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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers 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 an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

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

B. Program Title:
Aged and Disabled Waiver

C. Waiver Number:WV.0134
Original Base Waiver Number: WV.0134.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
07/01/22
Approved Effective Date of Waiver being Amended: 07/01/20

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

1. Add Medical Adult Day Care
2. Add Additional Slots
3. Add Environmental Accessibility Adaptations (EAA)Home and Vehicle for traditional and self-directed SDM. Maximum $1,000 per SP year.
4. Remove need for MNER on annual applications, use PAS anchor date for renewal dates.
5. Accepting Certified Nursing Assistants (CNA) as credentials for PA upon proof of documentation of certification and completion of first aid and CPR to expedite hiring process.
6. Removed the requirement of use of EVV for CMs

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A Waiver Administration and Operation	
☐ Appendix B Participant Access and Eligibility	
☒ Appendix C Participant Services	
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☐ Appendix I Financial Accountability	
☒ Appendix J Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☒ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☒ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☐ **Other**

Specify:

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

1. Request Information (1 of 3)

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

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

Aged and Disabled Waiver

C. Type of Request: amendment

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.0134
Draft ID: WV.006.07.05

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/20
Approved Effective Date of Waiver being Amended: 07/01/20

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: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 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 in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

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

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

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

2. Brief Waiver Description

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

The Aged and Disabled Waiver (ADW) Program is a long-term care alternative that provides services that enable an individual to remain at or return home rather than receive nursing home care. The program provides home and community-based services to West Virginia residents who are eligible to participate in the program. Individuals must be at least 18 years of age and choose home and community-based services rather than nursing home placement. The goals and objectives of this program are focused on providing services that are person-centered and promote choice, independence, participant-direction, respect, dignity and community integration.

The organizational structure for this waiver includes the West Virginia Department of Health and Human Resources Bureau for Medical Services (BMS) as the Single State Medicaid Agency as well as an Operating Agency for daily operations and a Utilization Management Contractor for assessment and re-assessment. BMS retains final authority over this waiver and the administration and operation of the program.

The Bureau for Medical Services (BMS) contracts with another State agency, the Bureau of Senior Services, to operate the program (OA). BMS also contracts with a Utilization Management Contractor (UMC) to assess medical eligibility for program applicants, as well as, annual re-evaluations for those receiving Waiver services. The UMC also authorizes ADW services for eligible applicants and maintains the Managed Enrollment List (MEL). BMS contracts with a claims processing entity to process claims. For people who choose to direct their own services, BMS contracts with a sole Government sub-agent Fiscal Employer Agent (FE/A) Financial Management Service (FMS), hereafter referred to as Personal Options, to provide support.

Members have free choice of qualified providers, however, they must choose one agency to provide Case Management Services and another agency to provide all other ADW services.

Members on the ADW program can choose one of two service delivery models - Traditional or Personal Options. Members choosing the Traditional Model receive their services from certified ADW Personal Attendant and Case Management Agencies. The services available include Case Management, Personal Attendant Services, Skilled Nursing, Transportation, Personal Emergency Respondent Systems, Environmental Accessibility Adaptations, and Adult Medical Day Care.

Members who choose to self-direct their services through the Personal Options model are allotted a monthly budget which they can use to hire employees to provide Personal Attendant Services. They may also budget for Transportation, Personal Emergency Respondent Systems, EAA, and Adult Medical Day Care per policy guidelines if they prefer. Members who choose Personal Options must access case management services from a certified ADW Case Management Agency.

The number of Personal Attendant hours an eligible member can receive under the Traditional Model and the personal options model,is based upon their assessed level of service.

The Operating Agency is responsible for implementing the Quality Improvement System (QIS) for the ADW program. The Operating Agency employs staff who review providers every twelve (12) months to ensure provider qualifications and the delivery of quality services. Case Management agencies have front line responsibility for ensuring the health and safety of members on the ADW program. The West Virginia Incident Management System (WVIMS) is a web-based application that allows providers to report incidents, enter information about their follow-up investigations, document referrals to appropriate authorities such as Adult Protective Services or law enforcement, and track incidents. The Operating Agency’s staff utilizes the WVIMS to monitor and track critical incidents in real time and generates monthly statewide reports. Reports are analyzed at the monthly contract management meetings and the ADW Quality Improvement Advisory (QIA) Council.

An ADW Quality Improvement Advisory (QIA) Council, representing a wide range of stakeholders, reviews and evaluates all quality management data and makes quality improvement recommendations to BMS and the Operating Agency. Specific quality improvement goals and objectives are incorporated into the Quality Work Plan. The Quality Work Plan is used to guide the work of the Quality Improvement Advisory Council meeting.

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

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

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

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

I. Public Input. Describe how the state secures public input into the development of the waiver:

WV put a notice in the state's largest newspaper announcing the 30 day public comment period and sent a copy of the notice to all the ADW providers directing them to put the notice in a prominent place in their offices and to direct all of their case managers to call the members on their caseloads and advise them of the 30 day pubic comment period. Additionally BMS posted a notice on the BMS website and posted it on the BMS FaceBook page.

The public comment period for this draft amendment was from September 16, 2020 to October 15, 2020. The comments made and the responses indicating whether a change was made or not can be found here: https://dhhr.wv.gov/bms/Programs/Documents/ADW%20Waiver/CMS%20approved%20Waiver%20and%20Reports/ADW_Draft_

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:
Hill

First Name:
Randall

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

Agency:
Bureau for Medical Services

Address:
350 Capitol Street, Room 251

Address 2:

City: Charleston, WV

State: **West Virginia**

Zip: 25301

Phone: (304) 558-1700 **Ext:** ☐ **TTY**

Fax: (304) 558-4398

E-mail: Randall.K.Hill@wv.gov

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

Last Name: Silverman

First Name: Susan

Title: Director of Medicaid Operations

Agency: Bureau of Senior Services

Address: 1900 Kanawha Blvd.

Address 2:

City: Charleston

State: **West Virginia**

Zip: 25305

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

Fax: (304) 558-5609

E-mail: Susan.R.Silverman@wv.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously

operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Manning

First Name: Becky

Title: Deputy Commissioner

Agency: WV Bureau of Medical Services

Address: 350 Capitol Street, Room 251

Address 2:

City: Charleston

State: **West Virginia**

Zip: 25301

Phone: (304) 558-1700 **Ext:** ☐ **TTY**

Fax: (304) 558-1451

E-mail: Becky.A.Manning@wv.gov

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:

1. Add Medical Adult Day Care
2. Add Additional Slots
3. Add Environmental Accessibility Adaptations
4. Remove need for MNER on annual applications, use PAS anchor date for renewal time
5. Accepting Certified Nursing Assistants as credentials for PA

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

The state assures this waiver amendment will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based setting Statewide Transition Plan. The state will implement CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

The West Virginia Bureau of Senior Services (BoSS)

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Aged and Disabled Waiver (ADW) is operated by a separate agency of the State Under the Supervision and guidance of the West Virginia Bureau for Medical Services (BMS). BMS provides administrative oversight and issues policies, rules and regulations related to the operation of the ADW program. A copy of the interagency agreement between BMS and Operating Agency outlining specific activities, functions, and responsibilities is on file. The administrative functions delegated to the operating Agency include:

- Member waiver enrollment
- Qualified provider enrollment and continuing certification
- Provider monitoring reviews (assessments, service plans,plan of care, employee qualifications, etc.)
- Quality assurance and quality improvement activities

Per the interagency agreement with BMS, the Operating Agency will:

- Perform on-site and/or virtual visits to prospective ADW providers to evaluate certification requirements
- Refer potential service providers for enrollment as ADW providers
- Enroll new members on the ADW
- Monitor provider compliance with Program policies and certification criteria
- Monitor the delivery of ADW services for appropriateness and effectiveness
- Provide monthly reports on all provider monitoring activities
- Maintain ADW provider files, information, and reports necessary to determine compliance with established program standards
- Represent BMS's interests in all ADW Fair Hearings
- Provide ADW providers with appropriate Medicaid regulations and policies
- Confer with BMS staff on training and provide technical assistance to ADW providers
- Respond to all referrals and other requests (except for fiscal issues) in writing with consultation with BMS
- Establish and maintain secure Email capacity that complies with HIPAA regulations
- Provide the necessary appropriated state funds to match with federal administrative matching funds for ADW services and certify in writing, on a quarterly basis, the availability of such funds
- Invoice the Bureau for Medical Services for allowable administrative costs
- Repay any administrative funds that are disallowed as a result of federal and/or state audits
- Conduct an annual satisfaction survey for ADW members

Quality Improvement

- Maintain an ongoing and effective Quality Improvement system for the ADW
- Maintain and support an ADW Quality Improvement Advisory (QIA) Council
- Develop and monitor the implementation of an annual Quality Work Plan for the ADW
- Develop and distribute the ADW Discovery and Remediation (D&R) Report and distribute quarterly to the QIA Council and distribute monthly to BMS
- Manage an Incident Management System and complaint line for the ADW
- Maintain minutes of the monthly operational/contract meeting with BMS
- Conduct quality reviews of all ADW providers and prepare review reports. (Final reports must be approved by BMS prior to any distribution or action)

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

-Monthly contract meetings with BMS,Operating Agency staff, and other contracted entities
- Monthly written reports prepared for and submitted to BMS and Operating Agency management staff
-Quarterly Quality Management Reports submitted to BMS and Operating Agency management staff
-Quarterly QIA Council Meetings

Transition Coordination

The contractor will provide Transition Coordination to support residents of nursing facilities, hospitals and IMDs who qualify for Waiver transition services. The contractor will provide a network of at least five (5) Full-Time Equivalent (FTE) Transition Coordinators located strategically throughout the state. Transition Coordinators will work one-on-one with eligible residents and their Transition Teams to:
-Accept and follow-up with referrals from the Aging & Disability Resource Network (ADRN);
-Conduct interviews to share information about options for returning to the community, including the availability of Waiver transition services;
-Assess residents' transition support needs, including risk factors that may jeopardize a safe and successful transition to the community;
-Facilitate the development of a Transition Team consisting of the resident, the Transition Coordinator, the Waiver Case Manager, the facility social worker and other appropriate staff and anyone else the resident chooses to include in the transition process;
-Work with the resident and his/her Transition Team to develop a written Transition Plan which incorporates specific services and supports to meet identified transition needs;
-Conduct a Risk Analysis and develop a written Risk Mitigation Plan to address and monitor all identified risks that may jeopardize the resident's successful transition;
-Arrange and facilitate the procurement and delivery of needed transition services and supports including Waiver transition services prior to transition.:

The contractor will also provide one (1) Transition Manager to:
-Oversee the day-to—day operations and delivery of Transition Coordination;
-Participate in monthly contract meetings with designated staff from the contractor and the Bureau for Medical Services (BMS);
-Review and approve all Transition Plans prior to the delivery of Waiver transition services;
-Organize and facilitate monthly calls with Transition Coordinators to share information, provide technical assistance as needed, acquire feedback and address concerns that may impact the delivery of effective Transition Coordination;
-Provide monthly Program and data reports as specified;
-Provide ad hoc reports as requested by BMS, and;
-Attend Waiver Quality Assurance and Improvement Advisory Council meetings.

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

BMS contracts with the following entities to perform operational and administrative functions as follows:

1. Operating Agency Overview and Functions:
   1. Member waiver enrollment
   2. Qualified provider enrollment and continuing certification
   3. Provider monitoring reviews (assessments, service plans, plan of care, employee qualifications, etc.)
   4. Quality assurance and quality improvement activities and data reporting
   5. Community Transition Coordination
   6. Conduct an annual satisfaction survey

2. Community Transition Coordination
   1. Transition Manager
   2. 5 Transition Coordinators located state-wide to assist individuals who require transition services to safely transition from long-term facilities, such as nursing homes and hospitals, to the community.
3. Part-time support staff.

3. Utilization Management Contractor (UMC) Overview and Functions:
   (UMC):
   1. Level of Care evaluation/re-evaluations
   2. Prior authorization of Waiver services
   3. Data Reporting
   4. Management of the Managed Enrollment List (wait list) database
   5. Maintenance of database (ADW CareConnection) that holds comprehensive list of all enrolled ADW members

4. Claims Processing Entity Overview and Functions:
   1. Pay provider claims in accordance with BMS guidelines and as prior authorized by the UMC;
   2. Provider education and technical assistance pertinent to claims; and
   3. Enrollment of qualified providers as directed by BMS.
   4. Data reporting

5. Government Fiscal Employer/Agent (F/EA) (Personal Options) Overview and Functions:
   1. Assists those who Self-Direct to exercise their budget authority;
   2. Act as a neutral bank, receiving and disbursing public funds, tracking and reporting on the member's budget funds(received, disbursed and any balances);
   3. Assists member in exercising employer authority;
   4. Assures the members' workers meet employment requirements including citizenship or legal alien status as specified on the BCIS Form I-9;
   5. Process support worker's timesheets and transportation invoices;
   6. Operate a payroll service, (including withholding taxes from workers' pay, filing and paying Federal (e.g., income tax withholding, FICA and FUTA), state (e.g., income tax withholding and SUTA), and, when applicable, local employment taxes, and garnishments);
   7. Distribute payroll checks on the member's behalf;
   8. Executing provider agreements on behalf of the Medicaid agency;
   9. Provide orientation/skills training to members about their responsibilities when they function as the common law employer of their direct support workers; and
   10. Provide ongoing information and assistance to member and/or their legal/non-legal representative.
   11. Serve as FMS for processing Community Transition Service invoices.

6. EVV Contractor

The EVV system will verify:

1. The type of service performed
2. The member receiving the services
3. The date of the service
4. The location of the service delivery
5. The individual providing the service

6. The time the service begins and ends

Services requiring EVV will be utilized by direct care staff (personal attendants)who will use the system to check in at the beginning of the visit. After the visit, the member or authorized representative will use the system to verify the correct visit has been provided. This system is currently in place.

○ **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 Health and Human Resources, 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 Operating Agency , Take Me Home (TMH) and the Personal Options vendor. 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 ADW Discovery and Remediation (D&R) report and the monthly activity reports of the contracted agencies (OA,UMC, FEA) and reviewed at least monthly by BMS at its contract meetings. Information from the ADW D&R report is also reviewed quarterly by the ADW Quality Improvement Advisory Council.

