver population. The annual review process includes assessment of individual IPPs for person-centered planning requirements. Each IDDW provider agency has at least 10% of files reviewed every other year. BMS meets with the UMC monthly to review audits conducted and to finalize a Final Disallowance Report, which is sent to the IDDW provider along with Remittance Forms and payment options to repay BMS for disallowed services.

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, when the individual's circumstances or needs change significantly, or at the request of the individual, 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

Case manager

Other

Specify:

Each IDDW provider agency currently providing or has provided services to the member is required to maintain a copy of the service plan and billing/financial information for a minimum of five years. The Personal Options vendor is responsible for maintaining a copy of participant-directed spending plans for a minimum of five years. Any record that is disputed or under investigation must be maintained until the issue is resolved.

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, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Case Manager is required to conduct at least monthly contacts regardless of the service delivery options chosen by the member. The primary purpose of this contact is to verify that services are being delivered in accordance with the IPP in a safe environment. Information obtained through these contacts with the member and their legal representative (if applicable) will be used by the Case Manager to update progress towards obtaining services and resources and discuss progress toward achieving objectives outlined in the IPP. The Case Manager will also elicit information from the member and their legal representative (if applicable) on their assessment of services, achievements, and/or unmet needs. The Case Manager will also evaluate the effectiveness of back-up plans for staffing needs and emergency circumstances.

Any concern related to the member's health and safety must be reported through the WV Incident Management System (IMS). The UMC will review a representative sample of service plans at a minimum bi-annually to monitor compliance and identify systemic problems/trends.

b. Monitoring Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation. *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

The Case Manager has the primary responsibility for the development of the IPP, facilitating the IDT Meeting and evaluating the implementation of the IPP and service delivery under all service delivery options (Traditional and Personal Options). These responsibilities allow the Case Manager to monitor the health and welfare of the person. There is an additional health and welfare safeguard through the UMC which conducts on-site provider reviews. The UMC also conducts desk audits of staff credentialing as monitored during provider self-reviews.

The UMC will prior authorize all services with the claims agent including responding to emergency requests for service changes resulting from critical junctures--i.e. medical, behavioral or other emergent needs. The UMC will monitor health and welfare as it relates to requests for service authorizations.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the member.

Specify:

a. The OA/UMC notifies members of all available providers and services upon application. The member signs a Freedom of Choice form then identifies their preferred provider, which will be forwarded to the provider of choice. The members are also informed that they may choose to receive services from a different provider of their choosing at any time while receiving services.

b. WV utilizes the following criteria to make determinations regarding geographical exceptions:

(1) The number of conflict-free case managers could not meet the capacity for the number of members in the geographical area.

(2) The number of conflict-free case managers certified by waiver type could not meet the capacity to serve members by waiver type.

(3) Only one provider agency or case management agency serves the geographical area, eliminating the member's opportunity for choice of Case Manager.

(4) There were no other willing and qualified providers of HCBS services or case management services in a geographical area.

Members will be given the opportunity to file a grievance/complaint. OA/UMC oversees grievances/complaints by the members and providers. A member will contact the OA/UMC to dispute the state's assertion that there is not another entity or individual that is not that member's provider to develop the person-centered service plan. The OA/UMC approves applications for exceptions after thorough vetting, including requests for additional information, if needed. Exceptions are awarded for one year, unless another willing and able provider becomes available, to provide agencies with sufficient program operation time before revisiting the continued need for an exception. During the one-year exception period, BMS or its designee has the right to review agency policies and operations.

c. WV will monitor the CFCM process via retro-reviews conducted by the state OA/UMC and may periodically request additional reports from the OA/UMC.

d. WV restricts the entity that develops the person-centered service plan from providing services without the direct approval of the state. BMS will allow for cultural and geographical exceptions based on the availability of willing and qualified providers in the member's catchment area. If a member disagrees with the BMS regarding the availability of willing and qualified providers, this may be grieved through the OA/UMC.

e. For providers granted an exception to the conflict-free requirements, the State has ensured conflict of interest protections, certifying that case managers employed by that provider remain neutral during the development of the person-centered service plan and including the requirement that the provider separate direct care services and case management into distinct functions, with separate oversight.

(1) Case management agencies must have a policy to ensure there will not be a conflict of interest if an exception has been made.

- a. Include a basic description of the duties of the HCBS services supervisor(s) and the case management supervisor(s).
 - b. Explain how members are assigned a Case Manager.
 - c. Explain how members are given a choice of HCBS services and other natural supports or services offered in the community.
 - d. Explain how the agency ensures that the Case Manager is free from the influence of direct service providers regarding member care plans.
- (2) Any Case Manager working for a case management agency that will also be providing other waiver services will need to sign a CM Conflict of Interest Assurance form.
- a. The completed and signed form must be placed in the member file at the CM Agency. Failure to have the form in the file when reviewed will result in sanctions.
- (3) Evidence of administrative separation on organizational chart that includes position titles and names of staff
- (4) Attestation/Conflict of Interest Exception Application for Home and Community-Based Waiver Services by agency owner/administrator of the following:
- a. The agency has administrative separation of supervision of case management and other waiver services.
 - b. The attached organizational chart shows two separate supervisors, one for case management and one for other waiver services.
 - c. Case management members are offered choices among available providers.
 - e. Case management members are provided case managers within the agency.
 - f. Disputes involving case management and other waiver providers are resolved.
 - g. Members are free to choose or deny other waiver services without influence from the internal agency Case Manager
 - h. Members choose how, when, and where to receive their approved waiver services.
 - i. Members are free to communicate grievance(s) regarding case management and/or other waiver services delivered by the agency.
 - j. The grievance/complaint procedure is clear and understood by members and legal representatives.
 - k. Grievances/complaints are resolved in a timely manner.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;

An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;

Direct oversight of the process or periodic evaluation by a state agency;

Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and

Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

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'½ 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:

Percent of files of people receiving services whose service plan reflected the person's desired outcomes
Numerator-Number of files of people receiving services whose service plan reflected desired outcomes
Denominator-Number of files reviewed

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 Confidence Interval = <div>95%</div>
Other Specify: <div>UMC</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
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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: <div style="border: 1px solid black; padding: 5px; width: 100%;">UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

Performance Measure:

Percent of files of people receiving services whose service plan reflected assessed needs. Numerator-Number of files of people receiving services reviewed whose service plan reflected assessed needs. Denominator-Number of files reviewed.

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 Confidence Interval = <div>95%</div>
Other Specify: <div>UMC</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

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: <div>UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

Percent of files of people receiving services whose service plan reflected identified health and safety risks. Numerator-Number of files of people receiving services whose service plan reflected identified health and safety risks. Denominator-Number of files reviewed.

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 Confidence Interval = <div>95%</div>
Other Specify: <div>UMC</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: 150px; margin-top: 5px;">UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 5px;"></div>

- b. Sub-assurance:** *Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.*

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:** *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:

Percent of files of people receiving services whose service plans were updated at least

annually and revised as needed Numerator-Number of files of people receiving services whose service plans were updated at least annually and revised as needed
Denominator-Number of files reviewed

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 Confidence Interval = <div>95%</div>
Other Specify: <div>UMC</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

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 Specify: <div style="border: 1px solid black; padding: 2px; width: 150px; margin-top: 5px;">UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>

d. Sub-assurance: Participants are afforded choice 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:

Percent of files of people receiving services reviewed that reflected the type, scope, duration, amount, and frequency of services specified in the Service Plan Numerator-Number of files of people receiving services reviewed that reflected the types, scope, duration, amount and frequency of services specified in the Service Plan Denominator-Number of files reviewed

Data Source (Select one):

Record reviews, off-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 Confidence Interval = <div>95%</div>
Other Specify: <div>UMC</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>UMC</div>	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):
	<div style="border: 1px solid black; height: 30px; width: 100%;"></div>

e. 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:

Percent of files of people receiving services reviewed that had a signed and current Freedom of Choice form designating a Service Delivery Model Numerator-Number files of people receiving services reviewed with a signed and current Freedom of Choice form designating a Service Delivery Model Denominator-Number of files reviewed

Data Source (Select one):

Record reviews, off-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 Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block;">95%</div>
Other Specify:	Annually	Stratified Describe Group:

<div> <div>UMC</div> </div>		<div> <div></div> </div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

Percent of files of people receiving services reviewed with a signed and current Freedom of Choice form designating a Service Coordination Agency Numerator-Number of people receiving services reviewed with a signed and current Freedom of Choice form designating a Service Coordination Agency Denominator-Number of files reviewed

Data Source (Select one):**Record reviews, off-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 Confidence Interval = <div>95%</div>
Other Specify: <div>UMC</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> UMC	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The Operating Agency collects all information related to this assurance through the review of individuals receiving services 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. The Operating Agency must approve all Corrective Action Plans. Services provided that are not documented on the service plan are disallowed, and payment is recouped from the provider agency.

The Bureau for Medical Services (BMS) is responsible for building and maintaining the Intellectual and/or Developmental Disabilities Waiver's (IDDW's) Quality Improvement System (QIS). The IDDW provider and the Personal Options vendor are responsible for participating in all activities related to the QIS. The IDDW's QIS is used by BMS and the Utilization Management Contractor (UMC) as a continuous system that measures system performance, tracks remediation activities, and identifies opportunities for system improvement. Achieving and maintaining program quality is an ongoing process that includes collecting and examining information about program operations and outcomes for members receiving services, and then using the information to identify strengths and weaknesses in program performance. This information is used to form the basis of remediation and improvement strategies. The QIS is designed to collect the data necessary to provide evidence that the CMS Quality Assurances are being met and to ensure the active involvement of interested parties in the quality improvement process.

In addition to the QIS, BMS also engages the Quality Improvement Advisory (QIA) Council to analyze information from individual problems, identify systemic deficiencies, and implement remediation activities. The QIA Council is the focal point of stakeholder input for the IDDW Program and plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies.

The role of the QIA Council is to advise and assist BMS and UMC staff in program planning, development, and evaluation consistent with its stated purpose. In this role, the QIA Council uses IDDW Performance Indicators as a guide to:

- Recommend policy changes;
- Recommend program priorities and quality initiatives;
- Monitor and evaluate policy changes;
- Monitor and evaluate the implementation of Waiver priorities and quality initiatives;
- Serve as a liaison between the Waiver and interested parties; and
- Establish committees and work groups consistent with its purpose and guidelines.

The Council membership is composed of persons who formerly utilized IDDW services of the IDDW Program, members who currently are utilizing IDDW services (or their legal representatives), service providers, advocates, and other allies of people with intellectual and/or developmental disabilities.

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px;">UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px;"></div>

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.

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.

WV utilizes the sole Government sub-agent Fiscal/Employer Agent Financial Management Service vendor model for the participant-directed service option, hereafter referred to as the Personal Options vendor. This option is available to every eligible IDDW individual with the following exception - people living in OHFLAC licensed residential settings. A person may appoint a representative who may or may not be their legal representative, to assist them in self-directing their services (hereby referred to as "representative"). The Personal Options program provides each person and representative (if applicable) with the opportunity to exercise choice and control over the participant-directed services they receive and the individuals and organizations who provide them (employer authority); and/or how the portion of their individualized budget associated with participant-directed services (i.e., their participant-directed budget) will be spent (budget authority). The seven (7) participant-directed services over which individuals and their representative (if applicable) will have the opportunity to exercise choice and control are:

- Family Person-Centered Support
- Home-Based Person-Centered Support
- Unlicensed Residential Person-Centered Support
- In-Home Respite
- Out-of-Home Respite
- Non-Medical Transportation
- Participant-directed Goods and Services
- Environmental Accessibility Adaptations - Home and Vehicle
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Dietary Therapy

With the Personal Options program, the person is the common law employer of the qualified support workers he or she hires directly. The Personal Options vendor acts as the employer agent to the common law employer. The Personal Options vendor is responsible for managing the receipt and distribution of the person's participant-directed budget funds, processing and paying qualified support workers' payroll, vendors' invoices for approved participant-directed goods and services, providing orientation at the time of enrollment in the Personal Options program and ongoing training and support to the person and their representative (if applicable) and their workers as appropriate.

The costs of administrative services provided by the Personal Options vendor are based upon a per-member-per-month (PMPM) rate which qualifies for the Federal Medical Assistance Percentage (FMAP) match and are not deducted from the person's participant-directed budget.

The Utilization Management Contractor (UMC) will complete an annual functional assessment as part of the annual re-determination evaluation for each eligible IDDW person. The annual re-determination assessment will generate an individualized budget for each eligible person. The individualized budget represents the total IDDW funds available for the planning and purchase of all services and supports for a person based on their current assessed needs. Additional services can be authorized if the person's needs change. The Personal Options program permits a person to cash out only the Medicaid funds associated with their participant-directed services and supports to create a participant-directed budget for each eligible person. There is an education component as part of the annual re-determination evaluation conducted by the UMC with each person and their representative (if applicable). The educational component provides the person and representative (if applicable) with information on all services and service options available in the IDDW (both Traditional and Personal Options), the roles, responsibilities of and potential liabilities for each of the key stakeholders related to the delivery and receipt of these services (i.e., the person and representative (if applicable), Personal Options staff, the UMC, the Case Management agency, other providers of IDDW services to the person and BMS); in order to inform their decision-making concerning the election of participant-directed services. It also will provide contact information for all service providers, including Personal Options. The person and legal representative (if applicable) will complete the Freedom of Choice form during the annual re-determination assessment and if Personal Options is chosen, then a referral will be sent to the Personal Options agency and the person or their legal representative will be contacted within five (5) business days to begin the enrollment process. A person and legal representative (if applicable) may complete a Freedom of Choice form at any time and may obtain the form from their Case Manager or from the BMS website.

In addition, the person and legal representative (if applicable) will have the opportunity to receive Information and Assistance (I&A) directly from the Personal Options agency by calling a toll-free number or accessing the information from the BMS website.

West Virginia is using the sole Government sub-agent Fiscal/Employer Agent Financial Management Service vendor model (Personal Options) that delegates certain F/EA FMS tasks to a sub-agent selected through a Request for Proposal (RFP) process and under contract to the West Virginia Bureau for Medical Services (BMS). West Virginia has delegated

the execution and management of limited Medicaid provider agreements with qualified support workers through a provider contract executed between BMS and the Personal Options agency.

Under this model, the person is the common law employer of the qualified support workers he/she hires directly. The person and representative (if applicable) have the opportunity to:

- Elect the participant-directed option
- Recruit and hire his /her qualified support worker.
- Provide required and participant-specific training to qualified support worker(s).
- Determine qualified support workers work schedule and how and when the qualified support worker should perform the required tasks.
- Supervise qualified support workers daily activities.
- Evaluate his/her qualified support worker's performance.
- Review, sign and submit qualified support worker's time sheets to the Personal Options vendor.
- Discharge his/her qualified support worker, when necessary.
- Work with his/her Case Manager (CM) to develop an emergency qualified support worker back-up plan to ensure staffing, as needed.
- Notify his/her CM of any changes in service need.

As mentioned earlier, the Personal Options vendor is not the employer of the person's qualified support worker(s). Rather, the Personal Options vendor is the employer agent to the common law employer (who is the person) performing all that is required of an employer for wages paid on their behalf and all that is required of the payer for requirements of back-up withholding, as applicable. The Personal Options vendor operates under §3504 of the IRS code, Revenue Procedure 80-4 and Proposed Notice 2003-70, applicable state and local labor, employment tax and workers compensation insurance and Medicaid program rules, as required. In addition, the Personal Options Vendor:

- Acts as a bank and receives, disburses and tracks public funds on behalf of the individual;
- Monitors the person's use of public funds including any underage/overage in accordance with person's approved spending plans;
- Develops and manages a customer service system for individuals/representative (e.g., provides a toll free phone, TTY and fax numbers);
- Provides information in alternate formats and provides foreign and American Sign Language interpreter services;
- Manages a call and complaint system that receives, tracks and resolves complaints and links with all mandatory reporting systems;
- Conducts and analyzes the results of satisfaction surveys;
- Conducts paper and/or web-based budget reporting;
- Assists the person/representative in enrolling with the Personal Options vendor by assisting with the completion and submission of support worker's employment forms and maintaining copies in the appropriate files;
- Assists in/conducts state and federal fingerprint-based checks and Federal Office of the Inspector General Medicaid Exclusion List checks of prospective qualified support workers;
- Assists in verifying qualified support workers citizenship and/or legal alien status;
- Collects, processes and maintains qualified support workers time sheets;
- Processes returned payments (i.e., payroll checks or invoice payments) in accordance with state unclaimed property law;
- Provides the person/representative with orientation and employer skills training (e.g., enrolling and using the Personal Options vendor and employer-related tasks such as, recruiting, hiring, training, managing and discharging qualified support workers, developing emergency qualified support worker backup plans and reporting and managing workplace injuries);
- Generates required financial reports for state and/or local government, as required;
- Implements fiscal accountability and individual protections (e.g., incident/mandatory reporting related to fiscal issues) and implementation of internal controls related to all vendor tasks); and
- Processes and pays invoices for approved participant-directed goods and services.