Reports:

BMS management staff will receive and review the following contract reports:
(1) ADW Discovery & Remediation Report and monthly activity reports on delegated functions and ad hoc reports as requested.
(2) Personal Options Monthly Report on delegated functions and ad hoc reports as requested.
(3) Claims Processing Vendor routine reports on claims data and ad hoc reports as requested.
(4) UMC monthly reports on delegated functions and ad hoc reports as requested.
(5) TMH monthly reports on delegated functions and ad hoc reports as requested.

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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 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 completed

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

UMC		
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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):
Record reviews, on-site
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

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):
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 =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Percent of request 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):
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 = 95%
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

UMC		
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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):
Record reviews, on-site
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Percent of written complaints followed up by the Operating Agency within established timelines. Numerator: Number of written complaints followed up on by the Operating Agency within established timelines Denominator: Number of written complaints submitted to the Operating Agency

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percent of provider validation reviews that were conducted following Continuing Certification reporting. Numerator= Number of provider reviews that passed validation Denominator= Number of provider validation reviews that were randomly selected for validation reviews

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 =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: 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 Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

○ **Not applicable. There is no maximum age limit**

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

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

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

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible

individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c*.

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

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

Specify the percentage:

○ **Other**

Specify:

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

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

The needs of the member on the ADW are addressed in their Service Plan (SP), which is developed by the ADW Case Manager and the member/legal representative receiving services. The SP includes waiver services, non-waiver services, informal supports, and emergency back up planning. The SP must address all identified needs, including risks to member health and welfare and member choice. If a member is denied eligibility then the denial letter sent to the member will include notification of how to file for a request or a Medicaid Fair Hearing.

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

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

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

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

☒ **Other safeguard(s)**

Specify:

A key Case Management function is to oversee the implementation of a member's ADW services as outlined on the Service Plan (SP). At a minimum, the Case Managers must contact ADW members monthly to review the implementation of the SP and address any issues or concerns. If a member experiences a change in medical status, the UMC may authorize an increase to the member's service level with documentation verifying the changes. At no time however would a service level be authorized for more than the maximum amount approved based on medical status on the PreAdmission Screen (PAS).

If circumstances arise that places the member's health and welfare at risk and cannot be adequately addressed with ADW services, the Case Manager must make appropriate referrals to other available resources in the community. As a last resort, if a member's health and welfare cannot be assured by utilizing ADW services and/or other available community resources, the member will be referred for nursing facility services.

Appendix B: Participant Access and Eligibility

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

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

neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	7912
Year 2	8500
Year 3	7500
Year 4	7026
Year 5	7026

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	
Transition Services	

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):*

Transition Services

Purpose *(describe):*

The State will reserve capacity in Waiver Years 1,2,3, 4 and 5 for individuals who are medically and financially eligible for the Aged and Disabled Waiver program, who have been in a facility, such as nursing home, hospital or IMD, for at least sixty consecutive days and who choose to transition to a community setting consistent with the CMS Integrated Setting Rule.

Describe how the amount of reserved capacity was determined:

The amount of capacity reserved is based on the number of transitions projected for Waiver Years 1,2,3,4 and 5. These projections were based on the experience of the Money Follows the Person demonstration grant.

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

Waiver Year	Capacity Reserved
Year 1	76
Year 2	76
Year 3	76
Year 4	76
Year 5	76

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

When the capacity for members served by the Aged and Disabled Waiver (ADW) program is reached, applicants for ADW services are placed on a Managed Enrollment List (MEL)until the time a funded slot is available.

Upon application, financial eligibility and medical eligibility must be determined. Once determined, applicants are placed on the MEL (if being utilized). Applications for entry to the program will be processed based on the date/time of their correctly completed Medical Necessity Evaluation Request (MNER) as capacity becomes available. If at any time there would not be a MEL, the applicant will be entrants to the waiver program upon completion of financial and medical eligibility.

Take me Home applicants are not subject to the same MEL requirements which requires an ADW funded slot be available. They may access a slot immediately as long as a slot ear marked for TMH is available in Waivers Years 1,2,3,4 and 5.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a *(select one)*:

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.
Indicate whether the state is a Miller Trust State *(select one)*:

- (●) **No**
- ( ) **Yes**

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

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

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

Select one:

○ **100% of the Federal poverty level (FPL)**

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

Specify percentage:

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

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

Specify:

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

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

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

Check each that applies:

☒ **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, 2019 (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 §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The state uses the post-eligibility rules at 42 CFR 435.726 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 §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 periods before January 1, 2014 or after December 31, 2018.

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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 the 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 member.

iii. 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 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 five-year period beginning January 1, 2014.

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

Answers provided in Appendix B-5-a indicate 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 five-year period beginning January 1, 2014.

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

Answers provided in Appendix B-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 five-year period beginning January 1, 2014.

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

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

Answers provided in Appendix B-5-a indicate 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 a government agency under contract with the Medicaid agency.**

Specify the entity:

Utilization Management Contractor

○ **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 UMC, all initial assessments for the determination of medical eligibility for the ADW program are conducted by registered nurses.

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

Medical Eligibility Criteria:

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

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

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

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

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

◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the**

state Plan.

○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

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

The Utilization Management Contractor (UMC) employs registered nurses located across the state who conduct assessments of medical eligibility for the Aged and Disabled Waiver Program (ADW). Staffing for the program is adjusted based on the volume of medical eligibility requests received by the UMC. The process detailed below applies to both initial assessments of medical eligibility:

Initial Evaluations

1. Initial evaluation requests (MNER) are submitted to the UMC to initiate scheduling of PAS evaluation.
2. The MNER must be signed by the required individuals per ADW policy.
3. For initials, the UMC enters the information from the referral into a database.
4. If WVDHHR notifies the UMC the applicant is not financially eligible, the referral is closed.
5. The UMC will attempt to contact the applicant/legal representative within established timeframes to schedule the PAS.

6. The UMC issues a potential closure if the applicant/person cannot be contacted within an established number of contact attempts. The potential closure notification includes a toll-free number to call to schedule the evaluation.
7. The UMC closes the referral if no response is received within established time frames. If the applicant/person decides to have the evaluation after the referral is closed, a new referral may be required depending on the period of time passed.
8. Upon contacting the applicant/person (or legal representative), the UMC schedules the evaluation visit.
9. The UMC sends an appointment confirmation to the applicant/person (or legal representative) once the PAS is scheduled; copies of the appointment confirmation are made available to the referring entity.
10. During the assessment, which may be in person or via telephone, an UMC RN distributes/shares information regarding the program to the applicant/person (or legal representative). The RN explains the reason for the visit/call and offers to read/explain any of the information distributed.
11. The RN reviews and explains the Service Delivery Model Options with the applicant during the initial visit/call if the applicant did not previously make selections.
12. The RN collects data for the PAS Assessment by asking questions and requesting the applicant/person demonstrates abilities (e.g. walking, transferring, raising arms)if an in person visit is completed. The RN reviews the assessment documentation with those present at the visit/call once the evaluation is complete and allows time for any questions or discussions surrounding the documentation.
13. The RN submits the evaluation. During the time between the assessment and submission of the evaluation, the RN attempts to clarify any outstanding issues with the applicant/person's treating physician. Such issues may include additional diagnoses.
14. The UMC runs the evaluation through an algorithm based on current BMS policy to determine eligibility. If the applicant/person has the required deficits, the algorithm will calculate the person's service level, consistent with BMS policy.
15. If the person is medically eligible, the UMC issues a medical eligibility determination letter.
16. If the evaluation shows less than the required number of deficits, the UMC issues a potential denial letter to the applicant/person and the referring entity, allowing time to submit additional clinical information. The UMC issues a final denial letter to the applicant/person (or legal representative)with appeal rights information and a copy of the evaluation if no additional information is submitted within timeframes.
17. A final denial letter is made available to the applicant/person (or legal representative, along with a copy of the final assessment form and appeal rights.Also available are the hearing request form with instructions for completion and the BMS approved insert with additional resources listed.
18. Once the applicant is determined both medically and financially eligible, an anchor date is assigned.

Re-evaluations:
The UMC conducts annual re-evaluations prior to the person's next Anchor Date.

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

Specify the other schedule:

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

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**
  Specify the qualifications:

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

Per contract, the UMC is responsible for completing all annual re-evaluations prior to the anchor date. Re-evaluations are completed prior to the anchor date. The UMC will begin scheduling PAS evaluations 90 - 45 days prior to anchor date.

The same process is followed for those individuals who self-direct.

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

All initial assessments and annual re-evaluations of medical eligibility determinations are maintained for a minimum of 5 years by the UMC.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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 initial Level of Care (LOC) determinations by the UMC within 45 days of receipt of DHS-2 form Numerator= Number of applicants who received initial Level of Care (LOC) determinations by the UMC within 45 days of receipt of DHS-2 form Denominator = Number of applicants for whom LOC determination was due within the reporting month

Data Source (Select one):
Other
If 'Other' is selected, specify:
Assessment tracking database

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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 initial Level of Care determinations made for which established criteria

were applied appropriately. Numerator= Number of Level of Care determinations made for which established criteria were applied inappropriately. Denominator= Number of Level of Care Determinations due within the calendar month.

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 = 95%
☒ **Other** Specify: UMC	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Reviews conducted for internal quality check. Review sample may not be representative.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

1.The UMC conducts monthly quality assurance and improvement activities on all field nurses. Retrospective reviews are conducted on PAS assessment utilizing a random 10% sampling each month. All elements of both medical eligibility and level of care are reviewed to determine if the nurse is applying the criteria accurately and appropriately. Feedback is given to each nurse monthly regarding the final outcome of the reviews.
2.Accompaniment to PAS appointments are made with the field nurses at least once a year and as needed thereafter as a quality assurance activity. Unannounced accompaniment with the nurse for assessments can occur at any time.
3.Periodically case scenarios are created based on actual PAS assessments, blinded and presented to all the field nurses. The nurses then complete the PAS assessment as a desk review and the outcomes both individually and collectively are tallied with feedback given to the staff.

b. Methods for Remediation/Fixing Individual Problems

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

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

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: 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:*

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

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

At the point of referral (receipt of the MNER by the UMC), the applicant is provided with an ADW Program Brochure that details services available to eligible individuals. The Brochure includes information about their right to choose between home and community based services and institutional services. A Consent Form is used to document the applicant's choice between home and community based services and institutional services.

The ADW Program Brochure also informs the applicant of their right to choose between a Traditional Model and Personal Options Model of services. A Service Delivery Model Selection Form is used to document the applicant's choice between Traditional Model services and Personal Options services. Freedom of Choice of Provider forms is also included at this time.

When the UMC conducts the initial medical eligibility assessment, applicants are presented with the ADW Program Brochure, the Consent Form and the Service Delivery Model Selection Form. If the applicant has not previously signed the forms, indicating their choices, they will be asked to do so at this visit.

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

Freedom of Choice forms (Consent Forms and Service Delivery Model Selection Forms) are maintained electronically for a minimum of 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 the Census 2010, 97.6% of West Virginian's speak only English. Due to this high percentage, the ADW program addresses any needs or requests for alternative material on an individual basis. All materials are currently available in alternate formats for individuals who cannot access standard print material. These formats include large print, audio and Braille. In addition, BMS and all contract staff are available to read printed materials upon request.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Case Management**		
Statutory Service	**Personal Attendant Services**		
Other Service	**Adult Medical Day Care**		
Other Service	**Community Transition Services**		
Other Service	**Environmental Accessibility Adaptations**		
Other Service	**Non-Medical Transportation**		
Other Service	**Personal Emergency Response System**		
Other Service	**Pre-Transition Case Management**		
Other Service	**Skilled Nursing**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services that assist members receiving ADW services in gaining access to needed waiver services and other State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.
Case Management responsibilities also include:
- The ongoing monitoring of the provision of services included in the member's service plan and member health and welfare.
- Initiating the process to re-evaluate the member's medical eligibility and the development of service plans.
- Development of a person-centered service plan that meets member's needs and considers preferences.
- Provides advocacy, coordination of and linkage to services.
- Ensures the health and safety of the member.
- Minimally make quarterly face to face contact in home with the member receiving services.
- Make monthly contact to member to ensure health and safety.
- Availability and/or plan in place to respond to a member in crisis whenever needed.

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**

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):*

The Case Management Agency must be certified by the Bureau for Medical Services (BMS) through the Operating Agency initially and annually thereafter.

Certificate *(specify):*

Agency must be an approved ADW agency.

Other Standard *(specify):*

Staff must have an 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, inspection per state law and registration, be able to perform the tasks and meet training requirements as mandated by BMS.

Case management services must be provided by an individual fully licensed (this does not include provisional or temporary license) in West Virginia as a social worker, counselor or registered nurse or may be an individual with a four year degree (BA or BS) in an approved human service field and successful completion of the CM certification in the on-line case management training developed by BMS. If the individual does possess a provisional or temporary license in social work, counseling or nursing, they also would need to successfully complete the on-line case management certification training developed by BMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is certified by the Operating Agency.
Agency staff training is verified by the Operating Agency.
The Operating Agency will perform certification validation during reviews.

Frequency of Verification:

Agency is certified annually.
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:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Attendant Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Personal Attendant services are defined as long-term direct care and support services that are necessary in order to enable a member to remain at home rather than enter a nursing facility, or to enable a member to return home from a nursing facility. This service provides members receiving ADW services to receive direct-care assistance with Activities of Daily Living (ADLs) such as eating, bathing, grooming, prompting with normally self-administered medications, essential light housekeeping, daily supervision etc. Personal Attendant staff are also responsible for reporting changes in the member's condition, needs, and the supervision of health and welfare risk factors in the home and community. Only qualified staff can provide this support. Personal Attendants will be subject to usage of the Electronic Visit Verification (EVV)and all of the requirements.

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

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

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

The following limits apply to members who utilize the Personal Options Model:
Personal Attendant - cannot exceed the member's monthly budget.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Attendant Agency
Individual	Personal Options

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Attendant Services

Provider Category:

Agency

Provider Type:

Personal Attendant Agency

Provider Qualifications

License *(specify):*

The Personal Attendant Agency must be certified by the Bureau for Medical Services (BMS) by the Operating Agency initially and annually thereafter.

Certificate *(specify):*

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

Other Standard *(specify):*

Agency staff must have current CPR and First Aid cards, have an 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 BMS.