The Personal Options vendor also will make available Information and Assistance (I&A) services to the person/representative to support the use of participant-directed services and to perform effectively as the common law employer of their qualified support workers. I&A provided by the Personal Options vendor will consist of the following:

- (1) person/representative orientation sessions once the person/representative choose to use participant-directed service and enroll with the Personal Options vendor, and
- (2) skills training to assist person/representatives to effectively use participant-directed services and perform the required tasks of a common law employer of qualified support workers.

The person/representative orientation will provide information on:

- (1) the roles, responsibilities of and potential liabilities for each of the key stakeholders related to the delivery and receipt

of participant-directed services (i.e., person/ representative, the Personal Options vendor, the UMC, the case management agency, other IDDW providers who serve the person and BMS,

(2) how to use the Personal Options program,

(3) how to effectively perform as a common law employer of his/her qualified support service workers,

(4) how to ensure that the person/representative is meeting the requirement of the Personal Options program, and

(5) how an person/representative would stop using the Personal Options program and begin to receive all traditional waiver services, if they so desire.

Skills training curricula will reinforce the IDDW and Medicaid policy, the Personal Options program, federal and state labor, tax and citizenship and legal alien status requirements and provide a review of best practices for performing the tasks required of a common law employer of a qualified support worker (i.e., the person/representative may be having difficulty reviewing, signing and submitting qualified support workers time sheets and skills training could be provided to help them improve their performance completing this task).

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

The Utilization Management Contractor (UMC) will complete an annual functional assessment as part of the annual re-determination evaluation for each eligible IDDW person. The annual re-determination assessment will generate an individualized budget for each eligible person. The individualized budget represents the total IDDW funds available for the planning and purchase of all services and supports for the person based on their current assessed needs. The Personal Options program permits the person to cash-out only the Medicaid funds associated with their participant-directed services and supports to create a participant-directed budget for the person. There is an education component that is part of the annual re-determination evaluation that is conducted by the UMC with each person and their representative (if applicable). The educational component provides the person and representative (if applicable) with information on all services and service options available in the IDDW (both Traditional and Personal Options), the roles, responsibilities of and potential liabilities for each of the key stakeholders related to the delivery and receipt of these services (i.e., the person and representative (if applicable), Personal Options staff, the UMC, the Case Management agency, other providers of IDDW services to the person and BMS in order to inform their decision-making concerning the election of participant-directed services. It also will provide contact information for all service providers, including Personal Options. The person and legal representative (if applicable) will complete the Freedom of Choice form during the annual re-determination assessment and if Personal Options is chosen, then a referral will be sent to the Personal Options agency and the person or their legal representative will be contacted within five (5) business days to begin the enrollment process. The person and legal representative (if applicable) may complete a Freedom of Choice form at any time and may obtain the form from their Case Manager or from the BMS website.

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.

- a. Prior to the award of a funded slot, an applicant and their legal representative (if applicable) will meet with the UMC and receive education on the self-directed program, Personal Options, regarding the benefits of participant-direction, participant responsibilities and potential liabilities. When the person's annual re-determination assessment is conducted by the UMC, the person and their legal representative (if applicable) will again receive education regarding the Personal Options program. The person may ask their Case Manager about the program during routine home visits and information about the Personal Options program is available on the BMS website. BMS, the UMC and Personal Options staff are always available to answer questions and provide technical assistance.
- b. The UMC is responsible for furnishing this information during the educational component of the initial meeting and annually during the re-determination assessment. The educational component will provide people and their representative (if applicable) with information on the self-directed option, Personal Options; the roles and responsibilities of each of the key stakeholders related to the delivery and receipt of Personal Options services (i.e., person, representatives (if applicable), the Personal Options vendor, UMC, the Case Management provider, other IDDW providers who serve the person and BMS); and traditional service options available to them in order to support their choice service models. The UMC is also responsible for fielding questions from people and representative (if applicable) by providing a toll-free telephone number. The Case Manager is responsible for providing this information to the person and their legal representative (if applicable) upon request. BMS and staff of the government FMS vendor are also available to provide information upon request.
- c. Individuals and their legal representative (if applicable) will receive this information at least annually during the annual functional assessment to determine medical eligibility conducted by the UMC.

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*):

Waiver services may be directed by a legal representative of the participant.

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:

Minor children under the age of 18 through their parent or legal representative must appoint a "Program Representative" to assist with the responsibilities of self-directing their services. The Program Representative cannot be the person's legal guardian. Adults without a legal guardian may choose to appoint a Program Representative to assist them. The appointed Program Representative cannot be a paid service provider for the individual. The appointed Program Representative is:

- Restricted to acting on the person's behalf and in a manner that reflects the person's wishes to the extent possible;
- Must complete and sign a Program Representative Appointment Form; and
- Must perform the required Program Representative's tasks which include hiring/supervising workers, approving workers' time-sheets and transportation invoices and completing requests for participant-directed goods and services as needed.

The Personal Options vendor will ensure that the Program Representative is acting in the best interest of the person and fulfilling his/her responsibilities. A Case Manager or the Personal Options vendor staff may submit a complaint with the UMC or BMS to review the Program Representative's ability to act in the best interest of the person. They also must report to the UMC any exploitation of the participant-directed option to benefit someone other than the person.

The Personal Options vendor and/or the UMC staff in consultation with BMS have the right to terminate the assistance and support provided to the person by a Program Representative at any time with documented evidence of abuse, neglect and exploitation of the person.

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.

Waiver Service	Employer Authority	Budget Authority
Occupational Therapy		
Speech Therapy		
Unlicensed Residential Person-Centered Support		
Non-Medical Transportation		

Waiver Service	Employer Authority	Budget Authority
Physical Therapy		
Home-Based Agency Person-Centered Support		
In-Home Respite		
Out-of-Home Respite		
Family Person-Centered Support		
Participant-Directed Goods and Services		
Environmental Accessibility Adaptations		
Dietary Therapy		

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 sole Government sub-agent Fiscal/Employer Agent (F/EA) Financial Management Service (FMS) vendor model (Personal Options) is used by the WV Bureau of Medical Services to perform delegated agent tasks procured through a Request for Proposal process and the execution of a contractual agreement with BMS. The Government F/EA FMS and sub-agent operates under §3504 of the IRS code, Revenue Procedure 80-4 and Proposed Notice 2003-70, applicable state and local labor, employment tax and workers' compensation insurance and Medicaid program rules, as required.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The Government Fiscal/Employer Agent (F/EA) is compensated through an administrative fee established by a competitive procurement (RFP) on a per member/per month (PMPM) basis.

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:

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

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:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

Provide Information and Assistance (I&A) services related to the person/legal/non-legal representative orientation and skills training.
Make available to the person and their Case Manager the person's spending plan and budget utilization data.

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.

BMS will execute a contractual agreement with the Government F/EA FMS vendor known as the Personal Options vendor that has been selected through a Request for Proposal process. The contractual agreement will identify the role and responsibilities of the Personal Options vendor. The contractual agreement will outline the specific requirements for the Personal Options vendor to successfully complete a Readiness Review prior to being approved by BMS to perform as the sub-agent to the Government F/EA FMS provider. The contract will stipulate the oversight methodologies to be implemented by BMS to ensure fiscal responsibility and accountability is achieved by the Personal Options vendor. These methods will include, but not be limited to, the collection and processing of time-sheets, the disbursement of payments, completing proper with-holdings from workers' pay, reporting with-holdings as required by federal and state laws, make available statements (written or electronic) for each person's budget authorization, distributing annual individual satisfaction surveys and completing end of year tax processing. BMS will complete an annual review of the fiscal integrity of the Personal Options vendor and review the satisfaction survey results.

If BMS finds that the Personal Options vendor is not meeting the requirements agreed upon, it may recommend the following options:

- Provide a letter of recommendation to the Personal Options vendor for passing their review and permit the contract to continue
- Provide a letter of completion to the Personal Options vendor for completing their review with technical assistance being provided
- Require a Plan of Correction be completed while continuing to provide Personal Options services.
- Require a Plan of Correction be completed, as well as, disallowances of noted Personal Options vendor administrative reimbursements due to review findings.
- Require a Plan of Correction to be completed with all Personal Options vendor administrative reimbursements being suspended until all identified deficits have been corrected
- Generate notice to discontinue contract initiate transfer support to people using the Personal Options program.

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:

Case Managers (CMs) assist the person upon request with information or links to information related to the Participant-Directed Model (Personal Options), including the benefits and responsibilities of self-directing some of their services. CMs will receive written educational materials regarding the Personal Options program which will be provided to individuals upon request. These materials will also be provided by the UMC during the annual re-determination assessment to ensure unbiased information is being provided.

Case Management activities include but are not limited to:

1. Informing people of the availability of the Personal Options program.
2. Explaining general rights, risks, responsibilities and the person's right to choose the Personal Options program.
3. Assisting in determining if a legal/non-legal representative is desired and/or needed by the person.
4. Providing or linking people with program materials in a format that they can use and understand.
5. Explaining person-centered planning and philosophy to people.
6. Linking people with the Personal Options program for completion of the necessary paper work for Participant-Direction.
7. Explaining to the person the roles and supports that will be available.
8. Reviewing and discussing the person's budget, including the portion of the budget available for participant-direction.
9. Ensuring that people know how and when to notify the Case Manager about any operational or support concerns or questions.
10. Monitoring the person's risk management activities.
11. Ensuring a seamless transition into the Personal Options program if chosen.
12. Coordinating services provided by traditional provider agencies if involved.
13. Notifying the UMC and the Personal Options program of concerns regarding potential issues which could lead to a person's dis-enrollment.
14. Notifying the UMC of concerns about the status of the health and welfare of people.
15. Follow-up with the person regarding the submission of critical incidents.

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
Occupational Therapy	
Crisis Intervention	
Speech Therapy	
Electronic Monitoring	
Skilled Nursing by a Licensed Practical Nurse	
Job Development	
Unlicensed Residential Person-Centered Support	
Non-Medical Transportation	
Physical Therapy	
Home-Based Agency Person-Centered Support	
In-Home Respite	
Facility-Based Day Habilitation	
Licensed Group	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Home Person-Centered Support	
Out-of-Home Respite	
Crisis Site Person-Centered Support	
Family Person-Centered Support	
Skilled Nursing by a Registered Nurse	
Participant-Directed Goods and Services	
Prevocational Services	
Environmental Accessibility Adaptations	
Behavior Support Professional	
Supported Employment	
Dietary Therapy	
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 individuals choosing the Personal Options program furnished by the Personal Options vendor.
- b) Supports are procured through an RFP and contract process.
- c) Supports are available to:
- provide general information and assistance on the opportunity to self-direct some of their services;
 - assist with the development of the individual spending 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 participant-directed goods and services;
 - monitor quality through monthly telephone contact; and
 - assist with required program paperwork
- d) Bureau for Medical Services (BMS) oversight of the Personal Options vendor includes:
- Monthly contract meetings;
 - Monthly review of program activity reports;
 - Quarterly and annual reporting to ensure compliance with IRS, state and local tax reporting;
 - Review of periodic consumer satisfaction survey results; and
 - Quarterly review of complaints and grievances report

In addition, as part of the Quality Improvement System (QIS), the UMC reviews a representative sample (on-site or desk review) of member records every 12 months.

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:

The state has a designated protection and advocacy organization (Disability Rights of West Virginia) available to provide independent advocacy services. Other resources (non-state agencies) include Legal Aid of West Virginia and Mountain State Justice.

Disability Rights of West Virginia can be reached by calling: 1-800-950-5250 or visiting the website at: <https://www.drofww.org/>

Legal Aid of West Virginia may be reached by calling: 1-866-255-4370 or visiting the website at: <https://www.lawv.net/>

Mountain State Justice may be reached by calling: 1-800-319-7132 or visiting the website at: <https://mountainstatejustice.org/get-help/>

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:

Voluntary termination may be initiated at any time. A transition plan will be developed to identify the supports required by the person, how the supports will be delivered and who will become responsible for the delivery of supports. The person/legal/non-legal representative will develop the transition plan with their IDT (whose composition varies due to the person's choice and needs), however a representative from the agency that will be providing future services must be present, if possible. The transition plan, with timelines identifying all services, must be approved by the person's IDT members. The Case Manager(CM) will be responsible for requesting service authorizations through the UMC web portal in completing the transition.

People who self-direct (or legal representative) can opt to transfer from the Participant-Directed Model to the Traditional Model, or vice versa, at any time. The Personal Options vendor, the Case Manager and UMC will assist the person 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.

The Case Manager and staff from the Personal Options vendor must submit a request to the UMC outlining the reasons the Personal Options vendor is requesting to terminate a person from Personal Options program. Issues such as the verification of Medicaid fraud, inability to maintain safe staffing supports, and/or repeated attempts to overspend the amount of funds specified in the spending plan would require the Personal Options vendor to notify BMS to review the person for involuntary removal from Personal Options. An additional concern that may be reported is the exploitation of the person for the legal or non-legal representative's benefit rather than the person's. This would be reported to the Adult or Child Protective Services and the Medicaid Fraud Control Unit. The Case Management agency may also report the same information to BMS.

An immediate notification of the lack of health and safety oversight must be reported through the WV IMS system as well as to the mandatory investigative agencies (Adult or Child Protective Services). Each person utilizing Personal Options program must have emergency and contingency plans developed by their Case Manager and addressed in their crisis plan. These plans must address the issues of staffing and transportation issues, severe weather and natural disaster effects to their support system, illness/epidemic/pandemic effects to supports and the back-ups for each situation. All paid and natural supports must be outlined in each person's IPP. The Case Magement provider is responsible for the oversight of program implementation, health, safety and welfare of each person.

The Case Manager will ensure that no break in vital services will occur and that a timely revision of the IPP occurs.

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	<input type="text"/>	<input type="text" value="2352"/>
Year 2	<input type="text"/>	<input type="text" value="2352"/>
Year 3	<input type="text"/>	<input type="text" value="2352"/>
Year 4	<input type="text"/>	<input type="text" value="2352"/>
Year 5	<input type="text"/>	<input type="text" value="2352"/>

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:

The person's employee is responsible for obtaining and paying for the National Crime Information Check (NCIC) as specified by policy.

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.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

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

Supervise staff

Evaluate staff performance

Verify time worked by staff and approve time sheets

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

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:*

Reallocate funds among services included in the budget

Determine the amount paid for services within the state's established limits

Substitute service providers

Schedule the provision of services

Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3

Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3

Identify service providers and refer for provider enrollment

Authorize payment for waiver goods and services

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.

The Participant-Directed Budget is a portion of the individualized annual budget assigned by the UMC and based upon the annual functional assessment of the person. Only the costs of the approved participant-directed services will be included in the participant-directed budget (Traditional Services will be separately authorized to the provider agency chosen by the person). Participant-Directed services will be monetized based on the amount, duration and frequency of services identified in the person's IPP. Participant-directed services must be based upon the person's needs as indicated in the annual functional assessment.

An annual allowance (maximum of \$1,000 per person) is available for participant-directed goods and services (if the person chooses to allocate a portion of their self-directed budget to this option; and must be included in the person's approved spending plan). This amount is consistent with funding for environmental accessibility adaptation (both home and vehicle) used in Traditional Services program.

The above information was 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.

Once CMS approves this application, it will be made available on the BMS website.

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.

Following the initial/annual functional assessment, the person is notified in writing by the UMC of the amount of his/her annual budget. Subsequently, the person, his/her legal representative (if applicable) and other members of the IDT meet to choose the types and amounts of services including the self-directed services that may be requested for authorization from the budget. The total cost of these services, including the cost of the self-directed services are documented on the person's IPP. The person or legal guardian (if applicable) is provided a copy of the IPP by the Case Manager.