Certified Nursing Assistants (CNA)s who are able to provide documentation of current Certification, can be hired with their CNA credentials once they have completed First Aid and CPR training. They will also be subject to fingerprint guidelines listed above.

Daily billing is required by the PA agency. Personal Attendants will be subject to usage of the Electronic Visit Verification (EVV) and all of the requirements.
.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is certified by the Operating Agency.
Agency staff training is verified by the Operating Agency.
The Operating Agency will perform certification validation during reviews.

Frequency of Verification:

Agency is certified annually.
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: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Attendant Services

Provider Category:
Individual
Provider Type:

Personal Options

Provider Qualifications

License *(specify):*

Not applicable as individual/Employer of Record utilizing the Personal Options program is not required to be an ADW Provider.

Certificate *(specify):*

Not applicable.

Other Standard *(specify):*

The employee of the member utilizing the Personal Options model 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 and general personal attendant training requirements section of the ADW Policy Manual.

Certified Nursing Assistants (CNA)s who are able to provide documentation of current Certification, can be hired with their CNA credentials once they have completed First Aid and CPR training. They are also subject to the same fingerprinting requirements as listed above.

Daily billing is required by F/EA agency. Personal Attendants not residing with the member are subject to Electronic Visit Verification (EVV) and all of the requirements.

Certified Nursing Assistants (CNA)s who are able to provide documentation of current Certification, can be hired with their CNA credentials once they have completed First Aid and CPR training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The member/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 Operating Agency will perform certification validation during reviews with the Personal Options Vendor.

Frequency of Verification:

The employee'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:

Adult Medical Day Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04050 adult day health
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Medical adult day care centers are an ambulatory health care facility which provides an organized day program of therapeutic, social, and health maintenance and restorative services and whose general goal is to provide an alternative to twenty-four-hour long term institutional care to elderly or disabled adults who need such services by virtue of physical and mental impairment. This service provides individuals with chronic physical or cognitive impairments the care they need. A highly cost-effective long-term care alternative, medical adult day health centers administer nursing care, meals, and therapeutic activities in a safe, structured, and homelike environment. Approved providers can bill Non-Emergency Medical Transportation to and from the members place of residence and the facility.

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

The licensee shall establish regular hours of operation of not less than four (4) hours per day and not more than fourteen (14 hours per day, a minimum of five (5) days per week. The Center's hours of operation should be during times that encompass a normal workweek for the member's caregivers. Services are specified in the member's service plan. The services must be provided in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the member. Meals provided as part of these services shall not constitute a "full nutritional regimen" i.e 3 meals per day.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Adult Medical Day Center

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Medical Day Care

Provider Category:
Agency
Provider Type:

Licensed Adult Medical Day Center

Provider Qualifications

License *(specify):*

Providers of medical adult day care centers are required to be a licensed facility via the Office of Health Facility Licensure and Certification (OHFLC) Providers must follow guidelines set forth in 64CSR2 Title 64 Legislative Rule Series 2 Licensure of Medical Adult Day Care Centers in WV.

Certificate *(specify):*

Agency must be enrolled WV ADW Medicaid Provider.

Other Standard *(specify):*

Staff must follow WV Cares requirements and possess an acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check
be able to perform the tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency Licensure is verified annually.
Agency staff training is verified by the OHFLC.

Frequency of Verification:

Agency licensure is verified annually by OHFLC.
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:

Community Transition Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

The Community Transition Service is the primary Waiver service available to support qualifying applicants with a safe and successful transition from facility-based living to the community. Community Transition Services are one-time expenses necessary to support applicants wishing to transition from a nursing facility, hospital or Institution for Mental Disease (IMD) to their own home or apartment in the community. Allowable expenses are those necessary to address barriers to a safe and successful transition identified through a comprehensive Transition Needs Assessment and included in an approved individualized Transition Plan. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the applicant is unable to meet such expense or when the services cannot be obtained from other services. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes. The components of the Community Transition Service include:

(a) Home accessibility adaptation modification - assistance to applicants requiring physical adaptations to a qualified residence. This service covers basic modifications such as ramps, widening of doorways, purchase and installation of grab-bars and bathroom modifications needed to ensure health, welfare and safety and/or to improve independence.
(b) Home furnishings and essential household items - assistance to applicants requiring basic household furnishings to help them transition back into the community. This service is intended to help with the initial set-up of a qualifying residence.
(c) Moving expenses - includes rental of a moving van/truck or the use of a moving or delivery service to move an applicant's goods to a qualified residence. Although this service is intended as a one-time set-up service to help establish a qualified residence, under certain circumstances it may be used throughout the transition period to relocate a member
(d) Security deposit - used to cover rental security deposit.
(e) Utility deposits - used to assist applicants with required utility deposits for a qualifying residence
(f) Transition support - services necessary for the member’s health and safety such as pest eradication and one-time cleaning prior to occupancy.

All transition services must be reasonable and necessary, not available to the member through other means, and clearly specified in the waiver member’s service plan.

Members will be directly responsible for their own living expenses post transition.

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

The total expenditures for Services cannot exceed $4000 per transition period.
Community Transition Services cannot be used to cover the following items. Please note that this is not intended to be an all-inclusive list of exclusions:
-Rent;
-Home improvements or repairs that are considered regular maintenance or upkeep;
-Recreational or illegal drugs;
-Alcohol;
-Medications or prescriptions;
-Past due credit card or medical bills;
-Payments to someone to service as a representative;
-Gifts for staff, family or friends;
-Electronic entertainment equipment;
-Regular utility payments;
-Swimming pools, hot tubs or spas or any accessories, repairs or supplies for these items;
-Travel;
-Vehicle expense including routine maintenance and repairs, insurance and gas money;
-Internet service;
-Pet/Service/Support Care, including food and veterinary care;
-Experimental or prohibited treatments;
-Education;
-Personal hygiene services (manicures, pedicures, hair cuts, etc.), or;
-Discretionary cash
-Assistive Technology

Any service or support that does not address an identified need in the Transitional Plan, or decrease the need for other Medicaid services, or increase the member's safety in the home, or improve and maintain the member's opportunities for full membership in the community is excluded.

For individuals ages 22-64 transitioning from an Institution for Mental Disease (IMD), the individuals will not receive community transition services because Federal Financial Participation (FFP) is not permitted for services rendered to individuals in this age range while they are in an IMD.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Community Transition Service Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Individual
Provider Type:

Community Transition Service Provider

Provider Qualifications

License *(specify):*

The FMS 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):*

Not applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS vendor is responsible for validating vendor qualifications prior to processing invoices and verifies that the item is on an approved transition plan. The UMC vendor verifies the item is not on the exclusion list and a receipt is present for the purchase.

Frequency of Verification:

The contracted FMS vendor verifies prior to each purchase. The UMC vendor verifies the item is not on the exclusion list and a receipt is present for the purchase during the quality review process.

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

Environmental Accessibility Adaptations-Home (EAA-Home) are physical adaptations to the private residence of the member who receives services or the family in which the member resides and receives services which maximize physical accessibility to the home and within the home. EAA-Home must be documented in the Service Plan. Additionally, these adaptations enable the member 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 the vehicle including paying for accessibility adaptations if the member who receives services has the capacity to drive. EAA-Vehicle must be documented in the members Service Plan. The purpose of this service is to maximize accessibility to the vehicle only.

All EAA requests must be submitted by the Personal Attendant provider to the UMC for approval. If approved, the personal attendant provider is responsible for ensuring the adaptation to the home is completed as specified prior to receiving payment and/or paying contracted vendor(s). Documentation including dated and itemized receipts of the completed adaptation must be maintained by the personal attendant provider.

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

EAA - Home:
•EAA-Home is not intended to replace the responsibility of the member who receives services, their family, or their landlord for routine maintenance and upkeep of the home. Those not allowed activities 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 walkway 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 Service Plan year for either Traditional or Self-Directed Service Delivery model (SDM) but not both should the member change SDM within the service plan year. This includes Environmental Accessibility Adaptations for home and vehicle.

EAA - Vehicle:
•$1000 available per Service Plan year for either Traditional or Self-Directed Service Delivery model (SDM) but not both should the member change SDM within the service plan year. This includes Environmental Accessibility Adaptations for home and vehicle.
•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 member 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 personal attendant agency must not pay EAA funds to the member who receives services, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service.

The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Personal Attendant services and Non-Medical Transportation.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Provider Agency
Individual	Personal Options

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:

Certified Provider Agency

Provider Qualifications

License *(specify):*

The EAA vendor must have a business license and possess the skills relevant to providing the work requested.
The ADW Certified PAA provider agency will process the EAA and only pay for work performed by a vendor that has a Business license
and/or relevant skills for work to be performed.

Certificate *(specify):*

NA

Other Standard *(specify):*

NA

Verification of Provider Qualifications

Entity Responsible for Verification:

The PAA is responsible for validating vendor qualifications prior to processing invoices and verifies that the item is on the an approved service plan and not on an exclusion list.
CM is responsible for listing the EAA needs on the member's Service Plan.
The UMC is responsible prior to authorization to assure items/services are not on the exclusion list and are indicated on the Service Plan as a documented need.

Frequency of Verification:

The PAA will verify EAA prior to each purchase.

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 EAA vendor must possess a Business license and possess the relevant skills for the work to be performed.
The Personal Options Vendor is responsible for validating vendor qualifications (business license and possesses the relevant skills for work to be performed) prior to submitting invoices and verifying that an item is on the approved service plan.

Certificate *(specify):*

NA

Other Standard *(specify):*

NA

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 Personal Options vendor.
The CM is responsible to ensure the service is on the service plan.
The Personal Options vendor is responsible for validating that the item is not on the exclusion list and the vendor qualifications prior to processing invoices.
The UMC is responsible prior to authorization to assure items/services are not on the exclusion list and are indicated on the Service Plan as a documented need.

Frequency of Verification:

The Personal Options vendor verifies prior to each purchase.

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:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Non-Medical Transportation is used for non-Medicaid reimbursed medical appointments, essential errands and, community activities. Non-Medical Transportation assists the member with essential errands which are activities necessary for the member to remain in their home and promote independent living (grocery shopping, pharmacy, etc.). Community activities allow opportunities to integrate the member into his/her home community and utilize local community resources (library, park, restaurants). This transportation can also be utilized to transport members to medical appointments that are not Medicaid reimbursed services.

All Non-Medical Transportation with, or on behalf of, a member receiving services must be included on the Service Plan. The Service Plan must address the availability of family, friends or other community agencies to provide the Non-Medical Transportation for the member prior to utilizing this service.

Non-Medical Transportation Services are only to be utilized for the member receiving services needs and cannot be for the benefit of the Personal Attendant, the member's family, friends or others.

These services are provided to members who receive ADW services for trips to and from the home, or to the site of a planned local community activity or service which is addressed on the Service Plan and based on assessed need. Non-Emergency Medical Transportation is available through the state plan for transportation to and from Medicaid reimbursed medical appointments.

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

Non-Medical Transportation Miles: The maximum annual units: Miles cannot exceed 3,600 miles per service plan year (based on average of 300 miles per month).

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

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

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

- ☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Attendant Agency
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:

Personal Attendant Agency

Provider Qualifications

License *(specify):*

Agency must be certified by the Bureau for Medical Services.

Certificate *(specify):*

Agency must be an approved ADW provider and an enrolled WV Medicaid provider.

Other Standard *(specify):*

Agency staff must have current CPR and First Aid cards, have an 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, registration and inspection per state law,be able to perform the tasks and meet training requirements as mandated by the Bureau for Medical Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the Operating Agency.
Agency staff certification is verified by the Operating Agency.
The Operating Agency will perform certification validation during reviews.

Frequency of Verification:

Agency is certified annually.
Agency staffs' credentials are verified initially and annually with the 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: 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 participant/Employer of Record is not required to have a Behavioral Health License or be an enrolled ADW 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, inspection per state law and registration, the ability to perform the tasks and be currently trained on all training requirements listed in the Personal Options section of the ADW Policy Manual.

Verification of Provider Qualifications

Entity Responsible for Verification:

The member/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 Operating Agency will perform certification validation during reviews of the personal options vendor.

Frequency of Verification:

The employee'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:

Personal Emergency Response System

HCBS Taxonomy:

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

14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)

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

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

Service Definition *(Scope):*

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

Personal Emergency Response System (PERS) is an electronic device and monitoring service that enables members to secure help in an emergency. PERS services shall be limited to those individuals who have expressed a desire to have the monitoring system in place or during the person-centered planning assessment and Service Planning meeting, it is determined that the member lives alone or is alone for significant parts of the day, has no regular caregiver/informal supports for extended period of time, and who would otherwise require routine supervision can also be offered the service.
PERS is a service that monitors member's safety in their homes, and provides access to emergency assistance for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the member's home telephone system.
PERS services shall not be used as a substitute for providing adequate supervision for the member enrolled in the waiver

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

Monthly event code up to $50.00 per month.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Attendant Agency
Individual	Personal Options

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:
Agency
Provider Type:

Personal Attendant Agency

Provider Qualifications

License *(specify):*

Agency must be certified by the Bureau for Medical Services

Certificate *(specify):*

Agency must be an approved ADW provider and an enrolled WV Medicaid Provider

Other Standard *(specify):*

The ADW Personal Attendant Agency will choose one or more PERS vendor(s) to provide the service for members that they are serving and who desire or are in need of the service. The PERS vendor must provide an emergency response center with fully trained operators who are capable of receiving signals for help from a member's PERS equipment 24-hours a day, 365 or 366 days per year as appropriate, of determining whether an emergency exists, and notifying an emergency response organization or an emergency responder that the PERS service member needs emergency help.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Personal Attendant Agency is responsible for verifying all of the PERS requirements are met.
Operating Agency does review of program during on-site reviews.
The Operating Agency will perform certification validation during reviews of the Personal Attendant Agency.

Frequency of Verification:

Agency is certified yearly.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Individual

Provider Type:

Personal Options

Provider Qualifications

License *(specify):*

Not applicable as individual/employer of record utilizing the Personal Options program is not required to be an ADW provider.

Certificate *(specify):*

NA

Other Standard *(specify):*

The member/employer participating in the Personal Options Program will choose a PERS vendor to provide the PERS service. The PERS vendor must provide an emergency response center with fully trained operators who are capable of receiving signals for help from a member's PERS equipment 24-hours a day, 365 or 366 days per year as appropriate, of determining whether an emergency exists, and of notifying an emergency response organization or an emergency responder that the PERS service member needs emergency help.