Per policy, people receiving IDW services have the opportunity to request a change in authorized services at any time if there has been a documented change in need. The request must include clinical documentation sufficient to support the request. If approved by the UMC/BMS, the authorizations will be adjusted accordingly. If denied, the persons receiving IDW services 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:

The person may make changes to the types and amounts of services identified in their participant-directed budget but the changes must be consistent with the person's IPP and cannot exceed the specified dollar value of the Participant-Directed Budget. If the changes are not consistent with the IPP, the person may request a modification to the IPP. The person will then work with their Case Manager to develop a modified IPP that is mutually agreed upon and approved. The Personal Options vendor is notified of such changes by the Case Manager. Only services requested by the CM and authorized by the UMC may be included in the participant-directed budget.

If more Personal Options in-home or out-of-home respite is requested, the person/representative may shift funds from other authorized self-directed services except Participant-Directed Goods and Services (PDGS) to obtain the additional respite services. However, respite funds may not be shifted in order to obtain additional PCS of any kind or transportation services or PDGS.

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:

The Personal Options vendor is responsible for converting the annual participant-directed budget into monthly spending plans based upon input from the person and/or his/her representative. This safeguards premature depletion of the participant-directed budget.

The Personal Options vendor makes available a monthly utilization report to identify the person's use of budget funds. There are many reasons a person may not use their entire allocated budget (hospitalization, periodic increase of informal/non-paid supports, etc.). Unused funds from one month may not be carried over to later months within the person's annual budget period. The Personal Options vendor assigns a Personal Options Resource Consultant to assist and support each self-directing person to develop and monitor the monthly spending plans. The Resource Consultants will ensure the person/representatives are aware of under-utilization and/or any attempts to over spend the monthly spending plan. The person enrolled in Personal Options may revise the Spending plan 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.

The person and their legal representative (if applicable) and their chosen Case Managers are notified in writing by the UMC of their fair hearing rights when:

- 1) The person does not meet medical eligibility requirements for ICF/IID level of care on initial assessment;
- 2) The person does not meet medical eligibility requirements for ICF/IID level of care on their annual reevaluation assessment;
- 3) The person has not accessed a direct care service for a period of 180 continuous days; or
- 4) The person has been denied a service or the requested amount of the service has not been approved.

If a person does not meet financial eligibility requirements, then the local WV DoHS will notify the person in writing about their fair hearing rights.

The person and their legal representative (if applicable) wishing to implement their Fair Hearing options may complete the "Request For Fair Hearing" form provided by the UMC at the time of denial, termination or discharge resulting in undesired reduction in benefit.

WV DoHS Policy allows for a member to continue receiving their same level of services if they submit their request for Fair Hearing within 13 days of notice of denial/reduction of services. This information is available in the policy manual, and is also included in a "Statement of Rights" attached with the letter notifying the member of their reduction or denial of service. The UMC maintains all such documents electronically.

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 Utilization Management Contractor.

- 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).

A person who is dissatisfied with the services received from a provider agency has the right to file a grievance. All IDDW Provider agencies have a written grievance procedure. The UMC will explain to the person and/or legal representative at the time of initial application/re-evaluation. Service providers will only afford people with a grievance procedure for services that fall under the particular service provider's authority; for example, a Case Management Agency will not conduct a grievance procedure for another agency's services.

A person may by-pass the level one grievance and file a level two grievance with the UMC if he/she chooses.

The grievance procedure consists of two levels:

A. Level One:

The IDDW Provider has 10 business days from the date they receive a Grievance Form to hold a meeting with the person and/or legal representative (if applicable), in person or by telephone. The meeting will be conducted by the agency director or their designee with the person and/or their legal representative (if applicable). The agency has five business days from the date of the meeting to respond in writing to the grievance. If the person is dissatisfied with the agency decision, he/she may request that the grievance be submitted to the UMC for a Level Two review and decision.

B. Level Two:

If an IDDW Provider is not able to address the grievance in a manner satisfactory to the person and the person requests a Level Two review, the UMC will, within 10 business days of the receipt of the Grievance Form, contact the person and/or their legal representative (if applicable) and the IDDW Provider to review the Level One decision. Level Two decisions will be based on Medicaid policy and/or health and safety issues. The UMC will provide notice of the decision in writing to the person and/or legal representative (if applicable), the Provider agency and the Bureau for Medical Services (BMS).

The IDDW grievance process is intended to resolve complaints not subject to the Medicaid Fair Hearing process such as person's allegations of Provider noncompliance with Waiver policy and/or non-implementation of the person's current Service Plan.

The grievance process is not utilized to address decisions regarding medical or financial eligibility, a change in service(s) or case closure or to address employer/employee disputes.

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).

IDDW agencies 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 people 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 (WVIMS). Providers shall classify all incidents as:

- Allegation of abuse, neglect, or exploitation - must be reported to Adult Protective Services (APS) for individuals over the age of 18 or Child Protective Services (CPS) for individuals under the age of 18.
- Critical incident - a high likelihood of producing real or potential harm to the health and welfare of the person.
- Simple incident - unusual events occurring to a person that cannot be characterized as a critical incident and does not meet the level of abuse or neglect.

Any incident involving a person utilizing IDDW services must be reported to the UMC by entering the incident into the WVIMS within 24 hours of learning of the incident. The IDDW Provider's Director or designated staff will immediately review each Incident Report and determine whether the incident warrants a thorough investigation. Investigations must be initiated within 24 hours of learning of the incident. A completed Incident Report must be entered into the WVIMS (when available) 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 or CPS as mandated by State Code. Providers are responsible to investigate all incidents, including those reported to APS or CPS. The Provider will inform the person and/or their legal representative (if applicable) in writing the results of an investigation.

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 UMC to all applicants (or legal representative) during the initial visit prior to receiving a funded slot and by the UMC to all enrolled people (or legal representative) at their annual re-assessment.

- 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.

IDDW 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. Providers will be required to enter all Incident Reports into the WV IMS when available until such time reports are provided to the UMC.

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 or CPS as mandated by State Code. The person/legal representative may request to review APS or CPS investigation findings at any time, however, those mandated investigative agencies must follow WV state code regarding who can be informed of their investigative results. IDWW Providers are responsible to investigate all incidents, including those reported to APS or CPS. Per policy, when there has been an allegation of abuse, neglect or exploitation, IDWW Providers must:

- 1) Take immediate necessary steps to ensure the health and safety of the person while investigating the incident
- 2) Revise the person's IPP if necessary to implement additional supports, and
- 3) Implement necessary system's changes including additional 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 UMC generates a monthly report which is reviewed by the Bureau for Medical Services (BMS) and management staff of the UMC at regular contract meetings. The UMC monitors Provider incidents. The UMC will monitor Provider incidents in real time.

Each IDWW provider is required to be a licensed behavioral health center and must follow the requirements for Behavioral Health Licensure (64CSR11). Additionally, OHFLAC has created Guidelines for Incidents which is attached for your review (See Attachment 10). From these guidelines: "The investigation must begin within 24 hours of the report of the allegation unless otherwise instructed by Adult Protective Services. If the committee is instructed to hold its investigation by APS, the date, time and individuals involved in the instruction shall be documented. A preliminary report must be received within five (5) days by the administrator or designee (may be verbal, but must be documented) and a full written report must be completed no later than fourteen (14) days after the incident was identified." From 64CSR11 8.2.d If the administrator's findings and actions on behalf of a consumer regarding a violation of the consumer's rights in unfavorable, insufficient or not forthcoming within a reasonable time, the consumer, or his or her legal representative, may appeal to the governing body of the Center, the State licensure body, the West Virginia advocate or other appropriate resources.

- 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 UMC is responsible for monitoring the operation of the WVIMS, follows-up as necessary regarding provider incident investigations. Incidents submitted into the WV IMS are tracked and summarized by the UMC. The UMC makes available a monthly incident summary report which is reviewed by the BMS at regular contract meetings to identify and address issues or concerns. Quarterly incident summary reports are also reviewed by the Quality Improvement Advisory Council.

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:

--

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).

WV only permits the use of personal restraints in conjunction with a Positive Behavior Support Plan or in an emergency situation only to prevent harm to the person or others. Positive Behavior Support plans employ non-aversive methods to replace maladaptive behaviors with functional and useful behaviors. Any Positive Behavior Support plan is considered part of the person's Individual Program Plan. The person or legal representative (if applicable) consent is required prior to developing and implementing any Positive Behavior Support plan. If a plan utilizes any restrictive measures, the IDDW agency's Human Rights Committee must review and approve the restrictive measures. Additionally, Nonviolent Crisis Intervention training is required for any person providing paid supports to the person. This method focuses on proactive methods to reduce and prevent maladaptive behaviors, with physical restraint emphasized as a last resort. This training is not required for employees of the self-directing individual through the Personal Options program unless the Employer of Record requires it.

IDDW agencies must adhere to Behavioral Health Licensure 64 CSR 11 (or any version that replaces 64 CSR 11) in regards to using physical restraints, mechanical restraints or psychotropic medications. According to this policy, seclusion is not allowed in WV for the treatment of intellectual or developmentally disabled people. Also according to this policy, each IDDW agency must develop and implement policies and procedures for interventions in working with behaviors that are interfering with the person's ability to function socially or personally. All behavior intervention plans shall be based on a functional analysis of the behavior, include positive programming to teach an individual adaptive, more effective behavior, ensure that a person does not discipline another person, be a part of the person's IPP and ensure that physical restraints are used only as a last resort and used only as long as necessary to manage the behavior. Unauthorized use of restraints would be detected during retroactive reviews in alternating years by the UMC and OHFLAC in addition to reviews of incidences reported through the WVIMS and Adult and Child Protective Service reports. All IPP's are entered electronically into the UMC's web-based application system so reviews will be more readily available. Incident reports must be sent to OHFLAC by the IDDW provider agency if restraint is used.

Aversive procedures are only used with the written consent of the person or their legal representative (if applicable). A person shall not be placed in a mechanical device used as a physical restraint until he or she is either: examined by an attending physician or other licensed professional, and a discussion is held between the professional staff and available Interdisciplinary Team members; or a physician or other licensed professional has ordered by telephone these interventions after the professional staff has discussed the situation with the available Interdisciplinary Team members. No restraint order shall be valid for more than three (3) hours; but if ordered for longer, the Interdisciplinary Team shall review a person's status and develop a written plan for responding to the person's needs. When emergency control measures are used, a detailed report shall be written, describing the incident and the rationale for the emergency measures.

Psychotropic drugs are ordered only as part of the treatment plan and with documentation of the diagnosis and the specific behaviors that indicate a need for the medication and the rationale for its choice. All medications are administered in compliance with the physician's order and State law and all medication errors and adverse drug reactions are reported immediately in accordance with written procedures, including properly recording it in a person's record and notifying the physician who prescribed the drug.

All IDDW agency staff who provide direct service in the Waiver program must meet OHFLAC's standards which are also contained in 64 CSR 11 (or current replacement of this regulation) to include staff orientation, training in emergency care, first aid, infection disease control, cardiopulmonary resuscitation which includes the Heimlich maneuver, care of the person to whom they will be providing services, training in behavior management, including methods of de-escalating volatile situations and of using nonphysical techniques in such situations, to deal appropriately with aggressive or out of control behavior. In addition, agency staff who administer medications shall be Approved Medication Assistive Personnel (AMAPs). WV only permits the use of personal restraints in conjunction with a Positive Behavior Support Plan or in an emergency situation only to prevent harm to the person or others.

Restraints can only be used as an integral part of the IPP that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied. Physical restraints can only be used as an emergency measure, but only if absolutely necessary to protect the individual or others from injury. Physical restraints may also be used as a health-related protection prescribed by a physician, but only

if absolutely necessary during the conduct of a specific medical procedure or for the client protection during the time a medical condition lasts. If restraints are required the individual must have these included in the IPP and BSP. These same rules apply to medications used for behavior control.

The risks and benefits of restraints must be discussed with the person and their legal representative (if applicable) prior to being utilized.

Prior to restraints being utilized, each person must have a Positive Behavior Support Plan and staff trained in specific interventions/methods that are to be utilized. Some of these alternatives might include a functional behavior analysis and a positive behavior support plan or an individualized behavioral guideline to follow.

- 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:

OHFLAC is the state agency responsible for overseeing the use of restraints and ensuring that the state's safeguards are followed. Each IDWW agency must be a licensed Behavioral Health Center. In Behavioral Health Centers Licensure, 64 CSR 11, OHFLAC requires each provider agency to establish a Human Rights Committee. This committee's primary function is to assist the provider agency in the promotion and protection of a person's rights, and to review, approve and monitor individual programs designed to manage inappropriate behaviors and other programs that are intrusive or involve risks to the person's protection and rights. During the site reviews and interviews conducted biennially by the UMC and OHFLAC, any noted documentation or observation of unauthorized use of restraints will be reported to the proper authorities (Child Protective Services or Adult Protective Services). OHFLAC attends monthly Wavier Contract meetings with BMS and communicates their information and findings. Additional meetings are called if necessary. Incident reports must be sent to OHFLAC by the IDWW provider agency if restraint is used.

Unauthorized use of restraints may be detected during retroactive reviews in alternating years by the UMC and OHFLAC in addition to reviews of incidences reported through the WV Incident Management System and Adult and Child Protective Service reports. All IPP's are entered electronically into the UMC's web-based application system so reviews will be more readily available.

Providers are expected to follow guidelines in reporting incidents into the IMS within 48 hours of detection. The UMC monitors the IMS daily to track and detect appropriate incident documentation, investigation and follow-up by the agency.

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:

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.

The State allows the use of restrictive interventions when used in conjunction with a written Positive Behavior Support Plan, or in an emergency situation only to prevent harm to the person or others. Behavior support standards require that behavior plans employ non-aversive methods to replace maladaptive behaviors with functional and useful behaviors. Behavior Support Plans must be approved in advance of implementation by the IDT and the IDDW agency's Human Rights Committee as required by OHFLAC.

Each IDDW agency must be a licensed Behavioral Health Center. Once CFCM is implemented, case management only agencies will follow the certification guidelines as required by BMS. The use of seclusion is prohibited by Behavioral Health Centers Licensure 64 CSR 11, however mechanical and physical restraints are allowed. Use of these prohibited techniques or the use of unauthorized restrictive interventions is evaluated and any violations are reported to the proper entities by the Case Manager. OHFLAC and the UMC also evaluate unauthorized use of restrictive measures during periodic reviews and report to BMS during monthly contract meetings. Additional reports to Child or Adult Protective Services that detect the use of unauthorized restraints are reported to OHFLAC which in turn reports to BMS during monthly contract meetings or more often, if needed. Each IDDW agency must have a Human Rights Committee whose primary function is to assist the IDDW agency in the promotion and protection of a person's rights, and to review, approve and monitor individual programs designed to manage inappropriate behavior and other programs that are intrusive or involve risks to an individual's protection and rights.

Per OHFLAC regulations, beginning on the first day of employment, professional and direct care staff shall begin orientation and training on treatment policies and procedures, individual rights and the use of emergency procedures, such as crisis intervention and restraints. Staff assigned to work with an individual are required to be trained in advance on support and training programs which would include Positive Behavior Support plans and emergency procedures. Ongoing oversight of Positive Behavior Support Plans and implementation is provided by the Behavior Support Professional. OHFLAC regulations do not apply to people who are self-directing through the Personal Options program.

IDDW providers must comply with the OHFLAC regulation that requires when emergency control measures are used, a detailed report shall be written, describing the incident and the rationale for the emergency measures. In addition, the use of restrictive interventions must be reported to the agency's Human Rights Committee. These regulations do not apply to people who are self-directing through the Personal Options program.

Restraints can only be used as an integral part of the IPP that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied. Physical restraints can only be used as an emergency measure, but only if absolutely necessary to protect the individual or others from injury. Physical restraints may also be used as a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical procedure or for the client protection during the time a medical condition lasts. If restraints are required the individual must have these included in the IPP and BSP. These same rules apply to medications used for behavior control.

- 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:

OHFLAC is responsible for overseeing the use of restrictive interventions and ensuring that State safeguards concerning their use are followed. Oversight of the use of restrictive interventions at the individual level occurs through the IDT and the IDDW agency's Human Rights Committee (HRC). The IDT and HRC must approve these at least every six months. The Human Rights Committee reviews and approves all new restrictive interventions prior to implementation and every six months thereafter. The plans and implementation of the plans are reviewed biennially in alternating years by the UMC and OHFLAC and the findings of these reviews are shared with BMS during monthly contract meetings. This regulation does not apply to people who are self-directing through the Personal Options program.

Unauthorized use of restrictive intervention and violations of rights is monitored through the incident reporting process, the grievance process and the Case Management function--specifically through the review of the IPP and behavior support plan. In addition, on-site service provider reviews conducted in alternating years by the UMC and OHFLAC address behavior support services to assure that appropriate plans are in place and appropriately implemented.

The data obtained through agency self-reviews and on-site reviews conducted by the UMC is reported by the provider in aggregate form to BMS. This allows the identification of specific and/or systematic deficits as well as trends and patterns. This data is used to support improvement strategies.

The IMS system is an additional means of monitoring program quality and safety. The UMC monitors critical incidents via the web on a daily basis as well as all incident types on a monthly basis and reports findings to BMS as outlined above in monthly contract meetings.

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 state does not permit the use of seclusion. The state prohibits the use of seclusion.

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.

IDDW agencies are required to report via the WV Incident Management System (WVIMS) all general/minor and critical incidents involving medication errors. A reportable medication error involves one or more of the following: (1) medication administered to the wrong person; (2) incorrect medication administered; (3) incorrect dosage administered; (4) medication administered by incorrect route; (5) medication administered at incorrect time and (6) the administration of the medication not properly documented.

The UMC is responsible for ongoing monitoring of WVIMS data to ensure medication errors and other types of incidents are reported and adequate follow-up activities are performed by the provider. A significant medication error involving a single case can prompt the UMC to request additional information or conduct an on-site investigation. Systemic problems pertaining to medication errors at a particular IDDW agency location or on a state-wide level are also monitored by the UMC and aggregate data is reported to BMS on a monthly basis and to the QIA Council on a quarterly basis. Findings may result in the collection of additional data, on-site review(s) and/or QIA strategies.

In addition to the WVIMS, medication errors that could potentially or actually result in a negative outcome must be reported to The Office of Health Facility Licensure and Certification (OHFLAC). OHFLAC's regulations also require the provider to complete and document an internal investigation of these and other critical incidents. Depending on the case-specific or systemic impact of the error, OHFLAC may follow-up by requesting the results of the provider's internal investigation and/or conducting an on-site investigation.

Case Managers are required to meet with the people at their homes at least once a month. This meeting includes a review of incidents that have occurred—including those related to medication errors. The Case Manager is required to summarize these incidents and their outcomes in a note that documents the home visit.

WV State Code 16-50 and Legislative Rule 64 CSR 60 require non-licensed employees of Licensed Behavioral Health Centers who are responsible for medication administration to people to be certified Approved Medication Assistive Personnel (AMAPs). This Agency staff employee must meet the eligibility requirements to become an AMAP (including have a high school diploma or GED), must have successfully completed the required training and competency testing and has been deemed competent by the supervising RN to administer medications to people.

AMAPs are required to have monitoring and retraining quarterly by a Registered Nurse. Methods of oversight/retraining include observation and assessment of the AMAP passing medication. All medications administered by an AMAP must be documented on a Medication Administration Record (MAR) which is reviewed and signed by the supervising RN each month. This documentation system provides communication among all providers that administer medication and the monitoring of medication side effects and/or medication errors. The MAR and ongoing RN oversight serve a means to detect potentially harmful practices. Additionally, an RN must be available (on call) for AMAPs at all times.

The system for medication administration must include a storage and accountability of all medication, provisions for a medication administration record procedure and compliance with state and federal requirements. The process for prescribing and administering medications shall ensure:

- *That all orders for medications are reviewed at least every ninety (90) days by the physician;
- *That psychotropic drugs are ordered only as part of the treatment plan and with documentation of the diagnosis and the specific behaviors that indicate a need for the medication and the rationale for its choice;
- *That all medications are administered in compliance with the physician's order and State law; and
- *That medication errors, as defined by this rule, and adverse drug reactions are reported immediately in accordance with written procedures, including properly recording it in a person's record and notifying the physician who prescribed the drug.
- *The provider agency must note changes in a person's condition, including adverse reactions, as a result of receiving a medication.
- *A person to the extent capable shall administer his or her own medication.
- *The provider agency shall provide locked storage for the medication that is not administered by people.
- *The provider agency shall inform the person, or his or her legal representative, about the medication prescribed: the dosage, purpose, possible side effects, effects of not taking the medication; and about alternate treatments and their effects.

The UMC and OHFLAC conduct IDDW agency reviews in alternating years during which individual records will be retrospectively reviewed. All medication errors that result in serious consequences are considered to be Critical Incidents according to Behavioral Health Centers Licensure 64 CSR 11. Each provider agency must maintain a system for critical incident reporting and demonstrate that it uses the system to improve treatment planning and services. IDDW agency staff shall immediately notify a supervisor of any critical incident and clear other people from the area. Each provider agency must have policies and procedures for handling medical and psychiatric emergencies that ensures communication with the nearest medical emergency services, hospital and police; a twenty-four (24) hour telephone response system, toll-free to a person; and an investigation of any incident that results in serious injury or death, as reported by the IDDW agency to appropriate authorities and a written report on it.

The UMC and OHFLAC perform routine periodic on-site reviews of providers to ensure compliance with all policies & procedures including those pertaining to the handling and administration of medications and tracking/reporting medication errors. These on-site reviews are conducted on an annual basis alternatively by OHFLAC and the UMC staff. Any identified deficiencies are cited in a written exit report to which the provider must respond with a written plan of correction. Citations that indicate a serious and immediate threat to a person's health and safety may result in suspension of the provider's ability to administer medications, temporary or permanent revocation of the provider's license, etc.

BMS, OHFLAC and the UMC meet at least monthly to review program performance including data related to medication administration. The UMC and OHFLAC are each responsible for providing BMS with the findings of ad hoc and routine monitoring and evaluation activities.

The data from the WVIMS which includes critical incidents related to medication errors is reported by the UMC to BMS at regular monthly contract meetings.

The second-line monitoring that is conducted concerning the use of behavior modifying medications is as follows:

1. The Physician must prescribe the medication and it must be a part of a treatment plan; Physician must review every 90 days.
2. Member/Legal Representative must be informed about the drug. Each member has the right to appropriate medication.
3. Provider must conduct period evaluations of achievement related to medication prescribed and this must be documented on the IPP. If a medication is used to manage behaviors, the individual must have a Behavior Support Plan.
4. The IPP must provide for the review of drug dosages and types and must explain the rationale for changes or continuation of psychotropic drug regimens.
5. Psychotropic drugs are ordered only as part of the treatment plan and with documentation of the diagnosis and the specific behaviors that indicate a need for the medication and the rationale for its choice.
6. All orders for medications are reviewed at least every ninety (90) days by the physician.
7. The Center shall inform a consumer, or his or her legal representative, about the medication prescribed: the dosage, purpose, possible side effects, effects of not taking the medication; and about alternate treatments and their effects.
8. There shall be documentation in a consumer's record of periodic evaluations of educational achievement in relation to medications and psychotherapeutic needs.
9. Each person has the right to medication that is not used as punishment, for the convenience of staff, as a substitute for programming, or in quantities that interfere with the treatment program.
10. All Person-Centered Support staff, respite staff or day services staff who administer medications must be licensed AMAP under the direction and supervision of an Registered Nurse and must follow the AMAP policy.

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.

The IDDW agency's Registered Nurse oversees AMAP medication administration. This oversight ensures medications are managed appropriately and harmful practices are identified (e.g. medication errors). All medications are recorded and communicated on a central document, the Medication Administration Record (MAR). The RN follows up if any medication errors are indicated, and can take action to ensure the health and welfare of the person, up to and including revocation of the IDDW agency's staff AMAP status.

Any medication error that results in serious consequence must be reported as a Critical Incident via the WV Incident Management System and possibly to Adult or Child Protective Services or to OHFLAC for follow-up. The UMC and OHFLAC report to BMS on a monthly basis or more frequently if necessary. At least quarterly a report is presented to BMS and the IDDW QIA Council during which trends are discussed and actions are recommended.

On a state level, OHFLAC is responsible for policy implementation and ongoing monitoring of the AMAP program. Ongoing monitoring activities include:

- * Biennial on-site provider reviews which include review of AMAP policies/procedures and their implementation
- * Providers are required to submit all medication/treatment errors into the WV Incident Management System which is monitored by the UMC. Medication errors that result in serious outcome must be further reported to Adult Protective Services, Child Protective Services and OHFLAC as neglect
- * AMAPS failing to meet requirements and/or responsibilities are reported by the supervising RN and no longer certified as AMAP's through OHFLAC.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

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).

IDDW provider agencies must follow CHAPTER 16 of the WEST VIRGINIA STATE CODE SUB-SECTION 50 (or a more current version when it becomes available) which specifies that:

Administration of medication shall be performed only by:

1. Registered professional nurses;
2. Other licensed health care professionals; or
3. Facility staff members who have been trained and retrained every two years and who are subject to the supervision of and approval by a registered professional nurse.

Subsequent to assessing the health status of an individual resident, a registered professional nurse, in collaboration with the resident's attending physician and the facility staff member, may recommend that the facility authorize a facility staff member to administer medication if the staff member:

1. Has been trained pursuant to the requirements of this article;
2. Is considered by the registered professional nurse to be competent;
3. Consults with the registered professional nurse or attending physician on a regular basis; and
4. Is monitored or supervised by the registered professional nurse

The program developed by the department shall require that any person who applies to act as a facility staff member authorized to administer medications pursuant to the provisions of this article shall:

1. Hold a high school diploma or general education diploma;
2. Be trained or certified in cardiopulmonary resuscitation and first aid;
3. Participate in the initial training program developed by the department;
4. Pass a competency evaluation developed by the department; and
5. Subsequent to initial training and evaluation, participate in a retraining program every two years.

A registered nurse who is authorized to train facility staff members to administer medications in facilities shall:

1. Possess a current active West Virginia license in good standing to practice as a registered nurse;
2. Have practiced as a registered professional nurse in a position or capacity requiring knowledge of medications for the immediate two years prior to being authorized to train facility staff members; and
3. Be familiar with the nursing care needs of residents of facilities as described in this article.

Oversight of medication administration by unlicensed personnel.

a. Each facility in which medication is administered by unlicensed personnel shall establish in policy an administrative monitoring system. The specific requirements of the administrative policy shall be established by the department through rules proposed pursuant to section eleven of this article.

b. Monitoring of facility staff members authorized pursuant to this article shall be performed by a registered professional nurse employed or contracted by the facility.

Withdrawal of authorization.

The registered professional nurse who monitors or supervises the facility staff members authorized to administer medication pursuant to this article may withdraw authorization for a facility staff member if the nurse determines that the facility staff member is not performing medication administration in accordance with the training and written instructions. The withdrawal of the authorization shall be documented and shall be relayed to the facility and the department in order to remove the facility staff member from the list of authorized individuals.

Limitations on medication administration:

The following limitations apply to the administration of medication by facility staff members:

- a. Injections or any parenteral medications may not be administered;
- b. Irrigations or debriding agents used in the treatment of a skin condition or minor abrasions may not be administered;
- c. No verbal medication orders may be accepted, no new medication orders shall be transcribed and no drug dosages may be converted and calculated; and
- d. No medications ordered by the physician or a health care professional with legal prescriptive authority to be given "as needed" may be administered unless the order is written with specific parameters which preclude independent judgment.

Self-administration of medication:

Supervision of self-administration of medication by facility staff members who are not licensed health care professionals may be permitted in certain circumstances, when the substantial purpose of the setting is other than the provision of health care.

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:

Medication errors are reported to BMS through the Incident Management System. The UMC is responsible for ongoing monitoring of the IMS and preparing summary reports to BMS and other contracted entities.

Medication errors resulting in negative outcomes (medical follow-up, hospitalization, etc.) for the person must be reported as neglect to OHFLAC, Adult Protective Services and/or Child Protective Services.

- (b) Specify the types of medication errors that providers are required to *record*:

All medication errors are required to be recorded. Medication errors are defined as: (1) incorrect route of administration; (2) incorrect time of administration; (3) incorrect dosage; (4) incorrect drug; (5) medication administered to the incorrect person; and (6) incorrect or failure to document administration of medication.

- (c) Specify the types of medication errors that providers must *report* to the state:

All medication administration errors that result in critical incidents or abuse, neglect or exploitation must be reported to BMS through the IMS. Additionally, medication errors that result in abuse, neglect, exploitation or negative outcomes for the person must be reported to APS or CPS as well as OHFLAC.

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.

BMS monitors program performance utilizing data that is obtained through a variety of sources including the UMC; OHFLAC; the Medical Eligibility Contract Agent (MECA); the state's claims payer and Adult & Child Protective Services agencies. The type of data and frequency at which it is collected and reported is driven by the IDW Quality Plan which includes performance indicators pertaining to CMS Quality Assurances as well as performance indicators identified by BMS and the QIA Council.

Examples of the types of data collected include: Incident data reported by providers through the Incident Management System (IMS); data pertaining to program policies and procedures collected during routine on-site reviews of provider agencies; data regarding the volume and types of grievances and complaints filed by people; claims data; etc.

The UMC is responsible for coordinating the collection of data and using it to prepare monthly reports that are submitted to BMS and reviewed during the IDW Contract Management meetings. These meetings are held at least monthly and include representatives from BMS, the UMC, OHFLAC and MECA. Others are invited to attend as needed. Based upon a review of the performance indicators and all corresponding data the group may determine (1) the findings are satisfactory and do not require further action at this time; (2) a more detailed evaluation of the findings is needed and additional information/data may be requested; or (3) the findings are not satisfactory or indicate there is an opportunity for improvement. Further action will be taken which may include formation of a QI workgroup through the QIA Council.

On a quarterly basis, data pertaining to performance indicators and other program activities are presented to the QIA Council. Performance Indicator data failing to achieve desired outcomes are addressed through various methods including the formation of QI workgroups with members chosen from the Council, persons receiving services & family members, and other stakeholders.

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.

i. Sub-Assurances:

- a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.*

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:

Percent of agency staff files reviewed with state and federal fingerprint-based checks returned with satisfactory results within timelines

Numerator= Number of agency staff reviewed with NCICs returned with satisfactory results within timelines

Denominator= Number of agency staff files reviewed

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

WVIMS

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 = <div>95%</div>
Other Specify: <div>UMC</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

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: <div>UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

Percent of files of people receiving services with a document acknowledging receipt of training on information about how to report abuse, neglect, exploitation or other critical incidents signed by the person or the legal representative
Numerator= Number of files of people receiving services with that signed acknowledgement
Denominator= Number of files reviewed

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 Confidence Interval = <div>95%</div>

Other Specify: <div>UMC</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

Percent of agency staff files reviewed with monthly OIG exclusion list checks returned with satisfactory results
 Numerator= Number of agency staff files reviewed with OIG exclusion list checks with satisfactory results
 Denominator= Number of agency staff files reviewed.

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 Confidence Interval = <div>95%</div>
Other Specify: <div>UMC</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

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	Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Specify: <div>UMC</div>	
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

Percent of files of people receiving services that have a document signed by person or legal representatives acknowledging they know how to report abuse, neglect, exploitation or other critical incidents. Numerator= Number of files of people receiving services with that signed document Denominator= Number of files of people receiving services reviewed

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

	Ongoing	Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

- 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.

Performance Measure:

Percent of reported critical and abuse/neglect/exploitation incidents resolved within fourteen days
Numerator= Number of reported critical and abuse/neglect/exploitation incidents marked resolved within fourteen days
Denominator= Number of reported critical and abuse/neglect/exploitation incidents entered into the WVIMS for any given period

Data Source (Select one):

Record reviews, off-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 Confidence Interval = <div>95%</div>
Other Specify: <div>UMC</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: 150px;">UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px;"></div>

Performance Measure:

Percent of reported critical and abuse/neglect/exploitation incidents followed-up on by providers with established timelines. Numerator-Number of reported WVIMS critical & abuse/neglect/exploitation incidents followed-up on by the provider with timelines. Denominator-Number of reported WVIMS critical & abuse/neglect/exploitation incidents.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: 100px;">95%</div>

Other Specify: <div>UM</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

Percent of mortality reports of people receiving services reported by the Case Manager that coincide with cause of death on death certificate. Numerator-Number of mortality reports of people receiving services that coincide with the cause of death on the death certificate. Denominator-Number of mortality reports submitted.