Verification of Provider Qualifications

Entity Responsible for Verification:

The member/employer is responsible for verifying all of the PERS requirements are met.
The Personal Options vendor is responsible for verifying all of the PERS requirements are met.
Operating Agency does review of program during reviews.

Frequency of Verification:

Yearly

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:

Pre-Transition Case Management

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

The purpose of the Pre-Transition Case Management service is to ensure that Waiver services are in place day one of the member's transition to the community. Prior to the member's transition from the facility, Pre-Transition Case managers will:
• Participate in the transition assessment and planning process to help ensure that home and community-based services and supports needs are thoroughly considered in transition planning;
•Conduct the Member Assessment as required by Waiver policy;
•Complete the required Waiver Service Plan;
-Facilitate the development of the Assessment for those eligible for and planning to enroll in the Aged and Disabled Waiver Program when returning to the community;
•Facilitate the development of the Service Plan by the selected Waiver Personal Attendant Agency;
•Coordinate with the Personal Attendant Agency to ensure that direct-care services are in place the first day the member returns home;
•Enroll the member in the Waiver program immediately prior to their transition home. Individuals who have been determined eligible are not "enrolled" in the program until they are ready to receive services. Residents of nursing homes may apply and be determined eligible, but are not enrolled into the Waiver until they have been discharged from the facility (transitioned) and begin Waiver services.

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

Individuals eligible to receive this service:
1. Live in a nursing facility, hospital, Institution for Mental Disease or a combination of any of the three for at least 90 consecutive days, and;
2. Have been determined medically and financially eligible for the Aged and Disabled Waiver program, and;
3. Wish to transition from facility-based living to their own homes or apartments in the community consistent with 42 CFR 441.301(c)(4)-(5).;
4. Have a home or apartment in the community to return to upon leaving the facility that is consistent with the 42 CFR 441.301(c)(4)-(5)C,
5. Require Waiver transition services to safely and successfully transition to community living, and;
6. Can reasonably be expected to transition safely to the community within 180 days of initial date of transition service.

The pre-transition case management service may be billed up to 24 units (a unit is 15 minutes) only one-time following transition to the community. This service is not available once the member transitions to the community and enrolls in the Waiver.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Pre-Transition Case Management

Provider Category:

Agency

Provider Type:

Case Management Agency

Provider Qualifications

License *(specify):*

ADW Case Management Agency must be certified by the Bureau for Medical Services' (BMS)Operating Agency initially and annually thereafter.

Certificate *(specify):*

Agency must be an approved ADW Agency.

Other Standard *(specify):*

Staff must have an acceptable background check through WV CARES per policy, be over the age of 18, valid driver's license, proof of current vehicle insurance and inspection per state law and registration, be able to perform the tasks and meet training requirements as mandated by BMS.

Case management services must be provided by an individual fully licensed (this does not include provisional or temporary license) in West Virginia as a social worker, counselor or registered nurse or may be an individual with a four year degree (BA or BS) in a human service field and certification in the on-line Case management training developed by BMS. If the individual does possess a provisional or temporary license in social work, counseling or nursing, they also would need to successfully complete the on-line case management certification training developed by BMS.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the Operating Agency.
Agency staff is verified by the Operating Agency.
The Operating Agency will perform certification validation during reviews.

Frequency of Verification:

Agency is certified annually.
Agency staff's credentials are verified initially and annually with the exception of the fingerprint-based checks through the WV CARES which are checked every five years.

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

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Registered Nurse (RN) services listed in the service plan are within the scope of the West Virginia Nurse Practice Act and are provided by a RN licensed to practice in the State. RN services are services which only a licensed RN can perform. This service consists of only two components: Annual Nursing Assessment and On-Going RN Duties.

The purpose of the Annual Nursing Assessment is to assess a person's needs to allow for comprehensive service planning.

The purpose of the On-Going RN duties is to ensure supervision and oversight of the services provided by Personal Attendants.

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

The Annual Nursing Assessment is one event per calendar year.

On-Going RN Duties is 6 units (15 minute) per month.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Attendant Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

Personal Attendant Agency

Provider Qualifications

License *(specify):*

Agency must be certified by the Bureau for Medical Services (BMS)
ADW Personal Attendant RN must be a WV Licensed Registered Nurse

Certificate *(specify):*

Agency must be an approved ADW provider and an enrolled WV Medicaid Provider.

Other Standard *(specify):*

Agency staff must have an 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 Bureau for Medical Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the Operating Agency.
Staff verification is verified by the Operating Agency.
The Operating Agency will perform certification validation during reviews.

Frequency of Verification:

Agency is certified annually.
Agency staffs' credentials are verified initially and annually with the exception of the state and federal fingerprint-baseed checks wh ich are checked every 5 years and the OIG which is checked monthly.

Appendix C: Participant Services

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

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

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

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

Appendix C: Participant Services

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

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

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

◉ **Yes. Criminal history and/or background investigations are required.**

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

For the Traditional Option:
The ADW Case Management and Personal Attendant agencies are responsible for ensuring all of their employees complete state and federal fingerprint-based checks through the WV Clearance for Access: Registry & Employment Screening (WV CARES) prior to providing services.

For Personal Options:
The Personal Options vendor is responsible for ensuring all of the member's employees complete state and federal fingerprint-based checks through the WV Clearance for Access: Registry & Employment Screening (WV CARES) 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; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

Appendix C: Participant Services

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

Note: Required information from this page (Appendix C-2-c) 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 to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

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

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

- ☐ **Self-directed**
- ☐ **Agency-operated**

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

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

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

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

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

Relatives may be paid for providing Personal Attendant and/or Transportation services through the ADW excluding the person's legal guardian,spouse and, the parent of a minor child. However the provision of the services must be for the sole benefit of the member receiving the ADW services. If the member chooses to self-direct their services and needs a Program Representative to assist them, then the Program Representative may not be a paid employee. The OA conducts an annual review of member's charts to monitor compliance and to ensure that services are furnished in the best interest of the member. Service Plans are developed by the Case Management agency along with the member,for both traditional and personal options SDM. The OA conducts an annual review of the member's charts to monitor compliance with the Service Plan.

○ **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:

Certification of any provider applicant will be conducted by the Operating Agency. Once certified by the OA, the Bureau for Medical Services (BMS) claims processing entity provides entities interested in becoming an Aged and Disabled Waiver (ADW) provider an enrollment packet, including a provider agreement, along with specific requirements and procedures to qualify. Per policy, the BMS claims processing entity has five (5) business days to process the enrollment application.

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

Workers and vendors providing services under the Personal Options program, must meet established provider qualifications as specified in the service description section. The Personal Options vendor verifies that qualifications are met. The CMA vendor verifies that qualifications for case managers are also met.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and Percent of provider initial certifications conducted by the operating agency in compliance with provider certification standards. Numerator - # of provider initial certifications conducted by the operating agency in compliance with certification standards. Denominator - # of provider initial certifications conducted by the operating agency.

Data Source (Select one):
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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Percent of agency providers who continue to meet licensure and/or certification standards Numerator= Number of agency providers who continue to meet licensure and/or certification standards Denominator= Number of active agency providers

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

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

		Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

requirements.

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

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

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

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

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

Performance Measure:
Percent of agency staff whose Personal Attendant skills training is current
Numerator= Number of agency staff whose Personal Attendant 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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of provider initial certifications conducted by the OA in compliance with provider certification standards. Numerator- Number of provider initial certifications conducted by the OA in compliance with certification standards. Denominator- Number of provider initial certifications conducted by the OA.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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 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 =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Percent of agency staff whose CPR Training is current Numerator= Number of agency staff whose CPR 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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

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

Data Aggregation and Analysis:

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percent of agency staff whose Infectious Disease Control training is current Numerator= Number of agency staff whose Infectious Disease Control 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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☒ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Percent of agency staff whose First Aid training is current Numerator= Number of agency staff whose First aid 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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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 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 =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Percent of agency staff whose recognition and reporting of Abuse/Neglect/Exploitation training is current. Numerator= Percent of agency staff whose recognition and reporting of Abuse/Neglect/Exploitation 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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid**	☐ **Weekly**	☒ **100% Review**

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

All data surrounding this sub-assurance will be collected through the Operating Agency's Quality and Utilization Review process. As individual problems are identified by the OA during the review process, any agency staff who does not meet the required training components will not be permitted to provide any Waiver service and the provider will repay BMS for any disallowances for services provided by unqualified staff. The provider agency must submit proof of required training prior to reinstating the staff. The provider agency must also submit a Plan of Correction which identifies the means by which they will monitor and track required staff training.

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: Quality Improvement Advisory Council (analysis only by QAI)	☒ **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 Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

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

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

WV assures that this Waiver will be subject to any provisions or requirements included in WV's most recent and/or approved home and community based settings Statewide Transition Plan. WV will implement any Center for Medicaid (CMS) required changes by the end of the transition period as outlined in the home and community based settings Statewide Transition Plan.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Service 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 *(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:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

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

1. a. The OA/UMC notifies members of all available providers and services upon application. The member completes a Freedom of Choice form to identify 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 providers of HCB 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 their 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 HCB services supervisor(s) and the case management supervisor(s).
b. Explain how case managers are selected.
c. Explain how members are given choice of HCB services and other natural supports or services offered in the community.
d. Explain how the agency ensures that the case manager is free from 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 provided case manager from 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.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

At the time of the initial medical eligibility assessment, applicants (or legal representative) are provided information regarding their rights to direct and be actively engaged in the Service Plan (SP) development process. General information regarding Person-Centered Planning is also provided. Program information regarding service delivery models (Traditional and Personal Options)is provided as well.

Person-Centered Planning is the process by which the Case Manager (CM) works in collaboration with the member (and legal representative) to develop the SP. The initial SP is scheduled and developed in collaboration with informal supports as requested by the member/legal representative). Subsequent annual and bi-annual revisions to the SP are conducted in collaboration with service providers and informal supports or as needed and requested by the member(and legal representative).

The SP is developed utilizing the medical eligibility assessment and the Person-Centered Assessment. It incorporates the preferences and needs identified by the member. By participating in the assessment process and having access to the support of the CM and other professionals and informal supports, the member has the opportunity and tools to be actively engaged in the Service Plan development process.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a. ADW Case Managers (CMs) are responsible for the development of the Service Plan (SP) in collaboration with the member receiving services or legal representative (if applicable. Participation in the initial SP development is mandatory for the member receiving services and the Case Manager. The member receiving services or legal representative (if applicable) may choose to have whomever else they wish to participate in the process. Participation in subsequent reviews and annual SP updates are mandatory for the member receiving services, the Case Manager, staff of the Personal Attendant Agency, the Resource Consultant for members who choose self directed service delivery model,and State Plan Personal Care provider agency staff(if applicable). The Case Management section of the Person-Centered Assessment must be completed within timeframe required in policy. The SP, which is scheduled in collaboration with the member, must be completed within required timeframe in policy.

In order to begin services immediately and address any health and safety concerns, an Interim SP may be developed and implemented upon enrollment. The Interim SP can be in effect up to the number of days in policy for assessments to be completed, the SP meeting to be scheduled and the SP to be developed.

b. There are two/three primary assessments conducted to support the SP development process. The medical eligibility assessment (PAS) and the Person-Centered CM and RN PAA (where applicable) Assessment. These assessments identify medical issues and functional deficits in Activities of Daily Living. The Person Centered Assessments review independent living skills, medical and behavioral health status, goals and preferences, formal and informal supports, risks to health and welfare, communication, environmental issues including assistive technology needs, emergency and back-up planning, and socialization and community integration.

d. The medical eligibility assessment and the Person-Centered Assessments must be completed and reviewed with the member prior to the development of the SP. The medical eligibility assessment and the Person-Centered Assessments must be completed and reviewed with the member prior to subsequent reviews and annual SP updates. It is the CM's responsibility to ensure that all assessments are considered in the plan development. The SP document requires that these areas be addressed. As part of the Quality Improvement System (QIS), the Operating Agency reviews files to ensure that SPs address member goals, outcomes, needs (including health care needs) and preferences.

e. Identification of services commences with the Person-Centered Assessments. Coordination of services begins with the SP development process. It is the Case Manager's responsibility through collaboration with the member to ensure that all Waiver and other services are identified as part of the plan. The CM is responsible for coordinating the implementation of the plan through case review, referral, monitoring and advocacy. As part of the Quality Improvement System (QIS), the Operating Agency reviews files and conducts Participant Experience Surveys (CAHPS) to ensure that services have been delivered as planned.

f. Specific providers for Waiver services and other services are listed on the SP. The Case Manager, via monthly contact, is responsible for monitoring the implementation of the plan to ensure service delivery. As part of the Quality Improvement System (QIS), the Operating Agency reviews files and conducts Participant Experience Surveys (CAHPS) to ensure that services have been delivered as planned.

g. Through the assessment and planning process, member's healthcare needs are identified and addressed. The Case Manager is responsible for assisting in scheduling and/or referral for evaluations, routine health care, medical equipment, and medical appointments when requested by the member.

h. State Plan services such as State Plan Personal Care Programs Services, State Medical Services, and non-emergency medical transportation are available for use by waiver members. The Case Manager identifies needed services, makes referrals for additional services, and includes the services in the Service Plan. Providers of non-waiver service can participate in service plan development if requested by the member. State Plan Personal Care program services provider staff must participate in service plan development. Veteran's services, hospice, home health are also available to waiver members. The case Manager is responsible for coordination of services and assures no duplication of services.

i. SPs are updated annually and at six months or as the member's needs change. The member may request an update at any time. The Case Manager is required to have monthly contact with the member to monitor plan implementation, identify when needs change and revise the SP to address changing needs. Additionally, SPs must be reviewed at least every six month during a face to face home visit and updated at that point as necessary. An annual SP meeting to develop a new plan is required and must include a face to face home visit. Case managers are expected to schedule these meetings at times and locations convenient to the member.

j. An interim service plan is available to be developed by the Case Manager in conjunction with the member. The member informs the Case Manager of their immediate needs and the Case Manager completes the interim service plan. The interim service plan is communicated to the Personal Attendant Agency and a Personal Attendant is chosen to deliver services until a Person-Centered Assessment and Service Plan can be developed (up to 21 calendar days after activation on the waiver program).

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 completes a Freedom of Choice form to identify 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 providers of HCB 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 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 their 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 HCB services supervisor(s) and the case management supervisor(s).
b. Explain how members are assigned a case manager.
c. Explain how members are given choice of HCB services and other natural supports or services offered in the community.
d. Explain how the agency ensures that the case manager is free from 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 provided a 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

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.

Risk assessment is a component of the required Person-Centered Assessment. Identified risks must be incorporated into the Service Plan (SP) subject to the member's needs and preferences. The member participates in the service plan development including identification of solutions for risks.

The SP requires a detailed description of emergency back up plans/arrangements that are to be implemented if a Personal Attendant or the Personal Attendant Agency is unable to fulfill their duties. Strategies may include the utilization of an identified back-up agency, family members, other informal supports, available community resources etc. As part of the Quality Improvement System (QIS), staff of the Operating Agency review files and conduct Participant Experience Surveys (CAHPS) to monitor the effectiveness of risk assessment and back-up planning.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The applicant (or legal representative) is given the opportunity to choose a Personal Attendant provider through the Traditional Model or choose to self-direct their Personal Attendant services through the Personal Options model. Freedom of Choice Selection forms, which list both types of models and both types of ADW providers (Personal Attendant and Case Management) by county with contact information, are provided to applicants. A list of available providers is made available to ADW applicants on the Operating Agency's website. There is also contact information about the Personal Options vendor. Applicants may also call the Operating Agency for a list of agencies that provide services in their community. Information is provided in accessible formats when requested to meet the applicant's needs.

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):

Responsibility for approving Service Plans is delegated to qualified Case Management Agencies (CMAs). The Operating Agency reviews a representative sample of SPs every 12 months as part of the Quality Improvement System (QIS). BMS and the OA meet to review draft disallowance reports prior to issuing final disallowance reports which may recoup payments for services provided by unqualified staff or not included in the service plan.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☒ **Case manager**
- ☒ **Other**

Specify:

Service Plans are maintained by the Case Management agency for a minimum period of 5 years.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

Case Management Agencies (CMAs) certified by the Operating Agency are responsible for monitoring the implementation of the Person Centered Service Plans (PCSPs). Case Managers (CMs) are responsible for quarterly home visits and monthly calls with the member to review the implementation of the PCSP in order to identify and address any issues and concerns related to the member's choice of providers (Case Management and Personal Attendant Agencies) and the delivery of services, verification of the delivered services, and monitoring of the back-up plan. Incidents that create a risk to the member's health and welfare must be reported using the WV Incident Management System (WVIMS) and as a appropriate, reported to Adult Protective Services (APS).

As part of the Quality Improvement System (QIS), the Operating Agency (OA) reviews a representative sample of Case Management files every 12 months to monitor compliance with this requirement. The OA conducts an exit interview to review the results of each provider monitoring. The OA staff provide technical assistance to providers as needed to address any identified issues or concerns and require a corrective action plan to ensure that all identified issues are remediated within established time frames. The OA prepares draft monitoring reports which are sent to the provider for comment and returned within 30 calendar days. The provider's comments are reviewed by the OA and BMS and a final report is issued to the ADW provider.

BMS and the OA review monitoring findings at contract meetings and develop improvement strategies as indicated in collaboration with the Quality Improvement Advisory Council.

PCSP Services are furnished in accordance with the PCSP; The OA compares claims to the PCSP during on-site provider review.

Members have access to waiver services identified in the PCSP (e.g.,has the member encountered problems in sercuring services authrorized in the PCSP); The OA reviews Case Management notes and monthly contact forms which ask the member to describe if they received all the services according to the PCSP during the month, including needed medcial equipment or resources, etc. The Case Manager is responsible for arranging for needed services and supports and that services meet the needs of the member. The Case Manager coordinates with the Personal Attendant Agency to ensure service delivery.

The Case Manager evaluates this monthly via the monthly contact form completed during monthly calls and/or quarterly during face to face meetings completed during the home visit. The OA reviews these forms during provider review and determines whether or not the Case Manager has ensured the member's needs were met.

CM services under this waiver are limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with Waiver objective of avoiding institutionalization.

Member health and welfare is assured during provider reviews. The OA monitors incident report submissions and follow-up by providers, initial contact made by CM with member within 7 days of completing the assessment, whether or not the member needed referrals to specialists and/or health professionals (per the member assessment), and whether these referrals occurred, and whether or not PCSP meetings are conducted within timelines.

The Case Manager will monitor and coordinate with the member on the back-up plan to ensure prevention/mitigation of health and safety risks. The OA also receives and reviews incident reports as they are submitted into the WVIMS within 24 hours of learning of the incident.

All information is compiled and shared with the Quality Improvement Advisory Council quarterly and with BMS monthly.

Members exercise free choice of Case Management and Personal Attendant Providers. The UMC conducts annual assessments which include education about available service models and providers. The member is required to complete a Freedom of Choice Form in which they designate their choosen service model, Case management agency, and personal attendant agency. This form is also available on the state's web site and via provider agencies. The member may choose a new service model or provider at any time. The member may not have the same case management agency provider and personal attendant agency provider unless a waiver is given and safeguards are enforced.

Members have access to non-waiver services identified in the PCSP including Medicaid State Plan Services including access to health services. Needed non-waiver services are captured in the member assessment and the member PCSP.

During review, the OA evaluates whether these referrals were made.

Case Managers are responsible to make quarterly home visits with members.

Members are provided information on how to contact their Case Managers and should contact them immediately if they have a problem with their services. Members are provided education related to member grievances (and can contact the OA) should the Case Manager not resolve their issues. The OA assists members toward resolution.

Members must have different Case Management agencies and personal attendant agencies unless a cultural or geographical exception has been approved by BMS. In these cases, agencies are required to have written policies and procedures to avoid conflict of interest if the agencies provide both Case Management and Personal Attendant Services. The OA reviews and measures demonstration of these policies upon review to make sure there is a statement prohibiting conflict of interest and self-referral, that there are separate staff for each service, that there are separate Case Management and Personal Attendant member files.

b. Monitoring Safeguards. *Select one:*

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

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

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

The following safeguards are followed:

a. The OA/UMC notifies members of all available providers and services upon application. The member completes a Freedom of Choice form to identify 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 providers of HCB 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 their 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 HCB services supervisor(s) and the case management supervisor(s).
b. Explain how members are assigned a case manager.
c. Explain how members are given choice of HCB services and other natural supports or services offered in the community.
d. Explain how the agency ensures that the case manager is free from 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 provided 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.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
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 = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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 = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

procedures.

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
Percent of files of people receiving services whose service plans were updated annually and every six months and revised as needed Numerator-Number of files of people receiving services whose service plans were updated annually and every six months 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 = 95%

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
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, 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 = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***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 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):
Other
If 'Other' is selected, specify:
UMC Data Collection System

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

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

All information relating to this assurance is collected by the Operating Agency through the review of 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. All Corrective Action Plans must be approved by the Operating Agency. Services provided that are not documented on the Service Plan are disallowed and payment is recouped from the provider agency.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: Quality Improvement Advisory Council (analysis only)	☒ **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 Service Plans that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

For Self-Directed Services, WV utilizes a sole Government sub-agent Fiscal/Employer Agent Financial Management Service, herein after referred to as Personal Options. The Self-Directed service option,Personal Options, is available to every eligible ADW member. All applicants are given a service delivery model selection form that allows them to chose their service delivery model. Members are educated annually about Freedom of Choice which includes the service delivery model. Members are given the opportunity to transfer to this service delivery model throughout the year. A member may appoint a representative who may or may not be their legal representative, to assist them in self-directing their services (hereby referred to "representative"). The Personal Options program provides each member and representative (if applicable) with the opportunity to exercise choice and control over the self-directed services they receive and the employees they hire (employer authority); and/or how the portion of their individualized budget associated with self-directed services (i.e., their budget) will be spent (budget authority).

Services provided through the Traditional Model and the Personal Options Model are comparable in description, scope, amount and duration. Members can transfer from the Personal Options Model to the Traditional Model, and vice a versa, at any time without an interruption of services.
The services directed by persons who choose Personal Options include:

- Personal Attendant
- Transportation
- Personal Emergency Response System
- Environmental Accessibility Adaptations

Under the Personal Options model, the person is the common law employer of the qualified Personal Attendant 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 member's self-directed budget funds, processing and paying the member's qualified personal attendants, providing orientation at the time of enrollment with the Personal Attendant Options vendor and, ongoing training and support to the member and their Personal Attendant employees.

The cost of administrative services provided by the Personal Options vendor are based upon a per-member-per-month (PMPM) rate which qualifies for the Federal Medicaid Administrative Percentage (FMAP).

The person choosing the Personal Options Model is allocated an annual budget based on his/her assessment and person-centered outcomes documented on their PCSP. Services under the Personal Options Model must be for the sole benefit of the person receiving ADW services.

The Personal Options vendor provides both financial management and Resource Consulting (assistance and information) services for members.

The Financial Management Services provided by the Personal Options vendor include:
1) Issuing payroll checks to qualified employees of the member receiving services via approved timesheets and Personal Attendant logs
2) Executing provider agreements on behalf of BMS
3) Assuring the adherence to Federal and State laws and regulations
4) Verify employment fitness determinations by WV Clearance for Access: Registry and Employment Screening (WVCARES)for each Personal Attendant previous to employment by the member. WVCARES is the established framework for WV Medicaid employers to conduct background checks, review the results, and provide the employers with a fitness determination for potential employees.
5) Verifying employee qualifications (including that the potential employee is not the member's legal guardian or spouse)
6) Verifying employee time records
7) Verifying that services are within approved limits(compliance with member's PCSP)
8) Monitoring of underpayments and overpayments
9) Assisting the member in revising Spending Plans as necessary
10) Recognizing and reporting critical incidents (including abuse, neglect and exploitation).
11) Assist the employer of record with the responsibility of verifying employee's citizen status.

12) Providing for payment of employee benefits where applicable
13) Verifying with proper documentation initial/on-going monthly Office of Inspector General (OIG) checks
14) Verifying all training requirements have been met prior to providing services

The Personal Options vendor also provides Resource Consulting (information and assistance) services for the member accessing the self-directed model. This support is an administrative activity and is reimbursed as such. Resource Consulting provides the member with the supports needed to self-direct and are available as needed and/or requested by the member.

Resource Consulting supports include:
1) Assisting the member as needed and/or requested with information regarding employment of personal attendants and budget matters.
2) Explaining and assisting the member with the completion of the employer packet. The Resource Consultant submits the completed employer packet to the F/EA.
3) Providing practical skills training, such as hiring, managing and terminating employees, problem solving, and conflict resolution
4) Assisting the member as needed and/or requested in the recruitment and hiring of employees
5) Maintaining a roster of qualified personal attendants.
6) Maintaining/providing training modules for the member's employees
7) Verification of required training for the member's employees
8) Monitoring the financial and employment aspects of the member's cases through required monthly calls and face/to/face contact at least every 6 months. Resource Consultants monitor more frequently as needed based on the member's needs and/or requests
9) Recognizing and reporting critical incidents (which are then investigated by the F/EA, Operating Agency, APS, Medicaid Fraud, police, etc. as appropriate). All critical incidents are entered into the WV Incident Management System (WVIMS) by the Personal Options vendor and the Operating Agency to analyze for trends
10) Providing information on employee benefits when applicable
11) Participate in the development of the member's PCSP when requested.
12) Assisting the member as needed and/or requested in the development of the member's Spending Plan
13) Assisting the member as needed with revisions to their spending plan
14) Education of member on provision of employee training and proper documentation for Personal Attendant Services (i.e. Personal Attendant Logs)

Personal Options vendor Resource Consultants do not provide case management: therefore, Personal Options members choose a Case Management Agency to assist with advocacy needs and for development of service plan. The Case Management agency will follow all guidelines set forth under the services identified for case managers for personal options members.

The Personal Options vendor also operates a call center for the member or their employees to access needed information about the program. Customer Service representative support the primary role of the Resource Consultant and payroll specialists by performing the following functions:
1) Assisting the member/employer with inquiries related to budgeting, employer responsibilities, paperwork such as tax forms, employee background checks, training requirements/certifications, timesheets, and invoices and spending activity
2) Assisting employees and other service providers with issues related to pay periods, the status of timesheets and invoices, the status of payments, and tax withholdings
3) Placing courtesy calls to the member and their employees regarding incorrect Timesheets, Personal Attendant Logs, and invoices, providing additional training and helpful hints to ensure accurate and timely payments
4) Placing courtesy calls and mailing reminder letters to the member in advance of expiration date of their employee's certifications
5) Mailing out timesheets, invoices, forms and training materials as requested by the caller or as directed by the Resource Consultant
6) Maintaining an electronic notification system to inform the Resource Consultant of all inquiries and additional follow up if necessary

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

(a) At the time of the initial medical eligibility assessment, the UMC provides written education on the self-directed program, Personal Options, regarding the benefits and potential liabilities of the model. This information is called the Comparison Guide.

If a person requests additional information about the service delivery models available, a general overview of the participant-directed opportunity is provided. A general overview of the Personal Options model is provided via an informational brochure about self-direction.

When the member's annual re-evaluation assessment is conducted by the UMC, the member and their legal representative (if applicable) will again receive education regarding Personal Options. The Comparison Guide is provided again to the member. The member may also ask their Case Manager about the available service delivery models during routine home visits. Information about Personal Options is also available on the BMS website. BMS and OA are always available to answer questions and provide technical assistance.

(b) Prior to choice of a service delivery model, the UMC provides a Comparison Guide which provides members the information about pros and cons (liabilities) of self-direction. The UMC is responsible for handing out the Comparison Guide at the time of medical assessment and annually during the re-evaluation assessment. Once the member is enrolled, the FE/A gives the member a Quick Start Guide which includes an overview of self-direction, supports for self-direction, participating in the team that develops the Service Plan, developing the spending plan, selecting, hiring, training and supervising employees, the roles and responsibilities of each key stakeholder as well as the Aged and Disabled Waiver (ADW) program responsibilities.

The Operating Agency is also responsible for fielding questions from members and their legal representative (if applicable) by providing a toll-free telephone number. The Case Manager is responsible for providing this information to the member and their legal representative (if applicable) upon request. BMS and staff of the Personal Options vendor are also available to provide information upon request.