Data Source (Select one):

Mortality reviews

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 = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: 100%;">UMC</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

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	Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Specify: <div>UMC</div>	
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

Percent of unexplained, suspicious and untimely deaths for which review/investigation that did not in the identification of preventable causes

Numerator: Number of unexplained, suspicious and untimely deaths for which review/investigation resulted in the identification of preventable causes **Denominator:** Total number of deaths

Data Source (Select one):

Mortality reviews

If 'Other' is selected, specify:

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

	Ongoing	Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

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.

Performance Measure:

Percent of Positive Behavior Support Plans (BSPs) of people receiving services recommending restrictive interventions that are approved by the provider's Human Rights Committee (HRC). Numerator-Number of BSPs of people receiving services recommending restrictive interventions that are approved by the provider's HRC. Denominator-Number of BSPs reviewed that recommend restrictive interventions.

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 Confidence Interval = <div>95%</div>
Other Specify: <div>UMC</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: 150px;">UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px;"></div>

- 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.

Performance Measure:

Percent of files of people receiving services reviewed with a current and appropriate backup/crisis plan in their file
Numerator: The number of files of people receiving services reviewed with a current and appropriate backup/crisis plan in their file
Denominator: The number of files reviewed

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid	Weekly	100% Review

Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>UMC</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>UMC</div>	Annually
	Continuously and Ongoing
	Other

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Specify: <div></div>

Performance Measure:

Percent of files of people receiving services reviewed whose Service Plan reflected a person's health care needs were coordinated. Numerator: The number of files of people receiving services reviewed whose Service Plan reflected a person's health care needs were coordinated. **Denominator:** The number of files reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

- 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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The Operating Agency collects all information related to this assurance through the review of individuals receiving services 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. The Operating Agency must approve all Corrective Action Plans. Services provided that are not documented on the service plan are disallowed, and payment is recouped from the provider agency.

The Bureau for Medical Services (BMS) is responsible for building and maintaining the Intellectual and/or Developmental Disabilities Waiver's (IDDW's) Quality Improvement System (QIS). The IDDW provider and the Personal Options vendor are responsible for participating in all activities related to the QIS. The IDDW's QIS is used by BMS and the Utilization Management Contractor (UMC) as a continuous system that measures system performance, tracks remediation activities, and identifies opportunities for system improvement. Achieving and maintaining program quality is an ongoing process that includes collecting and examining information about program operations and outcomes for members receiving services, and then using the information to identify strengths and weaknesses in program performance. This information is used to form the basis of remediation and improvement strategies. The QIS is designed to collect the data necessary to provide evidence

that the CMS Quality Assurances are being met and to ensure the active involvement of interested parties in the quality improvement process.

In addition to the QIS, BMS also engages the Quality Improvement Advisory (QIA) Council to analyze information from individual problems, identify systemic deficiencies, and implement remediation activities. The QIA Council is the focal point of stakeholder input for the IDDW Program and plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies.

The role of the QIA Council is to advise and assist BMS and UMC staff in program planning, development, and evaluation consistent with its stated purpose. In this role, the QIA Council uses IDDW Performance Indicators as a guide to:

- Recommend policy changes;
- Recommend program priorities and quality initiatives;
- Monitor and evaluate policy changes;
- Monitor and evaluate the implementation of Waiver priorities and quality initiatives;
- Serve as a liaison between the Waiver and interested parties; and
- Establish committees and work groups consistent with its purpose and guidelines.

The Council membership is composed of persons who formerly utilized IDDW services of the IDDW Program, members who currently are utilizing IDDW services (or their legal representatives), service providers, advocates, and other allies of people with intellectual and/or developmental disabilities.

ii. Remediation Data Aggregation

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

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

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 3)

Under Section 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 (QIS) 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; and
- 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 QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. 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 3)

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 Utilization Management Contractor (UMC) is responsible for monitoring the quality of IDDW services and ensuring that quality improvement strategies are implemented and evaluated. The IDDW Quality Improvement Advisory (QIA) Council 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 CMS assurances and sub-assurances. Specific data sources include provider monitoring, claims data, incident management reports, contract oversight meetings and reports, people/family focus groups/interview, and other stakeholder feedback and input.

The primary mechanism for involving stakeholders in the Waiver's quality improvement initiative is the IDDW Quality Improvement Advisory (QIA) Council. The Council strives for a minimum of fifteen (15) members comprised of at least five (5) current or former program participants (or family/legal representatives), IDDW agency staff, advocates and other interested stakeholders. The Council serves as a forum for people and the public to raise program issues and concerns affecting the quality of IDDW services and to make recommendations to BMS.

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 IDDW 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 Bureau for Medical Services (BMS) Management staff through regular meetings with contractors. The report is also reviewed quarterly with the QIA 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 Council meeting and guide the efforts of the Council and staff. The Quality Management Plan is evaluated on an annual basis and revised as necessary to reflect current quality issues.

ii. System Improvement Activities

Responsible Party (<i>check each that applies</i>):	Frequency of Monitoring and Analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: <div>UMC</div>	Other Specify: <div></div>

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 IDDW QIA is designed to: 1) Collect the data necessary to provide evidence that all CMS assurances and sub-assurances are consistently 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 people/legal representative complaints/grievances, administrative reports, oversight of delegated administrative functions, and stakeholder input.

Provider Reviews:

The primary means of monitoring the quality of IDDW services is through provider reviews conducted by the Office of Health Facility Licensing and Certification (OHFLAC) and the UMC.

To become an IDDW agency, an agency must apply for a Certificate of Need (CON) through expedited Summary Review process and be approved by the WV Health Care Authority and then obtain a Behavioral Health License through the Office of Health Facility Licensing and Certification (OHFLAC). Licensure of a new agency involves an initial on-site OHFLAC review followed by a six month comprehensive on-site review (if necessary) to ensure all certification standards are substantially met.

OHFLAC licenses are issued as follows:

An initial six (6) month license shall be issued to IDDW agencies establishing a new program or service for which there is insufficient individual participation to demonstrate substantial compliance with certification standards;

A provisional license shall be issued when an IDDW agency seeks a renewal license, and is not in substantial compliance with certification standards, but does not pose a significant risk to the rights, health and safety of the IDDW program individual. It shall expire not more than six (6) months from date of issuance, and not be consecutively reissued, unless the provisional recommendation is that of the state fire marshal.

A renewal license shall be issued when an IDDW agency is in substantial compliance with certification standards, and shall expire not more than two (2) years from date of issuance.

IDDW agencies are required to submit evidence to the UMC every other year to document continuing compliance with all certification requirements as specified in the IDDW Policy Manual. This evidence report must be signed by an appropriate official of the provider agency (e.g., Executive Director, Board Chair, etc.). The UMC performs on-site provider reviews annually to validate certification documentation. Targeted on-site provider reviews and/or desk audits may be conducted by OHFLAC and/or the UMC based on WV Incident Management Reports and complaint data.

A statewide representative sample of files is reviewed every other year. Files are reviewed by the UMC using the Quality and Utilization Review Tool. This tool has been developed to ensure that the critical data necessary to monitor CMS assurances are collected. A proportionate random sample, ensuring that at least two files from each provider agency are reviewed, will be identified with the assistance of BMS's Office of Program Integrity.

West Virginia Incident Management System (WVIMS):

Another key source for monitoring the quality of IDDW services is the online West Virginia Incident Management System (WVIMS). Per policy, IDDW agency are required to utilize the WVIMS to report and track all incidents including 1) Simple Incidents, 2) Critical Incidents, and 3) Abuse, Neglect, and Exploitation. The online system gives the IDDW agency the ability to generate agency specific reports to identify and monitor trends. The WVIMS also allows monitoring of reported incidents to ensure that timely, appropriate steps are taken by providers. The UMC generates periodic reports to identify & monitor statewide trends.

The UMC also employs a Member & Family Liaison to whom people and their legal representatives may report concerns with their services. The Liaison is responsible for providing education and assistance to the person/legal representatives and periodically compiles aggregate reports regarding concerns/complaints which are analyzed for trends.

Reports:

BMS management staff will receive and review the following contract reports:

- (1) UMC Monthly Discovery and Remediation Report and ad hoc reports as requested.
- (2) Participant-Directed Financial Management Services Vendor (Personal Options) Monthly Discovery and Remediation Report and ad hoc reports as requested.
- (3) Claims Vendor routine reports on claims data and ad hoc reports as requested.
- (4) Eligibility Vendor Monthly Report and ad hoc reports as requested.

Contract Oversight Meetings:

BMS management staff conduct monthly meetings with its contractors to monitor performance and address identified issues/concerns.

The quality management data collected through discovery methods is compiled using the Discovery and Remediation Report Template and reviewed at least monthly by BMS at the contract meetings and also reviewed quarterly by the IDWW QIA Council. A comprehensive report summarizing the findings of provider reviews is compiled at the end of each review cycle, reviewed and analyzed by UMC and BMS and presented to the QIA Council for its review and analysis.

The Quality Improvement Advisory Council:

The QIA Council is the focal point of stakeholder input for the IDWW 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 IDWW participants (or their legal representatives).

The Council provides the UMC and BMS feedback and guidance regarding quality improvement initiatives. In partnership with the UMC and BMS, 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 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 monitored quarterly by the Quality Improvement Advisory Council. 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 H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

- b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

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).

An annual independent audit from an accounting firm of the provider agency's choice is required for each provider agency. The provider must provide a copy of the finding of the independent audit to the SMA.

A statewide representative sample of member records are reviewed at least every 12 months by the OA to verify providers' documentation of services billed. The records 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 subject to a disallowance and repayment. All OA findings are presented to BMS and OPI to ensure understanding and agreement with findings. Subsequently, the provider must submit a corrective action plan which must be approved by the OA and BMS. Disallowances recommended by the OA and approved by BMS and OPI are shared with the provider agency. Information regarding how to submit collections is also provided. All collections are submitted to OPI. OPI tracks payments and submissions of disallowances.

The Medicaid Program is audited annually under the West Virginia Statewide Single Audit. The State of West Virginia Statewide Single Audit is conducted by Ernst & Young, LLP.

Under the EVV open vendor model, provider agencies may choose to use the free EVV solution available through BMS' contracted EVV vendor or to use an alternate EVV solution through the agency's chosen vendor at their own cost. BMS has established the requirements for data collections or exchange with alternate EVV systems.

All EVV solutions verify and capture the six required elements defined in the CURES Act: (1) the type of service performed; (2) the individual receiving the service; (3) the date of the service; (4) the location of service delivered; (5) the individual providing the service; and (6) the time the service begins and ends. The following services are subject to EVV: Home-Based Agency Center Support, In-Home Respite, and Out-of-Home Respite.

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 Assurance:

The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

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

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:

Percent of provider claims reviewed that did not result in recoupment due to an unsatisfactory audit
Numerator: Number of provider claims reviewed that resulted in recoupment
Denominator: Number of provider claims reviewed

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 Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">95%</div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">UMC</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;"></div>	

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):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; padding: 2px; width: 150px; margin-top: 5px;">UMC</div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 5px;"></div>

Performance Measure:

Number and percent of waiver claims in a representative sample paid using the correct rate as specified in the Waiver application. Numerator = Number of waiver claims paid using the correct rate as specified in the Waiver application. Denominator = Total number of waiver claims paid

Data Source (Select one):**Financial audits**

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):
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <div style="border: 1px solid black; height: 30px; width: 100px; margin-top: 5px;"></div>
<i>Other</i> <i>Specify:</i>	<i>Annually</i>	<i>Stratified</i> <i>Describe Group:</i>

<div style="border: 1px solid black; padding: 2px; width: 100px;">UMC</div>		<div style="border: 1px solid black; width: 100px; height: 20px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	

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: <div style="border: 1px solid black; padding: 2px; width: 150px; height: 20px;">UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; width: 150px; height: 20px;"></div>

- 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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Evidence relating to this assurance is collected through the UMC's prior authorization system and through the UMC's Quality and Utilization Review process. All providers must initially submit request for and receive prior authorization through the UMC prior to billing for any Waiver service. Any issues identified at the prior authorization stage are identified and resolved immediately (prior to services being authorized). This sometimes lead to request by the UMC for the provider to submit additional information/documentation to support the request for service authorization.

All information relating to this assurance is collected through the review of files by the UMC 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 files are addressed immediately by the UMC 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.

The Operating Agency collects all information related to this assurance through the review of individuals receiving services 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. The Operating Agency must approve all Corrective Action Plans. Services provided that are not documented on the service plan are disallowed, and payment is recouped from the provider agency.

The Bureau for Medical Services (BMS) is responsible for building and maintaining the Intellectual and/or Developmental Disabilities Waiver's (IDDW's) Quality Improvement System (QIS). The IDDW provider and the Personal Options vendor are responsible for participating in all activities related to the QIS. The IDDW's QIS is used by BMS and the Utilization Management Contractor (UMC) as a continuous system that measures system performance, tracks remediation activities, and identifies opportunities for system improvement. Achieving and maintaining program quality is an ongoing process that includes collecting and examining information about program operations and outcomes for members receiving services, and then using the information to identify strengths and weaknesses in program performance. This information is used to form the basis of remediation and improvement strategies. The QIS is designed to collect the data necessary to provide evidence that the CMS Quality Assurances are being met and to ensure the active involvement of interested parties in the quality improvement process.

In addition to the QIS, BMS also engages the Quality Improvement Advisory (QIA) Council to analyze information from individual problems, identify systemic deficiencies, and implement remediation activities. The QIA Council is the focal point of stakeholder input for the IDDW Program and plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies.

The role of the QIA Council is to advise and assist BMS and UMC staff in program planning, development, and evaluation consistent with its stated purpose. In this role, the QIA Council uses IDDW Performance Indicators as a guide to:

- Recommend policy changes;
- Recommend program priorities and quality initiatives;
- Monitor and evaluate policy changes;
- Monitor and evaluate the implementation of Waiver priorities and quality initiatives;
- Serve as a liaison between the Waiver and interested parties; and
- Establish committees and work groups consistent with its purpose and guidelines.

The Council membership is composed of persons who formerly utilized IDDW services of the IDDW Program, members who currently are utilizing IDDW services (or their legal representatives), service providers, advocates, and other allies of

people with intellectual and/or developmental disabilities.

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: <div>UMC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

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).

BMS engages and oversees Myers and Stauffer LLC, a certified public accounting firm that provides professional accounting, consulting, data management and analysis services to government-sponsored healthcare programs, to review service rates and make recommendations for rate revisions for HCBS. BMS retains ultimate responsibility for the final rate determinations.

BMS is opting to use the CMS accepted HCBS rate setting methodology known as the rate “build” approach to review rates on an annual basis. This rate setting approach involves building a rate by estimating and adding together each element or component of cost necessary to deliver a service. Provider cost report data, Bureau of Labor Statistics (BLS) wage category, and/or other national benchmark information are utilized in determining the cost elements, which are then summed to create the total rate. These rates are commonly expressed in 15-minute, hourly, or daily increments.

The rate ‘build’ approach is a common, CMS-accepted HCBS rating setting methodology. This rate setting approach involves building a rate by estimating and adding together each element or component of cost necessary to deliver a service. Provider cost report data, Bureau of Labor Statistics (BLS) wage category, and/or other national benchmark information are utilized in determining the cost elements, which are then summed to create the total rate. These rates are commonly expressed in 15-minute, hourly, or daily increments.

The rate “build” approach is traditionally comprised of two major cost areas: Total Employee Cost and Total Operations Cost. The components that make up each of these two costs are described in more detail below.

There are elements of the rate build equation that are unique to each service type, while others have been calculated as a static and uniform percentage across service types. In the rate model example above, cost components (B) and (E) are calculated as static percentages that are applied across services and waivers. Conversely, components (A), (C), and (D) are independently derived from cost reporting data for each service. It should be noted that, as required by CMS, room and board costs are not included in service rate development.

The proposed rates included in this report are shown in 15-minute increments, which is the standard for West Virginia Medicaid billing practices. To ensure providers receive adequate payment, Myers and Stauffer rounds up when calculating 15-minute conversions.

*The components of the rate model represent the costs of delivering Medicaid services. The two broad categories of costs included in this model are employee-related costs and operations related costs. The total employee cost in the model is represented by components $((A) + (B)) * (C)$. Employee related costs include the wages paid to the person performing the service on behalf of the agency, the expenses that an agency incurs in hiring and maintaining employees (payroll taxes, benefits, etc.), and a multiplier which increases the employee costs to account for typical productivity (i.e., billable and non-billable time). Each of these components are listed below:*

Component A: Wages.