(c) The information is provided at the time of the initial medical eligibility and before enrollment. It is also provided annually during the re-evaluation assessment.

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:

Members who self-direct may appoint a non-legal representative (program representative)to assist them in the direction of their Waiver services. The nature of the assistance is determined by the member receiving ADW services. The Case Manager is responsible for developing the Service Plan and all employer related responsibilities remain with the member receiving ADW services, with the assistance of their program representative and/or staff of the Personal Options vendor as requested, and their Case Manager. Personal Options vendor staff (Resource Consultants) are required to make monthly telephone contact directly with the member to address any issues or concerns with their services. If unable to reach the member by telephone, the Personal Options vendor staff must make a home visit. A face-to-face contact with the member at least every six months is also required to review the Service Plan implementation and to identify and address any health and safety concerns. As part of the Quality Improvement System (QIS), the Operating Agency reviews files and conduct Participant Experience Surveys.

ADW services may be directed by a legal representative of the member. For that purpose, the member participates as much as is possible to make their wishes known. This information is used by the legal representative to direct services.

The criterion used to determine if an ADW applicant must have either a legal representative or a program representative to assist in the direction of their services is whether the box on the Medical Necessity Evaluation Request (MNER) is selected by the medical professional for Alzheimer's, Multi-infarct, or related conditions. Any updated documentation regarding medical diagnoses changes can also be utilized for existing members re-evaluations.

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
Environmental Accessibility Adaptations	☒	☒
Personal Emergency Response System	☒	☒
Personal Attendant Services	☒	☒
Non-Medical Transportation	☒	☒

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 for Medical Services and is 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 F/EA is compensated through a Per member/Per Month (PM/PM) fee as specified in the vendor contract.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **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:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

Bureau for Medical Services (BMS) oversight of the F/EA includes:

1) An initial readiness review

2) Quarterly review of IRS Form 941

3) Quarterly review of FUTA deposit

4) Quarterly review of State withholding and unemployment tax payments

5) Quarterly review of complaints and grievances report

6) Quarterly review of total allocated funds for members and total spent funds

7) Quarterly comparison of bank statements to IRS reports and MMIS billing

8) Monthly contract meetings

9) Monthly review of program activity reports

10) Review of periodic consumer satisfaction survey results

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an

element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Case Managers assist the member with information or links to information related to the Personal Options Model, including the benefits and responsibilities of choosing this option. This information will be distributed to the member/representative during their annual re-evaluation by the UMC to ensure unbiased presentations are being provided. CMs will receive training including a scripted presentation regarding the Personal Options Model. CMs will also be provided with the side-by-side comparison of the 2 service delivery models to review with the member if he/she has any questions.

Case Management activities specific to the Personal Options model include, but are not limited to:
1. Developing the PCSP
2. Informing the person of the availability of the Personal Options Model.
3. Explaining general rights, risks, responsibilities and the member's right to choose the Personal Options Model.
4. Assist in determining if a Program Representative is desired and/or needed by the member.
5. Providing or linking the member/Program Representative with program materials in a format that they can use and understand.
6. Explaining person-centered planning and philosophy to the member/Program Representative.
7. Linking the member with the Personal Options vendor for completion of the necessary paper work to enroll in this program.
8. Explaining to the member the roles and supports that will be available.
9. Monitoring and participating with the FE/A in the development and review of the budget available for participant direction.
10. Ensuring that the member/Program Representative knows how and when to notify the Case Manager about any operational or support concerns or questions.
11. Monitoring the member's risk management activities.
12. Ensuring a seamless transition into the Personal Options Model if chosen.
13. Notifying the OA and the Personal Options vendor of concerns regarding potential issues which could lead to a person's disenrollment.
14 Notifying the OA of concerns about the status of the health and welfare of the member.
15. Follow-up with the member 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
Skilled Nursing	☐
Case Management	☐
Environmental Accessibility Adaptations	☐
Personal Emergency Response System	☐
Pre-Transition Case Management	☐
Community Transition Services	☐
Personal Attendant Services	☐
Non-Medical Transportation	☐
Adult Medical	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Day Care	

☒ **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:

An FE/A and FMS for ADW members is procured through the Request for Proposal (RFP) purchasing process. The FE/A provides:

1) Supports for members choosing the Personal Options model
2) Supports are available to:
- provide general information and assistance on the participant-direction opportunity
- participate in PCSP meetings
- assist with the development of the 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 Personal Attendants
- maintain a roster of qualified direct-care workers and assist in the verification of qualified employees
- provide information on member employee benefits if applicable
- monitor quality through monthly telephone contact and face-to-face contact with people receiving services at least every six months
- monitor and assist with required program paperwork

Bureau for Medical Services (BMS) oversees the Personal Options vendor through:
-Monthly contract meetings
-Monthly review of program activity reports
-Monthly review of tax information
-Quarterly review of complaints and grievances report

The UMC provides unbiased information regarding the benefits and liabilities of the service delivery models. The UMC is procured through the RFP process.

Independent advocacy is available on a case by case basis when requested by the ADW member at no cost to the member by Disability Rights of WV. It is not contracted by BMS.

Members have the right to disagree within the Service Planning process.

Members have the right to file a grievance or complaint. Level I is with the FE/A and second level is with BMS.

Members have a right to Medicaid Fair Hearing Process. All correspondence for involuntary closure of ADW members includes free options to access for advocacy to regain ADW services.

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.drofwv.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:

Members (or their legal representative) who self-direct can opt to transfer from the Personal Options Model to the Traditional Model at any time. Members who voluntarily terminate from this Option will ordinarily be effective the first day of the month, except in cases of emergency. The Personal Options vendor, Case Management Agency and Operating Agency will assist the member to assure a seamless transition or emergency transfer to Traditional Personal Attendant Agency to prevent interruption of services (if applicable).

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.

Members who demonstrate the inability to manage the duties related to self-direction will be required to select a representative to assist them with the responsibilities of self-direction. If the member is unable or refuses to select a representative, they will be require to transfer to the Traditional Model. The Personal Options vendor, the Case Management Agency and the Operating Agency will assist the member to assure a seamless transition.

The Personal Options vendor must develop a report to OA/BMS outlining the reasons the Personal Options vendor is requesting to involuntarily transfer the member from Personal Options. Issues such as the inability to manage funds or services, the inability/unwillingness to maintain safe staffing reports, inability to provide a safe work environment for the FE/A staff and workers, and/or the inability to keep the spending plan within the budget would require the Personal Options Vendor to notify BMS and the OA to review for involuntary transfer from Personal Options. Also any issues of exploitation of the member that could occur will be reported to Adult Protective Services and the Medicaid Fraud Control Unit and possibly resulting in an involuntary transfer if needed to safeguard the health and welfare of the member. An incident report will also be entered by the FE/A in WVMIS.

An immediate notification of the lack of health and safety oversight must be reported through the WVIMS system as well as to the mandatory investigative agency (Adult Protective Services). Failure/inability to implement emergency or contingency plans developed within their Service Plan may result in involuntary transfer to Traditional Model to assure the health and welfare of the member. All paid and natural supports must be outlined in each member's Service Plan. The Case Management Agency is responsible for the oversight of program implementation, health,and welfare of each member.

The Case Management Agency will ensure that no break in vital services will occur and that a timely revision of the Service Plan 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		1315
Year 2		1315
Year 3		1315
Year 4		1315
Year 5		1315

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 member's worker is responsible for obtaining and paying for state and federal fingerprint-based checks.

☒ **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:

The Personal Options vendor is responsible for ensuring all of the member's employees complete state and federal fingerprint-based checks through the WV Clearance for Access: Registry & Employment Screening (WV CARES) prior to providing services. The Personal Options vendor is responsible for verifying the employee’s credentials.

☒ **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:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☒ **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.

Based on studies by West Virginia of the cost of FMS and I and A, a calculated PMPM was derived. This is claimed as administrative cost before development of a member's budget. The budget is based on assessed needs and monetized based on results of the assessment process. The budget (less the cost of FMS and Information and Assistance is claimed as service match accordingly.

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, from.

Budgets for each service level are derived by monetizing the amount of Personal Attendant services and ADW non-medical transportation services for each of the 4 level of service (max number of Personal Attendant service units per service level x rate + max number of ADW non-medical transportation services x rate).

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.

Members who self-direct (or legal representative) are notified of their service level in writing by the UMC at the point of medical eligibility and slot allocation. Through an agreement with BMS, the Personal Options vendor equates the approved service level to a participant-directed budget amount and informs the member. The budget is based on rates for the service within the number of hours allocated within the service level. This pertains to all members who self direct.

Per policy, members (or legal representative) have the opportunity to request an increase in their Service Level (an adjustment to budget) at any time based on a documented need. The request must include clinical documentation sufficient to support the request. The member's budget would increase accordingly if approved. If denied, the member (or legal representative) is offered the opportunity to request a Medicaid Fair Hearing.

Following the initial medical eligibility and annual re-evaluation, the member is notified in writing by the UMC of the amount of his/her annual budget. Subsequently, the member, his/her legal representative (if applicable) and the Resource Consultant, if consulted, choose the types and amounts of self-directed services that will be "purchased" from the budget based PCSP. The total cost of these services is documented on the member's Spending Plan. The member or legal representative (if applicable) is provided a copy of the Spending Plan by the Resource Consultant. The Spending Plan is an addendum to the PCSP for those in the Self-Directed service delivery model where service amount, frequency, and duration of services are specified. Case Management is authorized by the PCSP and is not deducted from the individual budget for members.

Per policy, members have the opportunity to request an increase in their individualized budget at any time if there has been a change in need. The request must include clinical documentation sufficient to support the request. If approved, the budget allocation will be adjusted accordingly. If denied, the member is offered the opportunity to request a Medicaid Fair Hearing.

The Personal Options budget methodology is included in the CMS approved waiver application which is posted and available to the public on the WV BMS website.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The Personal Options vendor is responsible for converting the annual budget into monthly spending plans based upon input from the member and/or his/her representative. This safeguards premature depletion of the budget.

The Personal Options vendor makes available a monthly utilization report to identify the member's use of budget funds. There are many reasons a member 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 member's annual budget period. The Personal Options vendor assigns a Personal Options Resource Consultant to assist and support each self-directing member to develop and monitor the monthly spending plans. The Resource Consultants will ensure members/representatives are aware of under-utilization and/or any attempts to over spend the monthly spending plan. Members enrolled in Personal Options may revise Service Plans if necessary.

The Personal Options vendor is flagging potential budget over-expenditures and potential underutilization of budget funding on a monthly basis so that it can be addressed in a timely manner.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Information on Fair Hearing rights is included in the packet of information sent by the UMC to all applicants(or legal representative) when they are notified that they are medically ineligible for the ADW program.

Members utilizing the Aged and Disabled Waiver (ADW) and their legal representative (if applicable) and their Case Managers are notified of their Fair Hearing rights when:

1. They do not meet medical eligibility requirements for nursing home level of care (re-evaluation assessment). They are notified by the UMC at the time of determination. The UMC maintains all records of medical eligibility denials.
2. Their services have been reduced at the time of the annual re-evaluation (e.g., from Service Level D to Service Level C). They are notified by the UMC. The UMC maintains all records of annual re-evaluations.
3. Their request for a Service Level increase is denied. They are notified by the UMC at the time of denial. The UMC maintains all records of requests for Service Level increases and decisions.
4. They are determined ineligible for Waiver transition services or denied a specific Waiver transition service. They are notified by the Transition Coordination contractor at the time of denial.
5. Their ADW case has been closed (per established policies and procedures). They are notified by the Operating Agency at the time of closure. The Operating Agency maintains all records of case closures.

Members only have access to the Fair Hearing Process in the above 5 circumstances. All other circumstances under which a member would complain/grieve are addressed through the complaint/grievance process.

In all cases, applicants/members and/or their legal representative (if applicable)and their Case Managers are notified that the UMC maintains all applicable records of medical eligibility, service denials and closures.

All notifications of Fair Hearing rights includes information that services will continue throughout the Fair Hearing process if applicable policy is followed when making the request. Information on available advocacy support is also provided. Members are also provided the opportunity for a Pre-Hearing Conference to attempt to resolve the issues with BMS through the Operating Agency.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The Operating Agency.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

A member/legal representative has the right to file complaints/grievances regarding (1) Program Services; and (2)Service Plan disagreement.

The grievance/complaint process is in place to resolve ADW service(s) grievances/complaints that are not subject to the Fair Hearing process. All ADW provider agencies are required to have a written grievance policy and procedure which is reviewed annually by the Operating Agency to monitor for compliance. The member may use the formal written grievance process or contact the Operating Agency by phone or written correspondence. The Operating Agency will conduct oversight and follow up to ensure grievances and complaints are resolved in a timely manner.

First Level Grievance
Responsible Party: ADW Provider
1. Member (or legal representative) completes the grievance form and submits it to the provider.
2. Provider has 10 days to hold a meeting with the member (or legal representative) either in person or by telephone.
3. Provider holds the meeting and completes the “Level One” response.
4. Member (or legal representative) and provider sign/date Level One decision.
5. Provider sends a copy of the grievance decision to the member (or legal representative) within three working days.
6. Provider maintains a copy of the grievance in an administrative file.
7. Provider maintains a record of the number of grievances filed, reasons for grievances, dates of grievances, and responses.

Second Level Grievance (If member (or legal representative) is not satisfied with Level One decision)
Responsible Party: The Operating Agency

1. The provider sends a copy of the Level One grievance decision to the Operating Agency and the member (or legal representative) within three working days.
2. The Level One decision and any additional information is reviewed by the Operating Agency.
3. The Operating Agency issues a Level Two decision within 10 days of receipt of the grievance request.
4. Notice of the decision is provided in writing to the member (or legal representative), the provider agency and the Bureau for Medical Services (BMS).

The member may lodge a Service Plan disagreement at the time of the Service Plan meeting.
1. The disagreement would first go to the Service Plan Meeting team to resolve the disagreement.
2. Any unresolved disagreements are referred to the Grievance process.

The Operating Agency maintains a Complaint Hotline and database. All complaints reported by phone or letter are documented on a complaint form and maintained by the Operating Agency who is responsible for oversight and follow up to ensure complaints are resolved.

The number and types of complaints are monitored by the Operating Agency and Quality Assurance.

Members only have access to the Fair Hearing Process delineated in Appendix F-1. All other circumstances under which a member would complain/grieve are addressed through the complaint/grievance process.

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).

All ADW providers have policies and procedures for the review, investigation, and tracking of critical incidents involving the risk or potential risk to the health and safety of ADW members. ADW providers are required to report and track incidents using the web-based WVIMS. Providers track critical incidents through the WVIMS and report identified incidents to BMS after investigation.

All incidents are classified as follows:

-"Critical incident" means the alleged, suspected, or actual occurrence of any of the following: abuse; neglect; death due to any cause; attempted suicide; behavior that will likely lead to serious injury or significant property damage; fire resulting in injury; relocation or interruption of services; any major involvement with law enforcement authorities; injury that requires hospitalization or results in permanent physical damage; life-threatening reaction because of food or drug; or a serious consequence resulting from an apparent error in medication or dietary ingestion.

-Allegation of abuse, neglect, or exploitation:
-"Abused Adult"- This is when the infliction or threat to inflict physical pain or injury on or the imprisonment of any incapacitated adult or facility resident
- "Neglected Adult"- This is when the unreasonable failure by a caregiver to provide the care necessary to assure the physical safety or health of an incapacitated adult
-Financial Exploitation/Misappropriation of Funds: Illegal or improper use of a person's or incapacitated adult's resources. Examples of financial exploitation include cashing a person's checks without authorization; forging a person's signature; or misusing or stealing a person's money or possessions. Another example is deceiving a person into signing any contract, will or other legal document (WV BMS provider manual, Ch 501, 512) * WV Code 9-6-1 Definitions

All critical incidents must be reported by ADW providers to Adult Protective Services (APS)for enrollees over the age of 18 per WV Code 9-6-1. The WV Code 49-2-803 details persons mandated to report suspected abuse and neglect. Persons required to report suspected abuse or neglect to DHHR immediately but not more than 48 hours after suspecting the abuse or neglect include, but are not limited to; any medical, dental, mental health professional, social service workers, emergency medical services personnel, peace officer or law enforcement officials, and circuit court or family court judges. If needed, involvement with emergency services, hospitals, and/police must follow the provider's policy and procedures for handling medical and psychiatric emergencies per WV Code 64-11-7.8a.

Any critical incident involving an ADW member utilizing ADW services must be reported into the WVIMS within 24 hours of learning of the incident. The OA will review each Incident Report and determine whether a thorough investigation is warranted. Investigations must be initiated within 24 hours of learning of the incident. A completed Incident Report will be entered into the WVIMS within 14 calendar days of the incident. At any time during the course of an investigation should an allegation of abuse or neglect arise, the ADW provider shall notify APS as mandated by State Code. ADW providers are responsible to investigate all incidents, including those reported to APS. The ADW provider will inform the member and/or their legal representative, and the OA in writing of the results of the internal investigation within 5 business days. In the event that a crisis occurs which results in a critical incident being substantiated, then a prevention plan will be created by the member and their Case Manager to support the crisis plan and outline strategies that will ensure similar incidents do not occur in the future.

ADW providers and the OA are required to regularly review and analyze incident reports to identify trends regarding health and safety of enrollees. Identified health and safety concerns and remediation strategies must be incorporated into the ADW Providers' Quality Management Plans.

The following will occur if an ADW provider is found to be out of compliance with program requirements: Following the first identified episode for the provider, the OA will complete technical assistance with the provider in an attempt to bring them back into compliance. If the provider continues to remain out of compliance after the OA completes technical assistance, the provider will be placed on a Corrective Action Plan. The Provider will have 30 days to provide the OA with its detailed corrective action plan outlining the steps they intend to take to remediate the deficiencies. In addition, the OA will conduct a follow-up review within 6 months of the deficiencies identified to ensure the corrective action plan has been implemented and followed accordingly. If the provider continues, to remain non-compliant after technical assistance and a corrective action plan, then further action will be taken up to and including payment withholding, and disenrollment as an ADW provider until they are determined compliant. The OA reports this type of information to BMS as part of the monthly Quality Meetings for ADW; additional meetings can be scheduled if an issue needs to be addressed prior to the monthly meeting.

In order to enhance its critical incident management system, BMS is currently developing an ADW HCBS Waiver Incident Reporting Guide (IRG);it will be completed prior to the implementation of the waiver. The ADW IRG outlines the activities that WV is undertaking to enhance reporting and monitoring of other types of critical incidents. The IRG's information is referenced in this application and will be available as separate document.

Restrictive interventions (including restraints and seclusion)are prohibited in the delivery of ADW services. All unauthorized use must be reported in the WVIMS system.

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.

The UMC provides information and resources to all members regarding identification, prevention, and reporting any instances of potential abuse, neglect, or exploitation. The UMC provides information to members and/or their legal representative (as applicable) as part of mailed materials sent after the initial medical eligibility determination, as well as during their annual medical eligibility re-evaluation that defines abuse, neglect, and exploitation and how to notify the appropriate authorities. The member and/or their legal representative is required to sign-off indicating receipt and understanding of this information.

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) at their initial medical assessment as well as to all members (or legal representative) at their annual medical re-evaluation.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

For allegations of abuse, neglect or exploitation, or critical incidents, ADW Provider designated staff and the OA must review each Incident Report and determine whether the incident warrants a full investigation. Providers are required to enter all Incident Reports into the WV IMS and issue a report to BMS. At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the ADW Provider or OA shall notify APS as mandated by State Code. ADW providers and the OA are required to investigate all incidents, including those reports to APS. Should APS substantiate the allegation, APS will inform BMS per MOU agreement.

Per policy, when there has been an allegation of abuse, neglect or exploitation, ADW providers must:
1. Take immediate action and any necessary steps to ensure the health and safety of the member while investigating the incident,
2. Revise the member's person-centered plan, in collaboration with the Case Management Agency, if necessary, to implement additional supports, and
3. Implement necessary systems changes, including additional training that might be helpful in preventing future incidents.

ADW Providers are required to report within 1 business day of learning of the incident. They are required to initiate an investigation of critical incidents and complete their follow-up within 14 calendar days. The Provider is responsible for taking appropriate action on both an individual and systemic basis in order to identify potential harm, or to prevent further harm, to the health and safety of all members served. The WVIMS does not supersede the reporting of incidents to APS. 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. ADW provider agencies are responsible to investigate all incidents, including those reported to APS. If requested by APS, a provider shall delay its own investigation and document such request in the web-based WVIMS.

In any case where mandated reporter believes that the ADW member suffered serious physical abuse, sexual abuse, and/or sexual assault, along with exploitation, the reporter must also report, or cause a report to be made to law enforcement. The report must be made to any law enforcement agency having jurisdiction to investigate the report. This report is in addition to the report made to APS.

ADW Providers are required to review their incident data and identify and address systemic issues and data trends on an annual basis per ADW policy. The OA is responsible for regular review of the number and types of incidents across settings providers, and provider types, identifying potential trends and patterns, opportunities for improvement and development and implementation of strategies to reduce the occurrence of incidents. The OA will monitor compliance with this policy during annual provider reviews.

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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 OA is responsible for the monitoring and oversight of the WVIMS and performs follow-ups as necessary regarding critical incident investigations. Incidents are entered into the WVIMS by ADW providers. Incidents submitted into the WVIMS are tracked, aggregated, and summarized by the OA, which also performs real time monitoring of critical incident investigations. BMS receives a monthly incident report summary form the OA to identify and address issues or concerns.

The OA reviews a representative sample of files annually, including (as applicable) compliance with Incident Management policies. This data is also reviewed and analyzed by BMS and the OA. ADW Providers and the OA are also required to analyze incident reports to identify health and safety trends and incorporate their findings into their Quality Management Plans. identified health and safety concerns and remediation strategies are incorporated into the agency quality Management Plan to address and remediate any potential concerns related to the population and/or ADW recipients.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Providers are mandatory reporters and as such are required to report any incidents of the use of restraints or seclusion directly to Adult Protective Services (APS).
APS is required to investigate these allegations. Providers also have a responsibility per policy to investigate and to report the incident in the WV Incident Management System (WVIMS).

WV does not permit use of restrictive restraints (including restraints and seclusion) in the ADW program. Personal restraints, chemical restraints, mechanical restraints or any other type of restraints are al prohibited in the delivery of ADW services.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

Providers are responsible for detecting and reporting any incidents of the use of restrictive interventions directly to Adult Protective Services (APS) and in the WVIMS. ADW agencies and the Personal Options vendor also have a responsibility per policy to investigate and to report the incident in the WV Incident Management System (WVIMS). The Operating Agency reviews incidents in WMIMS after submission to detect the use of restraints and restrictive interventions. The OA then reports monthly on their finding during contract management meetings.

APS is required to review and intervene on the use of restrictive interventions that meet threshold of maltreatment.

WV does not permit use of restrictive interventions (including restraints and seclusion) in the ADW program.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Providers are responsible for detecting and reporting any incidents of the use of seclusion directly to Adult Protective Services (APS) and in the WVIMS. ADW agencies and the Personal Options vendor also have a responsibility per policy to investigate and to report the incident in the WVIMS. The OA reviews incidents in WVIMS after submission to detect the use of seclusion. The OA then reports monthly on their finding during contract management meetings.

APS is required to review and intervene on the use of seclusion that meet threshold of maltreatment.

WV does not permit use of restrictive interventions (including restrains and seclusion) in the ADW program.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*

○ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ○ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Percent of agency staff with monthly OIG exclusion list checks returned with satisfactory results Numerator= Number of agency staff with OIG exclusion list checks with satisfactory results Denominator= Number of agency staff files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Operating Agency Data Collection System

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**	☐ **Weekly**	☒ **100% Review**

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

Data Aggregation and Analysis:

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

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

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):
Other
If 'Other' is selected, specify:
UMC Data Collection System

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of restrictive interventions brought to the attention of BMS.
Numerator - Number of restrictive interventions reported in the WVIMS system.
Denominator - Number of incidents entered into the WVIMS system.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

		Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data 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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Percent of files of people receiving services with signed document by person or legal representatives acknowledging they know how to report abuse, neglect, exploitation or other critical incidents. Numerator= Number of files with have that signed document Denominator= Number of files reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
UMC Data Collection System

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
UMC	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of agency staff with state and federal fingerprint-based checks returned with satisfactory results within timelines Numerator= Number of agency staff with state and federal fingerprint-based checks returned with satisfactory results within timelines Denominator= Number of agency staff files reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Operating Agency Data Collection System

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Percent of unexplained, suspicious and untimely deaths for which review/investigation resulted in the identification of preventable causes Numerator=

Number 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):
Other
If 'Other' is selected, specify:
WV Incident Management System

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Percent of mortality reports submitted by the Case Manager that coincides with the cause of death on death certificate Numerator= Number of mortality reports that coincide with the cause of death on death certificate Denominator= Number of mortality reports submitted

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Management Reports and Death Certificates

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Percent of reported critical and abuse/neglect/exploitation incidents followed up on by providers within established time-frames Numerator= Number of reported critical and abuse/neglect/exploitation incidents followed up on by providers within established time-frames Denominator= Number of reported critical and abuse/neglect/exploitation incidents for any given time period

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

WV Incident Management System

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Quality Improvement Advisory Council (analysis only)	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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):
Other
If 'Other' is selected, specify:
WV Incident Management System

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

BMS will review all mortality reports/death certificates and identify any unexplained, suspicious or untimely deaths and refer to BMS legal counsel for further action.

b. Methods for Remediation/Fixing Individual Problems

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

Information relating to this assurance is collected through the review of charts and/or the Provider Continuing Certification verification system by the Operating Agency. This process includes 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 charts are addressed immediately by the Operating Agency with providers during an exit interview. Providers may be required to submit Corrective Action Plans addressing identified issues that must be approved by the Operating Agency. When services are billed outside of policy guidelines, providers are required to repay those claims. Evidence collected via claims data is reviewed and analyzed by BMS and the claims processing entity in order to identify any system issues. As part of remediation if a provider is found to be substantially non-compliance, the provider will be removed from provider selection until the Operating Agency approves their corrective action.

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**
	☒ **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 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 §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; 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 Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 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 Operating Agency is responsible for monitoring the quality of Waiver services and implementing and evaluating quality improvement strategies. The ADW's Quality Improvement System (QIS) is evidence-driven and incorporates a broad-base of stakeholders in active roles in the process.

Discovery and remediation activities focus on the collection of data necessary to monitor the quality indicators established to provide evidence relating to the six CMS assurances and sub-assurances. Specific data sources include provider monitoring, claims data, incident management reports, contract oversight meetings and reports, Participant Experience Surveys (CAHPS) and other stakeholder feedback and input.

The primary mechanism for involving stakeholders in the Waivers quality improvement initiative is the ADW Quality Improvement Advisory (QIA)Council. It includes representation from providers of services, members who receive services, employees of the SMA, OA, and the UMC. The Council serves as a forum for members (or legal representatives) and the public to raise and address program issues and concerns affecting the quality of Waiver services.

The Council:
1. Reviews findings from discovery activities.
2. Recommends program priorities and quality initiatives.
3. Recommends policy changes.
4. Monitors and evaluates the implementation of Waiver priorities and quality initiatives.
5. Monitors and evaluates policy changes.
6. Serves as a liaison between the Waiver and its stakeholders.
7. Establishes committees and work groups consistent with its purpose and guidelines.

The Quality Management Report, which incorporates data from discovery and remediation activities, is reviewed and analyzed by the Bureau for Medical Services (BMS) Management staff through regular meetings with contractors. The report is also reviewed quarterly with the QI Advisory Council in order to identify trends and to monitor the effectiveness of quality improvement activities.

Quality improvement priorities are identified through data analysis and stakeholder input and are incorporated in the annual Quality Work Plan. Updates on the goals and objectives of this plan are reviewed at each quarterly meeting and guide the efforts of the Council and staff. The Quality Work Plan is evaluated at the annual QIA Council meeting and is revised if necessary to reflect current quality issues.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: UMC	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Findings from D&R report and overall quality improvement can result in systemic changes in policy, in the certification process, in the provider monitoring process, in the grievance/complaint process, in the incident management process, etc. These finding inform the quality improvement system that a change is necessary.