Component B: Employee Related Expenses

Component C: Productivity Multiplier

Component D: Program

Component E: General/Administrative

An example of the rate calculation for Personal Attendant is below:

Personal Attendant / Personal Care

Total Employee Cost

Wage Component (A) \$13.40

Employee Related Expenses Component (B) \$3.04

Productivity Multiplier (C) 1.26

*Total Employee Cost = $(A+B)*C$ \$20.65*

Total Operations Cost

Program Component (D) \$2.17

General/Admin Component (E) \$2.60

Total Hourly Rate \$25.42

15-minute Billing Unit \$6.36

During the most recent rate-setting process, a public comment period was held from October 1 to October 31, 2023,

through BMS website. Comments were reviewed as they were received. As West Virginia has not federally recognized Tribal Governments, tribal consultation was not required. Stakeholder engagement began in June 2023 and included Myers and Stauffer's participation in regular BMS monthly meetings, along with targeted stakeholder sessions.

The goal of these meetings was to accomplish the following: Gather provider feedback regarding current rate levels and service access after the exhaustion of American Rescue Plan Act (ARPA) funds; provide an overview of the rate development process to providers; discuss the development and design of a cost report to capture service-specific provider cost experience; offer training and help-desk support on cost report completion and submission; and share the cost report results and how the findings are incorporated into rate design.

Throughout this initiative, 33 scheduled meetings, focus groups, and in-depth interviews were conducted with external stakeholders. Comments received during these 33 meetings were related to the cost reports the providers were submitting and the process of the data collection. Adjustments were made to the cost reports during data collection to ensure accurate and complete data was received.

BMS publishes rates for all waiver services on the IDDW website. IDDW rates may be found here: <https://dhhr.wv.gov/bms/Programs/WaiverPrograms/IDDW/Pages/Rates.aspx>. Rates are also made available to the public when the waiver application is posted for public comment.

- 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 flow directly from waiver providers to the State's claims payment system.

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 person is eligible on the date of service, that the IDWW agency 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 person'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.

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.

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 section 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 section 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 section 1915(b)/section 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 section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent section 1115/section 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 section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver 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 section 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.

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:

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:

The source of funding is dedicated general revenue appropriated by the legislature annually.

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

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:

For people living in licensed group home settings (four or more beds) owned by leased by the IDWW agency, the people pay a daily rate (currently \$17.50 per day) for the cost associated with room and board. This daily rate is set by the WV Bureau of Behavioral Health and Health Facilities upon recommendation from the Medley Management Team. A staff person from BMS is a member of this team.

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: ICF/IID

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	91332.17	6886.93	98219.10	124533.30	5501.79	130035.09	31815.99
2	91332.17	6737.45	98069.62	126109.00	5461.68	131570.68	33501.06
3	91332.17	6688.32	98020.49	127684.20	5382.33	133066.53	35046.04
4	91332.17	6591.16	97923.33	129279.00	5343.09	134622.09	36698.76
5	91332.17	6543.11	97875.28	130893.80	5304.14	136197.94	38322.66

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:	
		ICF/IID	
Year 1	6165		6165
Year 2	6165		6165
Year 3	6165		6165
Year 4	6165		6165
Year 5	6165		6165

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.

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 and methodology for these estimates is as follows:

This renewal application includes the new rates from the rate study completed Myers & Stauffer. These rates were included in the amendment that was submitted with an effective date October 1, 2024. The projections were kept the same year over year due to these rates being implemented. Also, historical data from the annual 372 reports shows the actual cost of the waiver being less than the original approved estimate, with the most recent 372 report being SFY23. With the increased rates applied, the State felt the increase in utilization would cause the approved yearly amount to be overestimated.

Case Management Question:

Service Coordination G9002 U4 is a PMPM case management code for 24-hour sites. Many agencies have struggled to hire and retain case managers during and since the end of the PHE. To address the shortage, BMS has loosened some of the requirements for hiring case managers for the IDDW Program.

Electronic Monitoring Question:

HCPCS code S5161 is the code used for this service. It is an emergency response system that pays a service fee per month. It does not include the installation and testing of the equipment.

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:

Estimates for Factor D' were based on historical data and trend analysis using previous 372 reports. Factor D' comes from lag report WVCLMS306 which shows the cost and unduplicated participants for IDD members' acute care. Although SFY23 was the last year for the 372 reports to be submitted in WMS, the State received reports for SFY24 from its fiscal vendor to use for projections. The preliminary SFY24 reports showed a slight decrease in utilization for these reports. The number of unduplicated members and amounts paid in WVCLMS306 had a slight decrease.

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:

Estimates for Factor G were based on historical data and trend analysis using previous 372 reports. Factor G comes from lag report WVCLMS310 which shows the cost, unduplicated participants, and number of days paid for ICF/IID members.

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:

Estimates for Factor G' were based on historical data and trend analysis using previous 372 reports. Factor G' comes from lag report WVCLMS332 which shows the cost and unduplicated participants for ICF/IID members' acute care. Although SFY23 was the last year for the 372 reports to be submitted in WMS, the State received reports for SFY24 from its fiscal vendor to use for projections. The preliminary SFY24 reports showed a slight decrease in utilization for these reports. The number of unduplicated members and amounts paid in WVCLMS332 had a slight decrease.

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	
Facility-Based Day Habilitation	
Home-Based Agency Person-Centered Support	
In-Home Respite	
Prevocational Services	
Supported Employment	
Participant-Directed Goods and Services	
Behavior Support Professional	
Crisis Intervention	
Crisis Site Person-Centered Support	
Dietary Therapy	
Electronic Monitoring	
Environmental Accessibility Adaptations	
Family Person-Centered Support	
Job Development	
Licensed Group Home Person-Centered Support	
Non-Medical Transportation	
Occupational Therapy	
Out-of-Home Respite	
Physical Therapy	
Skilled Nursing by a Licensed Practical Nurse	
Skilled Nursing by a Registered Nurse	
Speech Therapy	
Unlicensed Residential Person-Centered Support	

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:						15596400.00
Service Coordination G9002 U3	15 minute	4576	12.00	200.00	10982400.00	
GRAND TOTAL:						563062808.68
Total Estimated Unduplicated Participants:						6165
Factor D (Divide total by number of participants):						91332.17
Average Length of Stay on the Waiver:						360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service Coordination G9002 U4	event	1538	12.00	250.00	4614000.00	
Facility-Based Day Habilitation Total:						22728173.18
Facility Based Day Habilitation T2021 U6	15 minute	973	1332.00	3.20	4147315.20	
Facility Based Day Habilitation T2021 U7	15 minute	331	256.00	2.03	172014.08	
Facility Based Day Habilitation T2021 U5	15 minute	1405	1754.00	7.47	18408843.90	
Home-Based Agency Person- Centered Support Total:						22801522.32
Home-Based Agency PCS S5125 U7	15 minute	955	3016.00	6.36	18318580.80	
Home-Based Agency PCS S5125 U8	15 minute	131	944.00	3.18	393251.52	
Home-Based Agency PCS S5125 U9	15 minute	1377	1000.00	2.97	4089690.00	
In-Home Respite Total:						29923175.28
In Home Respite Agency T1005 UA	15 minute	1431	1966.00	6.36	17892880.56	
In Home Respite Agency T1005 UB	15 minute	17	1112.00	3.18	60114.72	
In Home Respite Personal Options	15 minute	1215	3284.00	3.00	11970180.00	
Prevocational Services Total:						3611136.44
Prevocational Services T2021 U1	15 minute	432	650.00	7.47	2097576.00	
Prevocational Services T2021 U2	15 minute	350	1159.00	3.20	1298080.00	
Prevocational Services T2021 U3	15 minute	223	476.00	2.03	215480.44	
Supported Employment Total:						3545727.66
Supported Employment T2019 HQ	15 minute	49	897.00	3.02	132738.06	
Supported Employment T2019	15 minute	395	1149.00	7.52	3412989.60	
Participant-Directed						131238.00
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Goods and Services Total:						
Participant- Directed Goods and Services	each	207	634.00	1.00	131238.00	
Behavior Support Professional Total:						20367670.40
Behavior Support Professional T2021HN	15 minute	3924	372.00	12.80	18684518.40	
Behavior Support Professional T2025HO	15 minutes	144	206.00	15.34	455045.76	
Behavior Support Professional I IPP Planning T2024 HI	event	144	4.00	53.74	30954.24	
Behavior Support Professional II IPP Planning T2025 HI	Event	3800	4.00	78.76	1197152.00	
Crisis Intervention Total:						19774.40
Crisis Intervention	15 minute	2	680.00	14.54	19774.40	
Crisis Site Person- Centered Support Total:						617151.12
Crisis Site PCS T1005 U8	15 minute	18	2140.00	4.10	157932.00	
Crisis Site PCS T1005 U7	15 minute	22	2505.00	8.18	450799.80	
Crisis Site PCS T1005 U9	15 minute	12	257.00	2.73	8419.32	
Dietary Therapy Total:						80944.16
Dietary Therapy	15 minute	281	11.00	24.86	76842.26	
Dietary Therapy Modifier	15 minute	15	11.00	24.86	4101.90	
Electronic Monitoring Total:						146930.10
Electronic Monitoring S5161 U4	hour	2	1141.00	2.27	5180.14	
Electronic Monitoring S5161 U3	hour	2	2582.00	3.03	15646.92	
Electronic Monitoring S5161 U2	hour	2	3528.00	4.54	32034.24	
GRAND TOTAL:					563062808.68	
Total Estimated Unduplicated Participants:					6165	
Factor D (Divide total by number of participants):					91332.17	
Average Length of Stay on the Waiver:						360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Electronic Monitoring S5161 U1	hour	7	1480.00	9.08	94068.80	
Environmental Accessibility Adaptations Total:						34390.00
Environmental Accessibility Adaptations- Vehicle	event	5	744.00	1.00	3720.00	
Environmental Accessibility - Home Modifier	event	16	878.00	1.00	14048.00	
Environmental Accessibility - Vehicle Modifier	event	7	744.00	1.00	5208.00	
Environmental Accessibility Adaptations- Home	event	13	878.00	1.00	11414.00	
Family Person- Centered Support Total:						118888228.74
Family PCS - Shared Living Residential Habilitation S5125 U5	15 minute	1931	6684.00	4.73	61049182.92	
Family PCS - Shared Living Residential Habilitation S5125 U6	15 minute	21	4166.00	2.37	207341.82	
Family PCS - Shared Living Residential Habilitation Personal Options	15 minute	2186	8788.00	3.00	57631704.00	
Job Development Total:						55873.60
Job Development	15 minute	10	743.00	7.52	55873.60	
Licensed Group Home Person- Centered Support Total:						35872032.94
Licensed Group Home PCS S5125 U4	15 minute	111	4822.00	1.65	883149.30	
Licensed Group Home PCS S5125 U1	15 minute	270	6822.00	6.57	12101545.80	
Licensed Group Home PCS S5125 U2	15 minute	270	11746.00	3.29	10433971.80	
Licensed Group Home PCS S5125 U3	15 minute	241	8687.00	2.19	4584911.73	
GRAND TOTAL:					563062808.68	
Total Estimated Unduplicated Participants:					6165	
Factor D (Divide total by number of participants):					91332.17	
Average Length of Stay on the Waiver:						360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Licensed Group Home PCS S5125 U4 AMAP	15 minute	28	4822.00	2.07	279483.12	
Licensed Group Home PCS S5125 U1 AMAP	15 minute	68	6822.00	6.99	3242633.04	
Licensed Group Home PCS S5125 U2 AMAP	15 minute	68	11746.00	3.71	2963280.88	
Licensed Group Home PCS S5125 U3 AMAP	15 minute	61	8687.00	2.61	1383057.27	
Non-Medical Transportation Total:						11048016.60
Transportation - Trips	trips	1106	165.00	9.89	1804826.10	
Transportation - Miles - Personal Options	miles	966	5989.00	0.50	2892687.00	
Transportation - Miles	miles	3531	3597.00	0.50	6350503.50	
Occupational Therapy Total:						842977.74
Occupational Therapy	15 minute	123	89.00	24.86	272142.42	
Occupational Therapy Modifier	15 minute	258	89.00	24.86	570835.32	
Out-of-Home Respite Total:						915046.86
Out of Home Respite Agency T1005 U5	15 minute	27	347.00	3.18	29793.42	
Out of Home Respite Agency T1005 U6	15 minute	2	6.00	2.12	25.44	
Out of Home Respite Personal Options	15 minute	16	3536.00	3.00	169728.00	
Out of Home Respite Agency T1005 U1	15 minute	100	1125.00	6.36	715500.00	
Physical Therapy Total:						1363919.04
Physical Therapy	15 minute	493	108.00	24.86	1323645.84	
Physical Therapy Modifier	15 minute	15	108.00	24.86	40273.20	
Skilled Nursing by a Licensed Practical Nurse Total:						5649669.21
Skilled Nursing by a Licensed					29064.75	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Practical Nurse T1003 U2	15 minute	5	1355.00	4.29		
Skilled Nursing by a Licensed Practical Nurse T1003 U3	15 minute	1857	266.00	6.43	3176175.66	
Skilled Nursing by a Licensed Practical Nurse T1003 U4	15 minute	1320	144.00	12.86	2444428.80	
Skilled Nursing by a Registered Nurse Total:						9432165.72
Skilled Nursing RN IPP Planning	event	2544	2.00	80.34	408769.92	
Skilled Nursing RN	15 minute	3015	92.00	19.51	5411683.80	
Skilled Nursing Medication Administration T1003 TE	event	416	300.00	28.94	3611712.00	
Speech Therapy Total:						371664.00
Speech Therapy 92507 GN UG	15 minute	231	24.00	53.40	296049.60	
Speech Therapy 92507 GN	event	59	24.00	53.40	75614.40	
Unlicensed Residential Person- Centered Support Total:						259018981.17
Unlicensed Residential PCS Agency S5125 UP	15 minute	610	10417.00	2.19	13916070.30	
Unlicensed Residential PCS Agency S5125 HI	15 minute	1499	12755.00	6.57	125616724.65	
Unlicensed Residential PCS Agency S5125 UN	15 minute	1204	15636.00	3.29	61936697.76	
Unlicensed Residential PCS Personal Options	15 minute	27	25454.00	3.63	2494746.54	
Unlicensed Residential PCS Agency S5125 UP AMAP	15 minute	153	10417.00	2.61	4159820.61	
Unlicensed Residential PCS Agency S5125 HI AMAP	15 minute	375	12755.00	6.99	33434043.75	
Unlicensed Residential PCS					17460877.56	
GRAND TOTAL:					563062808.68	
Total Estimated Unduplicated Participants:					6165	
Factor D (Divide total by number of participants):					91332.17	
Average Length of Stay on the Waiver:						360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Agency S5125 UN AMAP	15 minute	301	15636.00	3.71		
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

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
Case Management Total:						15596400.00
Service Coordination G9002 U3	event	4576	12.00	200.00	10982400.00	
Service Coordination G9002 U4	event	1538	12.00	250.00	4614000.00	
Facility-Based Day Habilitation Total:						22728173.18
Facility Based Day Habilitation T2021 U6	15 minute	973	1332.00	3.20	4147315.20	
Facility Based Day Habilitation T2021 U7	15 minute	331	256.00	2.03	172014.08	
Facility Based Day Habilitation T2021 U5	15 minute	1405	1754.00	7.47	18408843.90	
Home-Based Agency Person- Centered Support Total:						22801522.32
Home-Based Agency PCS S5125 U7	15 minute	955	3016.00	6.36	18318580.80	
Home-Based Agency PCS S5125 U8	15 minute	131	944.00	3.18	393251.52	
Home-Based Agency PCS S5125 U9	15 minute	1377	1000.00	2.97	4089690.00	
In-Home Respite						29923175.28
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
In Home Respite Agency T1005 UA	15 minute	1431	1966.00	6.36	17892880.56	
In Home Respite Agency T1005 UB	15 minute	17	1112.00	3.18	60114.72	
In Home Respite Personal Options	15 minute	1215	3284.00	3.00	11970180.00	
Prevocational Services Total:						3611136.44
Prevocational Services T2021 U1	15 minute	432	650.00	7.47	2097576.00	
Prevocational Services T2021 U2	15 minute	350	1159.00	3.20	1298080.00	
Prevocational Services T2021 U3	15 minute	223	476.00	2.03	215480.44	
Supported Employment Total:						3545727.66
Supported Employment T2019 HQ	15 minute	49	897.00	3.02	132738.06	
Supported Employment T2019	15 minute	395	1149.00	7.52	3412989.60	
Participant-Directed Goods and Services Total:						131238.00
Participant- Directed Goods and Services	each	207	634.00	1.00	131238.00	
Behavior Support Professional Total:						20367670.40
Behavior Support Professional T2021HN	15 minute	3924	372.00	12.80	18684518.40	
Behavior Support Professional T2025HO	15 minute	144	206.00	15.34	455045.76	
Behavior Support Professional I IPP Planning T2024 HI	event	144	4.00	53.74	30954.24	
Behavior Support Professional II IPP Planning T2025 HI	Event	3800	4.00	78.76	1197152.00	
Crisis Intervention Total:						19774.40
Crisis					19774.40	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Intervention	15 minute	2	680.00	14.54		
Crisis Site Person-Centered Support Total:						617151.12
Crisis Site PCS T1005 U8	15 minute	18	2140.00	4.10	157932.00	
Crisis Site PCS T1005 U7	15 minute	22	2505.00	8.18	450799.80	
Crisis Site PCS T1005 U9	15 minute	12	257.00	2.73	8419.32	
Dietary Therapy Total:						80944.16
Dietary Therapy	15 minute	281	11.00	24.86	76842.26	
Dietary Therapy Modifier	15 minute	15	11.00	24.86	4101.90	
Electronic Monitoring Total:						146930.10
Electronic Monitoring S5161 U4	hour	2	1141.00	2.27	5180.14	
Electronic Monitoring S5161 U3	hour	2	2582.00	3.03	15646.92	
Electronic Monitoring S5161 U2	hour	2	3528.00	4.54	32034.24	
Electronic Monitoring S5161 U1	hour	7	1480.00	9.08	94068.80	
Environmental Accessibility Adaptations Total:						34390.00
Environmental Accessibility Adaptations-Vehicle	each	5	744.00	1.00	3720.00	
Environmental Accessibility - Home Modifier	event	13	878.00	1.00	11414.00	
Environmental Accessibility - Vehicle Modifier	event	7	744.00	1.00	5208.00	
Environmental Accessibility Adaptations-Home	each	16	878.00	1.00	14048.00	
Family Person-Centered Support Total:						118888228.74
Family PCS - Shared Living Residential Habilitation S5125 U5	15 minute	1931	6684.00	4.73	61049182.92	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family PCS - Shared Living Residential Habilitation S5125 U6	15 minute	21	4166.00	2.37	207341.82	
Family PCS - Shared Living Residential Habilitation Personal Options	15 minute	2186	8788.00	3.00	57631704.00	
Job Development Total:						55873.60
Job Development	15 minute	10	743.00	7.52	55873.60	
Licensed Group Home Person- Centered Support Total:						35872032.94
Licensed Group Home PCS S5125 U4	15 minute	111	4822.00	1.65	883149.30	
Licensed Group Home PCS S5125 U1	15 minute	270	6822.00	6.57	12101545.80	
Licensed Group Home PCS S5125 U2	15 minute	270	11746.00	3.29	10433971.80	
Licensed Group Home PCS S5125 U3	15 minute	241	8687.00	2.19	4584911.73	
Licensed Group Home PCS S5125 U4 AMAP	15 minute	28	4822.00	2.07	279483.12	
Licensed Group Home PCS S5125 U1 AMAP	15 minute	68	6822.00	6.99	3242633.04	
Licensed Group Home PCS S5125 U2 AMAP	15 minute	68	11746.00	3.71	2963280.88	
Licensed Group Home PCS S5125 U3 AMAP	15 minute	61	8687.00	2.61	1383057.27	
Non-Medical Transportation Total:						11048016.60
Transportation - Trips	trips	1106	165.00	9.89	1804826.10	
Transportation - Miles - Personal Options	miles	966	5989.00	0.50	2892687.00	
Transportation - Miles	miles	3531	3597.00	0.50	6350503.50	
Occupational Therapy Total:						842977.74
Occupational					272142.42	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapy	15 minute	123	89.00	24.86		
Occupational Therapy Modifier	15 minute	258	89.00	24.86	570835.32	
Out-of-Home Respite Total:						915046.86
Out of Home Respite Agency T1005 U5	15 minute	27	347.00	3.18	29793.42	
Out of Home Respite Agency T1005 U6	15 minute	2	6.00	2.12	25.44	
Out of Home Respite Personal Options	15 minute	16	3536.00	3.00	169728.00	
Out of Home Respite Agency T1005 U1	15 minute	100	1125.00	6.36	715500.00	
Physical Therapy Total:						1363919.04
Physical Therapy	15 minute	493	108.00	24.86	1323645.84	
Physical Therapy Modifier	15 minute	15	108.00	24.86	40273.20	
Skilled Nursing by a Licensed Practical Nurse Total:						5649669.21
Skilled Nursing by a Licensed Practical Nurse T1003 U2	15 minute	5	1355.00	4.29	29064.75	
Skilled Nursing by a Licensed Practical Nurse T1003 U3	15 minute	1857	266.00	6.43	3176175.66	
Skilled Nursing by a Licensed Practical Nurse T1003 U4	15 minute	1320	144.00	12.86	2444428.80	
Skilled Nursing by a Registered Nurse Total:						9432165.72
Skilled Nursing RN IPP Planning	event	2544	2.00	80.34	408769.92	
Skilled Nursing RN	15 minute	3015	92.00	19.51	5411683.80	
Skilled Nursing Medication Administration T1003 TE	event	416	300.00	28.94	3611712.00	
Speech Therapy Total:						371664.00
Speech Therapy 92507 GN UG	15 minute	231	24.00	53.40	296049.60	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech Therapy 92507 GN	event	59	24.00	53.40	75614.40	
Unlicensed Residential Person- Centered Support Total:						259018981.17
Unlicensed Residential PCS Agency S5125 UP	15 minute	610	10417.00	2.19	13916070.30	
Unlicensed Residential PCS Agency S5125 HI	15 minute	1499	12755.00	6.57	125616724.65	
Unlicensed Residential PCS Agency S5125 UN	15 minute	1204	15636.00	3.29	61936697.76	
Unlicensed Residential PCS Personal Options	15 minute	27	25454.00	3.63	2494746.54	
Unlicensed Residential PCS Agency S5125 UP AMAP	15 minute	153	10417.00	2.61	4159820.61	
Unlicensed Residential PCS Agency S5125 HI AMAP	15 minute	375	12755.00	6.99	33434043.75	
Unlicensed Residential PCS Agency S5125 UN AMAP	15 minute	301	15636.00	3.71	17460877.56	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

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
Case Management Total:						15596400.00
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service Coordination G9002 U3	event	4576	12.00	200.00	10982400.00	
Service Coordination G9002 U4	event	1538	12.00	250.00	4614000.00	
Facility-Based Day Habilitation Total:						22728173.18
Facility Based Day Habilitation T2021 U6	15 minute	973	1332.00	3.20	4147315.20	
Facility Based Day Habilitation T2021 U7	15 minute	331	256.00	2.03	172014.08	
Facility Based Day Habilitation T2021 U5	15 minute	1405	1754.00	7.47	18408843.90	
Home-Based Agency Person- Centered Support Total:						22801522.32
Home-Based Agency PCS S5125 U7	15 minute	955	3016.00	6.36	18318580.80	
Home-Based Agency PCS S5125 U8	15 minute	131	944.00	3.18	393251.52	
Home-Based Agency PCS S5125 U9	15 minute	1377	1000.00	2.97	4089690.00	
In-Home Respite Total:						29923175.28
In Home Respite Agency T1005 UA	15 minute	1431	1966.00	6.36	17892880.56	
In Home Respite Agency T1005 UB	15 minute	17	1112.00	3.18	60114.72	
In Home Respite Personal Options	15 minute	1215	3284.00	3.00	11970180.00	
Prevocational Services Total:						3611136.44
Prevocational Services T2021 U1	15 minute	432	650.00	7.47	2097576.00	
Prevocational Services T2021 U2	15 minute	350	1159.00	3.20	1298080.00	
Prevocational Services T2021 U3	15 minute	223	476.00	2.03	215480.44	
Supported Employment Total:						3545727.66
Supported Employment T2019 HQ	15 minute	49	897.00	3.02	132738.06	
Supported					3412989.60	
GRAND TOTAL:					563062808.68	
Total Estimated Unduplicated Participants:					6165	
Factor D (Divide total by number of participants):					91332.17	
Average Length of Stay on the Waiver:					360	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment T2019	15 minute	395	1149.00	7.52		
Participant-Directed Goods and Services Total:						131238.00
Participant- Directed Goods and Services	each	207	634.00	1.00	131238.00	
Behavior Support Professional Total:						20367670.40
Behavior Support Professional T2021HN	15 minute	3924	372.00	12.80	18684518.40	
Behavior Support Professional T2025HO	15 minute	144	206.00	15.34	455045.76	
Behavior Support Professional I IPP Planning T2024 HI	event	144	4.00	53.74	30954.24	
Behavior Support Professional II IPP Planning T2025 HI	Event	3800	4.00	78.76	1197152.00	
Crisis Intervention Total:						19774.40
Crisis Intervention	15 minute	2	680.00	14.54	19774.40	
Crisis Site Person- Centered Support Total:						617151.12
Crisis Site PCS T1005 U8	15 minute	18	2140.00	4.10	157932.00	
Crisis Site PCS T1005 U7	15 minute	22	2505.00	8.18	450799.80	
Crisis Site PCS T1005 U9	15 minute	12	257.00	2.73	8419.32	
Dietary Therapy Total:						80944.16
Dietary Therapy	15 minute	281	11.00	24.86	76842.26	
Dietary Therapy Modifier	15 minute	15	11.00	24.86	4101.90	
Electronic Monitoring Total:						146930.10
Electronic Monitoring S5161 U4	hour	2	1141.00	2.27	5180.14	
Electronic Monitoring S5161 U3	hour	2	2582.00	3.03	15646.92	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Electronic Monitoring S5161 U2	hour	2	3528.00	4.54	32034.24	
Electronic Monitoring S5161 U1	hour	7	1480.00	9.08	94068.80	
Environmental Accessibility Adaptations Total:						34390.00
Environmental Accessibility Adaptations- Vehicle	each	5	744.00	1.00	3720.00	
Environmental Accessibility - Home Modifier	event	16	878.00	1.00	14048.00	
Environmental Accessibility - Vehicle Modifier	event	7	744.00	1.00	5208.00	
Environmental Accessibility Adaptations- Home	each	13	878.00	1.00	11414.00	
Family Person- Centered Support Total:						118888228.74
Family PCS - Shared Living Residential Habilitation S5125 U5	15 minute	1931	6684.00	4.73	61049182.92	
Family PCS - Shared Living Residential Habilitation S5125 U6	15 minute	21	4166.00	2.37	207341.82	
Family PCS - Shared Living Residential Habilitation Personal Options	15 minute	2186	8788.00	3.00	57631704.00	
Job Development Total:						55873.60
Job Development	15 minute	10	743.00	7.52	55873.60	
Licensed Group Home Person- Centered Support Total:						35872032.94
Licensed Group Home PCS S5125 U4	15 minute	111	4822.00	1.65	883149.30	
Licensed Group Home PCS S5125 U1	15 minute	270	6822.00	6.57	12101545.80	
Licensed Group Home PCS S5125 U2	15 minute	270	11746.00	3.29	10433971.80	
GRAND TOTAL:					563062808.68	
Total Estimated Unduplicated Participants:					6165	
Factor D (Divide total by number of participants):					91332.17	
Average Length of Stay on the Waiver:					360	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Licensed Group Home PCS S5125 U3	15 minute	241	8687.00	2.19	4584911.73	
Licensed Group Home PCS S5125 U4 AMAP	15 minute	28	4822.00	2.07	279483.12	
Licensed Group Home PCS S5125 U1 AMAP	15 minute	68	6822.00	6.99	3242633.04	
Licensed Group Home PCS S5125 U2 AMAP	15 minute	68	11746.00	3.71	2963280.88	
Licensed Group Home PCS S5125 U3 AMAP	15 minute	61	8687.00	2.61	1383057.27	
Non-Medical Transportation Total:						11048016.60
Transportation - Trips	trips	1106	165.00	9.89	1804826.10	
Transportation - Miles - Personal Options	miles	966	5989.00	0.50	2892687.00	
Transportation - Miles	miles	3531	3597.00	0.50	6350503.50	
Occupational Therapy Total:						842977.74
Occupational Therapy	15 minute	123	89.00	24.86	272142.42	
Occupational Therapy Modifier	15 minute	258	89.00	24.86	570835.32	
Out-of-Home Respite Total:						915046.86
Out of Home Respite Agency T1005 U5	15 minute	27	347.00	3.18	29793.42	
Out of Home Respite Agency T1005 U6	15 minute	2	6.00	2.12	25.44	
Out of Home Respite Personal Options	15 minute	16	3536.00	3.00	169728.00	
Out of Home Respite Agency T1005 U1	15 minute	100	1125.00	6.36	715500.00	
Physical Therapy Total:						1363919.04
Physical Therapy	15 minute	493	108.00	24.86	1323645.84	
Physical Therapy Modifier	15 minute	15	108.00	24.86	40273.20	
Skilled Nursing by a Licensed Practical						5649669.21
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nurse Total:						
Skilled Nursing by a Licensed Practical Nurse T1003 U2	15 minute	5	1355.00	4.29	29064.75	
Skilled Nursing by a Licensed Practical Nurse T1003 U3	15 minute	1857	266.00	6.43	3176175.66	
Skilled Nursing by a Licensed Practical Nurse T1003 U4	15 minute	1320	144.00	12.86	2444428.80	
Skilled Nursing by a Registered Nurse Total:						9432165.72
Skilled Nursing RN IPP Planning	event	2544	2.00	80.34	408769.92	
Skilled Nursing RN	15 minute	3015	92.00	19.51	5411683.80	
Skilled Nursing Medication Administration T1003 TE	event	416	300.00	28.94	3611712.00	
Speech Therapy Total:						371664.00
Speech Therapy 92507 GN UG	15 minute	231	24.00	53.40	296049.60	
Speech Therapy 92507 GN	event	59	24.00	53.40	75614.40	
Unlicensed Residential Person- Centered Support Total:						259018981.17
Unlicensed Residential PCS Agency S5125 UP	15 minute	610	10417.00	2.19	13916070.30	
Unlicensed Residential PCS Agency S5125 HI	15 minute	1499	12755.00	6.57	125616724.65	
Unlicensed Residential PCS Agency S5125 UN	15 minute	1204	15636.00	3.29	61936697.76	
Unlicensed Residential PCS Personal Options	15 minute	27	25454.00	3.63	2494746.54	
Unlicensed Residential PCS Agency S5125 UP AMAP	15 minute	153	10417.00	2.61	4159820.61	
Unlicensed Residential PCS Agency S5125	15 minute	375	12755.00	6.99	33434043.75	
GRAND TOTAL:					563062808.68	
Total Estimated Unduplicated Participants:					6165	
Factor D (Divide total by number of participants):					91332.17	
Average Length of Stay on the Waiver:						360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
HI AMAP						
Unlicensed Residential PCS Agency S5125 UN AMAP	15 minute	301	15636.00	3.71	17460877.56	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

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 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 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						15596400.00
Service Coordination G9002 U3	event	4576	12.00	200.00	10982400.00	
Service Coordination G9002 U4	event	1538	12.00	250.00	4614000.00	
Facility-Based Day Habilitation Total:						22728173.18
Facility Based Day Habilitation T2021 U6	15 minute	973	1332.00	3.20	4147315.20	
Facility Based Day Habilitation T2021 U7	15 minute	331	256.00	2.03	172014.08	
Facility Based Day Habilitation T2021 U5	15 minute	1405	1754.00	7.47	18408843.90	
Home-Based Agency Person- Centered Support Total:						22801522.32
Home-Based Agency PCS S5125 U7	15 minute	955	3016.00	6.36	18318580.80	
Home-Based Agency PCS S5125 U8	15 minute	131	944.00	3.18	393251.52	
Home-Based					4089690.00	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Agency PCS S5125 U9	15 minute	1377	1000.00	2.97		
In-Home Respite Total:						29923175.28
In Home Respite Agency T1005 UA	15 minute	1431	1966.00	6.36	17892880.56	
In Home Respite Agency T1005 UB	15 minute	17	1112.00	3.18	60114.72	
In Home Respite Personal Options	15 minute	1215	3284.00	3.00	11970180.00	
Prevocational Services Total:						3611136.44
Prevocational Services T2021 U1	15 minute	432	650.00	7.47	2097576.00	
Prevocational Services T2021 U2	15 minute	350	1159.00	3.20	1298080.00	
Prevocational Services T2021 U3	15 minute	223	476.00	2.03	215480.44	
Supported Employment Total:						3545727.66
Supported Employment T2019 HQ	15 minute	49	897.00	3.02	132738.06	
Supported Employment T2019	15 minute	395	1149.00	7.52	3412989.60	
Participant-Directed Goods and Services Total:						131238.00
Participant- Directed Goods and Services	each	207	634.00	1.00	131238.00	
Behavior Support Professional Total:						20367670.40
Behavior Support Professional T2021HN	15 minute	3924	372.00	12.80	18684518.40	
Behavior Support Professional T2025HO	15 minute	144	206.00	15.34	455045.76	
Behavior Support Professional I IPP Planning T2024 HI	event	144	4.00	53.74	30954.24	
Behavior Support Professional II IPP Planning T2025 HI	Event	3800	4.00	78.76	1197152.00	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Crisis Intervention Total:						19774.40
Crisis Intervention	15 minute	2	680.00	14.54	19774.40	
Crisis Site Person- Centered Support Total:						617151.12
Crisis Site PCS T1005 U8	15 minute	18	2140.00	4.10	157932.00	
Crisis Site PCS T1005 U7	15 minute	22	2505.00	8.18	450799.80	
Crisis Site PCS T1005 U9	15 minute	12	257.00	2.73	8419.32	
Dietary Therapy Total:						80944.16
Dietary Therapy	15 minute	281	11.00	24.86	76842.26	
Dietary Therapy Modifier	15 minute	15	11.00	24.86	4101.90	
Electronic Monitoring Total:						146930.10
Electronic Monitoring S5161 U4	hour	2	1141.00	2.27	5180.14	
Electronic Monitoring S5161 U3	hour	2	2582.00	3.03	15646.92	
Electronic Monitoring S5161 U2	hour	2	3528.00	4.54	32034.24	
Electronic Monitoring S5161 U1	hour	7	1480.00	9.08	94068.80	
Environmental Accessibility Adaptations Total:						34390.00
Environmental Accessibility Adaptations- Vehicle	each	5	744.00	1.00	3720.00	
Environmental Accessibility - Home Modifier	event	16	878.00	1.00	14048.00	
Environmental Accessibility - Vehicle Modifier	event	7	744.00	1.00	5208.00	
Environmental Accessibility Adaptations- Home	each	13	878.00	1.00	11414.00	
Family Person- Centered Support Total:						118888228.74
Family PCS - Shared Living					61049182.92	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation S5125 U5	15 minute	1931	6684.00	4.73		
Family PCS - Shared Living Residential Habilitation S5125 U6	15 minute	21	4166.00	2.37	207341.82	
Family PCS - Shared Living Residential Habilitation Personal Options	15 minute	2186	8788.00	3.00	57631704.00	
Job Development Total:						55873.60
Job Development	15 minute	10	743.00	7.52	55873.60	
Licensed Group Home Person- Centered Support Total:						35872032.94
Licensed Group Home PCS S5125 U4	15 minute	111	4822.00	1.65	883149.30	
Licensed Group Home PCS S5125 U1	15 minute	270	6822.00	6.57	12101545.80	
Licensed Group Home PCS S5125 U2	15 minute	270	11746.00	3.29	10433971.80	
Licensed Group Home PCS S5125 U3	15 minute	241	8687.00	2.19	4584911.73	
Licensed Group Home PCS S5125 U4 AMAP	15 minute	28	4822.00	2.07	279483.12	
Licensed Group Home PCS S5125 U1 AMAP	15 minute	68	6822.00	6.99	3242633.04	
Licensed Group Home PCS S5125 U2 AMAP	15 minute	68	11746.00	3.71	2963280.88	
Licensed Group Home PCS S5125 U3 AMAP	15 minute	61	8687.00	2.61	1383057.27	
Non-Medical Transportation Total:						11048016.60
Transportation - Trips	trips	1106	165.00	9.89	1804826.10	
Transportation - Miles - Personal Options	miles	966	5989.00	0.50	2892687.00	
Transportation - Miles	miles	3531	3597.00	0.50	6350503.50	
GRAND TOTAL:					563062808.68	
Total Estimated Unduplicated Participants:					6165	
Factor D (Divide total by number of participants):					91332.17	
Average Length of Stay on the Waiver:						360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Occupational Therapy Total:						842977.74
Occupational Therapy	15 minute	123	89.00	24.86	272142.42	
Occupational Therapy Modifier	15 minute	258	89.00	24.86	570835.32	
Out-of-Home Respite Total:						915046.86
Out of Home Respite Agency T1005 U5	15 minute	27	347.00	3.18	29793.42	
Out of Home Respite Agency T1005 U6	15 minute	2	6.00	2.12	25.44	
Out of Home Respite Personal Options	15 minute	16	3536.00	3.00	169728.00	
Out of Home Respite Agency T1005 U1	15 minute	100	1125.00	6.36	715500.00	
Physical Therapy Total:						1363919.04
Physical Therapy	15 minute	493	108.00	24.86	1323645.84	
Physical Therapy Modifier	15 minute	15	108.00	24.86	40273.20	
Skilled Nursing by a Licensed Practical Nurse Total:						5649669.21
Skilled Nursing by a Licensed Practical Nurse T1003 U2	15 minute	5	1355.00	4.29	29064.75	
Skilled Nursing by a Licensed Practical Nurse T1003 U3	15 minute	1857	266.00	6.43	3176175.66	
Skilled Nursing by a Licensed Practical Nurse T1003 U4	15 minute	1320	144.00	12.86	2444428.80	
Skilled Nursing by a Registered Nurse Total:						9432165.72
Skilled Nursing RN IPP Planning	event	2544	2.00	80.34	408769.92	
Skilled Nursing RN	15 minute	3015	92.00	19.51	5411683.80	
Skilled Nursing Medication Administration T1003 TE	event	416	300.00	28.94	3611712.00	
Speech Therapy Total:						371664.00
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech Therapy 92507 GN UG	15 minute	231	24.00	53.40	296049.60	
Speech Therapy 92507 GN	event	59	24.00	53.40	75614.40	
Unlicensed Residential Person- Centered Support Total:						259018981.17
Unlicensed Residential PCS Agency S5125 UP	15 minute	610	10417.00	2.19	13916070.30	
Unlicensed Residential PCS Agency S5125 HI	15 minute	1499	12755.00	6.57	125616724.65	
Unlicensed Residential PCS Agency S5125 UN	15 minute	1204	15636.00	3.29	61936697.76	
Unlicensed Residential PCS Personal Options	15 minute	27	25454.00	3.63	2494746.54	
Unlicensed Residential PCS Agency S5125 UP AMAP	15 minute	153	10417.00	2.61	4159820.61	
Unlicensed Residential PCS Agency S5125 HI AMAP	15 minute	375	12755.00	6.99	33434043.75	
Unlicensed Residential PCS Agency S5125 UN AMAP	15 minute	301	15636.00	3.71	17460877.56	
GRAND TOTAL:					563062808.68	
Total Estimated Unduplicated Participants:					6165	
Factor D (Divide total by number of participants):					91332.17	
Average Length of Stay on the Waiver:						360

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 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 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						15596400.00
Service Coordination G9002 U3	15 minute	4576	12.00	200.00	10982400.00	
Service Coordination G9002 U4	event	1538	12.00	250.00	4614000.00	
Facility-Based Day Habilitation Total:						22728173.18
Facility Based Day Habilitation T2021 U6	15 minute	973	1332.00	3.20	4147315.20	
Facility Based Day Habilitation T2021 U7	15 minute	331	256.00	2.03	172014.08	
Facility Based Day Habilitation T2021 U5	15 minute	1405	1754.00	7.47	18408843.90	
Home-Based Agency Person- Centered Support Total:						22801522.32
Home-Based Agency PCS S5125 U7	15 minute	955	3016.00	6.36	18318580.80	
Home-Based Agency PCS S5125 U8	15 minute	131	944.00	3.18	393251.52	
Home-Based Agency PCS S5125 U9	15 minute	1377	1000.00	2.97	4089690.00	
In-Home Respite Total:						29923175.28
In Home Respite Agency T1005 UA	15 minute	1431	1966.00	6.36	17892880.56	
In Home Respite Agency T1005 UB	15 minute	17	1112.00	3.18	60114.72	
In Home Respite Personal Options	15 minute	1215	3284.00	3.00	11970180.00	
Prevocational Services Total:						3611136.44
Prevocational Services T2021 U1	15 minute	432	650.00	7.47	2097576.00	
Prevocational Services T2021 U2	15 minute	350	1159.00	3.20	1298080.00	
Prevocational Services T2021 U3	15 minute	223	476.00	2.03	215480.44	
Supported Employment Total:						3545727.66
Supported Employment	15 minute				132738.06	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
T2019 HQ		49	897.00	3.02		
Supported Employment T2019	15 minute	395	1149.00	7.52	3412989.60	
Participant-Directed Goods and Services Total:						131238.00
Participant- Directed Goods and Services	each	207	634.00	1.00	131238.00	
Behavior Support Professional Total:						20367670.40
Behavior Support Professional T2021HN	15 minute	3924	372.00	12.80	18684518.40	
Behavior Support Professional T2025HO	15 minute	144	206.00	15.34	455045.76	
Behavior Support Professional I IPP Planning T2024 HI	event	144	4.00	53.74	30954.24	
Behavior Support Professional II IPP Planning T2025 HI	Event	3800	4.00	78.76	1197152.00	
Crisis Intervention Total:						19774.40
Crisis Intervention	15 minute	2	680.00	14.54	19774.40	
Crisis Site Person- Centered Support Total:						617151.12
Crisis Site PCS T1005 U8	15 minute	18	2140.00	4.10	157932.00	
Crisis Site PCS T1005 U7	15 minute	22	2505.00	8.18	450799.80	
Crisis Site PCS T1005 U9	15 minute	12	257.00	2.73	8419.32	
Dietary Therapy Total:						80944.16
Dietary Therapy	15 minute	281	11.00	24.86	76842.26	
Dietary Therapy Modifier	15 minute	15	11.00	24.86	4101.90	
Electronic Monitoring Total:						146930.10
Electronic Monitoring S5161 U4	hour	2	1141.00	2.27	5180.14	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Electronic Monitoring S5161 U3	hour	2	2582.00	3.03	15646.92	
Electronic Monitoring S5161 U2	hour	2	3528.00	4.54	32034.24	
Electronic Monitoring S5161 U1	hour	7	1480.00	9.08	94068.80	
Environmental Accessibility Adaptations Total:						34390.00
Environmental Accessibility Adaptations- Vehicle	each	5	744.00	1.00	3720.00	
Environmental Accessibility - Home Modifier	event	16	878.00	1.00	14048.00	
Environmental Accessibility - Vehicle Modifier	event	7	744.00	1.00	5208.00	
Environmental Accessibility Adaptations- Home	each	13	878.00	1.00	11414.00	
Family Person- Centered Support Total:						11888228.74
Family PCS - Shared Living Residential Habilitation S5125 U5	15 minute	1931	6684.00	4.73	61049182.92	
Family PCS - Shared Living Residential Habilitation S5125 U6	15 minute	21	4166.00	2.37	207341.82	
Family PCS - Shared Living Residential Habilitation Personal Options	15 minute	2186	8788.00	3.00	57631704.00	
Job Development Total:						55873.60
Job Development	15 minute	10	743.00	7.52	55873.60	
Licensed Group Home Person- Centered Support Total:						35872032.94
Licensed Group Home PCS S5125 U4	15 minute	111	4822.00	1.65	883149.30	
Licensed Group Home PCS S5125 U1	15 minute	270	6822.00	6.57	12101545.80	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Licensed Group Home PCS S5125 U2	15 minute	270	11746.00	3.29	10433971.80	
Licensed Group Home PCS S5125 U3	15 minute	241	8687.00	2.19	4584911.73	
Licensed Group Home PCS S5125 U4 AMAP	15 minute	28	4822.00	2.07	279483.12	
Licensed Group Home PCS S5125 U1 AMAP	15 minute	68	6822.00	6.99	3242633.04	
Licensed Group Home PCS S5125 U2 AMAP	15 minute	68	11746.00	3.71	2963280.88	
Licensed Group Home PCS S5125 U3 AMAP	15 minute	61	8687.00	2.61	1383057.27	
Non-Medical Transportation Total:						11048016.60
Transportation - Trips	trips	1106	165.00	9.89	1804826.10	
Transportation - Miles - Personal Options	miles	966	5989.00	0.50	2892687.00	
Transportation - Miles	miles	3531	3597.00	0.50	6350503.50	
Occupational Therapy Total:						842977.74
Occupational Therapy	15 minute	123	89.00	24.86	272142.42	
Occupational Therapy Modifier	15 minute	258	89.00	24.86	570835.32	
Out-of-Home Respite Total:						915046.86
Out of Home Respite Agency T1005 U5	15 minute	27	347.00	3.18	29793.42	
Out of Home Respite Agency T1005 U6	15 minute	2	6.00	2.12	25.44	
Out of Home Respite Personal Options	15 minute	16	3536.00	3.00	169728.00	
Out of Home Respite Agency T1005 U1	15 minute	100	1125.00	6.36	715500.00	
Physical Therapy Total:						1363919.04
Physical Therapy	15 minute	493	108.00	24.86	1323645.84	
Physical Therapy					40273.20	
GRAND TOTAL:					563062808.68	
Total Estimated Unduplicated Participants:					6165	
Factor D (Divide total by number of participants):					91332.17	
Average Length of Stay on the Waiver:						360

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Modifier	15 minute	15	108.00	24.86		
Skilled Nursing by a Licensed Practical Nurse Total:						5649669.21
Skilled Nursing by a Licensed Practical Nurse T1003 U2	15 minute	5	1355.00	4.29	29064.75	
Skilled Nursing by a Licensed Practical Nurse T1003 U3	15 minute	1857	266.00	6.43	3176175.66	
Skilled Nursing by a Licensed Practical Nurse T1003 U4	15 minute	1320	144.00	12.86	2444428.80	
Skilled Nursing by a Registered Nurse Total:						9432165.72
Skilled Nursing RN IPP Planning	event	2544	2.00	80.34	408769.92	
Skilled Nursing RN	15 minute	3015	92.00	19.51	5411683.80	
Skilled Nursing Medication Administration T1003 TE	event	416	300.00	28.94	3611712.00	
Speech Therapy Total:						371664.00
Speech Therapy 92507 GN UG	15 minute	231	24.00	53.40	296049.60	
Speech Therapy 92507 GN	event	59	24.00	53.40	75614.40	
Unlicensed Residential Person- Centered Support Total:						259018981.17
Unlicensed Residential PCS Agency S5125 UP	15 minute	610	10417.00	2.19	13916070.30	
Unlicensed Residential PCS Agency S5125 HI	15 minute	1499	12755.00	6.57	125616724.65	
Unlicensed Residential PCS Agency S5125 UN	15 minute	1204	15636.00	3.29	61936697.76	
Unlicensed Residential PCS Personal Options	15 minute	27	25454.00	3.63	2494746.54	
Unlicensed Residential PCS Agency S5125	15 minute	153	10417.00	2.61	4159820.61	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						563062808.68 6165 91332.17 360

<i>Waiver Service/ Component</i>	<i>Unit</i>	<i># Users</i>	<i>Avg. Units Per User</i>	<i>Avg. Cost/ Unit</i>	<i>Component Cost</i>	<i>Total Cost</i>
<i>UP AMAP</i>						
<i>Unlicensed Residential PCS Agency S5125 HI AMAP</i>	<i>15 minute</i>	<i>375</i>	<i>12755.00</i>	<i>6.99</i>	<i>33434043.75</i>	
<i>Unlicensed Residential PCS Agency S5125 UN AMAP</i>	<i>15 minute</i>	<i>301</i>	<i>15636.00</i>	<i>3.71</i>	<i>17460877.56</i>	
<p><i>GRAND TOTAL:</i></p> <p><i>Total Estimated Unduplicated Participants:</i></p> <p><i>Factor D (Divide total by number of participants):</i></p> <p><i>Average Length of Stay on the Waiver:</i></p>						<p><i>563062808.68</i></p> <p><i>6165</i></p> <p><i>91332.17</i></p> <p><i>360</i></p>