The ADW Quality Improvement System (QIS) is designed to: 1) Collect the data necessary to provide evidence that the CMS assurances are being met and 2) ensure the active involvement of stakeholders in the quality improvement process. The primary sources of discovery include provider reviews, incident management reports and member complaints, administrative reports, oversight of delegated administrative functions, and stakeholder input.

Provider Reviews:

The primary means of monitoring the quality of Aged and Disabled Waiver (ADW) services is provider reviews conducted by staff of the operating agency.

Prior to enrolling as an ADW provider, agencies interested in providing ADW services are reviewed by the Operating Agency to ensure that all Certification standards are met. All new providers are reviewed after the first six (6) months in order to identify and address any issues or concerns. Technical assistance is provided to correct identified deficits.

Providers are required to submit evidence to the Operating Agency annually to document continuing compliance with all Certification requirements as specified in the ADW Policy Manual. This evidence must be signed by an appropriate official of the provider (e.g., Executive Director, Board Chair, etc.). If appropriate documentation is not provided, a Provisional Certification is issued until appropriate documents are submitted and approved by the Operating Agency. Providers receiving a Provisional Certification are required to have an on-site review by the Operating Agency prior to full re-certification. A percentage of providers are randomly selected each year for a review to validate certification documentation. Targeted on-site provider reviews may be conducted based on Incident Management Reports, claims trends and complaint data.

A statewide representative sample of charts are reviewed every 12 months. Charts are reviewed by staff of the Operating Agency using the Personal Attendant Monitoring Tool and the Case Management Monitoring Tool. The HCBS CAHPS was implemented in WV because it was presented as best practice and would enable data from WV to be compared to data from other states with HCBS waivers. It is a standardized assessment tool. Some of the items from the HCBS CAHPS can be used to inform certain performance measures. These tools have been developed to ensure that the critical data necessary to monitor CMS assurances are collected. A proportionate random sample is chosen ensuring that at least one chart from each provider site is reviewed.

West Virginia Incident Management System (WVIMS):

Another key source for monitoring the quality of ADW services is the online West Virginia Incident Management System (WVIMS). Per policy, ADW providers are required to use the online application to report and track all incidents including 1) Simple Incidents, 2) Critical Incidents, and 3) Abuse, Neglect, and Exploitation. The WVIMS also provides the Operating Agency the capability to monitor reported incidents in "real time" in order to ensure that timely, appropriate steps are taken by providers.

The Operating Agency also operates a toll-free hotline allowing people to contact them directly to report and address concerns with their services. Data from these calls are compiled and analyzed for trends.

Reports:

BMS management staff receive and review the following contract reports:

- Operating Agency - Monthly Program Report and ad hoc reports as requested.
- Personal Options Monthly Program report and ad hoc reports as requested.
- Utilization Management Contractor (UMC) - Monthly Activity Report, weekly Managed Enrollment Report, and various ad hoc reports as requested.
- Claims processing entity - regular claims data reports and ad hoc reports as requested.

Contract Oversight Meetings:

BMS management staff conduct monthly oversight meetings with each of their contractors to monitor performance and address identified issues/concerns. The D&R report is reviewed at least monthly by BMS and the OA at its contract meetings. The D&R report is also compiled and reviewed quarterly by the ADW QI Advisory Council The D&R report summarizing the findings of provider reviews is compiled at the end of each review cycle, reviewed and analyzed by Waiver staff and presented to the QI Advisory Council for its review and analysis.

The Quality Improvement (QI) Advisory Council:

The QI Advisory Council is the focal point of stakeholder input for the Waiver and plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies.The Council provides Waiver staff feedback and guidance regarding quality improvement initiatives. In partnership with Waiver staff, the Council reviews and analyzes data, identifies trends and priorities, and develops the annual quality Management Plan in which specific quality improvement goals and objectives are established.The Council may establish 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 Work Plan are continuously monitored by the ADW Quality Improvement Advisory Council, with regular updates being provided at each quarterly meeting. An annual planning meeting is held to review progress toward the goals and objectives of the plan and to update the plan as indicated by quality management data.

Appendix 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 charts are reviewed every 12 months by the OA to verify documentation of services billed. Provider reviews are conducted by staff of the Operating Agency to ensure the integrity of payments that have been made for Waiver services. When provider documentation does not support services billed, providers are subject to a disallowance and repayment. All OA findings are reviewed with both BMS and OPI to review all findings and be in agreement with the OA. In addition when a specific finding is identified the provider must submit a corrective action plan which must be approved by the OA. 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.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Percent of provider claims reviewed that resulted 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 =* *95%*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

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

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of processed claims that were denied per MMIS edits. Numerator - Number of processed claims that were denied per MMIS edits. Denominator - Number of processed claims.

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

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

		Review
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

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.*

An Excel spreadsheet will be used for all Final Reports which are logged and noting the number of claims reviewed using the correct rate. This will be shared at a meeting with BMS and OPI that will be scheduled upon completion of reviews.

All people on the ADW with paid claims over a selected three month period are used as the population size for the Raosoft, Inc. sample calculator. The margin of error is set as 5% (which is a common choice) and a confidence level is set at 95%. Since the random sampling of persons served may not include all providers, at least two people will be randomly selected from the claims using the Excel sampling formula to ensure claims are reviewed from each provider annually.

b. Methods for Remediation/Fixing Individual Problems

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

All information relating to this assurance is collected through a review and analysis of claims data provided by the claims processing entity. Individual issues/concerns related to appropriate documentation of services billed identified during the review of member charts are addressed immediately by the operating agency with providers during an exit interview. Providers may be required to submit Corrective Action Plans addressing identified issues that must be approved by the operating agency. Evidence collected via claims data is reviewed and analyzed by BMS and the claims processing entity in order to identify any system issues.

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***Other*** *Specify:* *claims processing entity*	☒ ***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 Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

West Virginia has a uniform rate determination method based on usual and customary fees that are uniformly and consistently applied to each provider of a waiver service. The basis for the usual and customary fees was an agreed upon rate. The Medicaid agency conducted the original negotiations that resulted in an approved rate, and has consistently applied them to waiver services and continues to determine rate changes. The rate for Personal Attendant Services was increased as follows at the direction of Department Administration following negotiations with providers; in October 2008 the rate was increased from $3.05 per 15 minute unit to $3.25; in August 2009 the rate was increased from $3.25 to $3.50 per 15 minute unit; in July 2011 the rate was increased from $3.50 to $3.75 per 15 minute unit.In January 2019 the rate was increased from $4.25 to $4.50 per 15 minute unit; in January 2021, the Personal Attendant rate was increased to assist providers with increased administrative costs for providing services, including the implementation of EVV, staff recruitment, training, and personal protective equipment. The Nursing rates have not changed since the 2010 renewal. In January 2021 the case management rate changed from $71.10 per member per month to $80.00 per member per month. Mileage reimbursement is based on the approved mileage rate as published by the West Virginia Division of Purchasing, Travel Management Office. In that rates have not limited access they are deemed to be sufficient to enlist sufficient provider participation and meet the provisions of section 1902(a)30(A) and 42 CFR section 447.200-205. BMS will post payment rates on the Agency website so that waiver participants and providers will be aware of the cost of waiver services. The state of West Virginia does not use a formula to base increases for inflation, and at this time does not anticipate rate increases.

The rate for the newly added Personal Emergency Response System service is based on the historical cost of the individual pendant through the Money Follows the Person demonstration grant.

The Pre-Transition Case Management services rates were established using existing case management rates for the TBI and ADW waivers.

All HCBS rates were developed using the method described below:

o In 2011 conducted a provider survey to obtain employment data and operational statistics about specific HCBS services
o WV used a factor-based calculation using the following factors;
Hourly Wages (source: Provider Surveys and Bureau for Labor Statistics data)
Payroll Taxes (e.g. Medicare, Social Security, Worker's Compensation)
Benefits (BLS data for insurance and Retirement)
Administration (non-billable time and administrative support)
Capital (repairs, interest, depreciation/amortization, rent, IT/systems)
Supplies & Materials (supplies and materials involved in cost of sales, communications)

Because of state budget constraints. rates for all waiver services have not been increased since the initial development in 2011 – 2012, except for ADW homemaker services.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Billing flows directly from waiver providers to the State's claims processing entity.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Each claim is subjected to a series of edits to ensure that the member is eligible on the date of service, that the provider has a valid enrollment status and that the service is eligible for payment. If the claim passes these initial edits, further assurances are provided through prior authorization of Personal Attendant services based on the waiver member's approved service plan. Edits are built in the other ADW services to ensure that the maximum number of units is not exceeded per month /year. Post-payment review activities are conducted to ensure that services were provided.

Currently, it is expected that the State will use a post-payment system to evaluate the presence and validity of EVV data as well as relevant claim matching.

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 §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent ?1115/?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 ?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 textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §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 §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:

This waiver program is funded through a lottery appropriation that is transferred from the Bureau of Senior Services to the Bureau for Medical Services, and may also include general revenue appropriation.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

  Check each that applies:

  - [ ] ***Health care-related taxes or fees***
  - [ ] ***Provider-related donations***
  - [ ] ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- (●) ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ( ) ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ( ) ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] ***Nominal deductible***
- [ ] ***Coinsurance***
- [ ] ***Co-Payment***
- [ ] ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	17694.26	7665.00	25359.26	57396.00	8406.00	65802.00	40442.74
2	17442.46	7867.00	25309.46	59440.00	9078.00	68518.00	43208.54
3	20042.01	8074.00	28116.01	61556.00	9804.00	71360.00	43243.99
4	21710.25	8287.00	29997.25	63747.00	10588.00	74335.00	44337.75
5	22026.72	8505.00	30531.72	66017.00	11435.00	77452.00	46920.28

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	7912	7912
Year 2	8500	8500
Year 3	7500	7500
Year 4	7026	7026
Year 5	7026	7026

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Estimate for average length of stay is derived from historical claims experience. The SFY2021 preliminary ALOS data of 1,689 days was used to provide the most recent data available at the time this waiver application was prepared.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

The estimates for Factor D are derived from historical trends of actual claims experience used in preparing the CMS-372 reports adjusted for inflationary increases based on the most recent two years reporting periods (due to significant shifts in earlier periods the last two years were used in an effort to reflect anticipated trend for the next five years). Additional consideration was given to years determined to be outliers and these were excluded for trending purposes. Methodology for the estimates provided remained the same. Estimates are based on estimated usage per participant from the 2019 Lag 372 report.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The estimates for Factor D' are derived from historical trends of actual claims experience used in preparing the CMS-372 reports adjusted for inflationary increases based on the most recent five year reporting periods. Additional consideration was given to years determined to be outliers and these were excluded for trending purposes. There are no wrap-around benefits provided to Medicare/Medicaid dual eligibles therefore the only prescription costs included would be for those drugs excluded from the Medicare formulary.

The Factor D decrease is attributable to revision of program policy changes, downward revisions of cost inflation factor, and the availability of recent year's historical procedure case mix date, to utilize in the waiver amendment projections.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The estimates for Factor G are derived from historical trends of actual claims experience used in preparing the CMS-372 reports adjusted for inflationary increases based on the most recent five year reporting periods. Additional consideration was given to years determined to be outliers and these were excluded for trending purposes.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The estimates for Factor G' are derived from historical trends of actual claims experience used in preparing the CMS-372 reports adjusted for inflationary increases based on the most recent five year reporting periods. Additional consideration was given to years determined to be outliers and these were excluded for trending purposes.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Case Management	
Personal Attendant Services	
Adult Medical Day Care	
Community Transition Services	
Environmental Accessibility Adaptations	
Non-Medical Transportation	
Personal Emergency Response System	
Pre-Transition Case Management	
Skilled Nursing	

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:						7832880.00
Case Management	monthly fee	7912	12.00	82.50	7832880.00	
Personal Attendant						126058271.22
			GRAND TOTAL:			139996963.48
			Total Estimated Unduplicated Participants:			7912
			Factor D (Divide total by number of participants):			17694.26
			Average Length of Stay on the Waiver:			322

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Total:						
Personal Attendant Services	15 minute	3243	3802.00	4.38	54004900.68	
Personal Attendant Services Modifier	15 minute	2679	3802.00	4.38	44612744.04	
Personal Attendant Services Personal Options	15 minute	738	5394.00	4.25	16918281.00	
Personal Attendant Services Personal Options Modifier	15 minute	459	5394.00	4.25	10522345.50	
Adult Medical Day Care Total:						19800.00
Adult Medical Day Care	event	198	100.00	1.00	19800.00	
Community Transition Services Total:						55350.00
Community Transition Services	event	27	2050.00	1.00	55350.00	
Environmental Accessibility Adaptations Total:						792000.00
Environmental Accessibility - Home Traditional	event	396	500.00	1.00	198000.00	
Environmental Accessibility - Home Self-Directed	event	396	500.00	1.00	198000.00	
Environmental Accessibility - Vehicle Traditional	event	396	500.00	1.00	198000.00	
Environmental Accessibility - Vehicle Self-Directed	event	396	500.00	1.00	198000.00	
Non-Medical Transportation Total:						1198937.46
Transportation Personal Options	mile	32	1931.00	0.42	25952.64	
Transportation	mile	3917	713.00	0.42	1172984.82	
Personal Emergency Response System Total:						1086600.00
Personal Emergency Response System	monthly fee	1811	12.00	50.00	1086600.00	
Pre-Transition Case Management Total:						5508.00
Pre-Transition					5508.00	

GRAND TOTAL:	139996963.48
Total Estimated Unduplicated Participants:	7912
Factor D (Divide total by number of participants):	17694.26
Average Length of Stay on the Waiver:	322

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management	15 minute	27	24.00	8.50		
Skilled Nursing Total:						**2947616.80**
RN Assessment	event	5298	2.00	120.00	**1271520.00**	
RN Monthly	15 minute	6412	20.00	13.07	**1676096.80**	
				GRAND TOTAL:		**139996963.48**
				Total Estimated Unduplicated Participants:		**7912**
				Factor D (Divide total by number of participants):		**17694.26**
				Average Length of Stay on the Waiver:		322

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:						**8868960.00**
Case Management	monthly fee	8212	12.00	90.00	**8868960.00**	
Personal Attendant Services Total:						**132940125.18**
Personal Attendant Services	15 minute	3366	3802.00	4.47	**57204968.04**	
Personal Attendant Services Modifier	15 minute	2781	3802.00	4.47	**47262928.14**	
Personal Attendant Services Personal Options	15 minute	766	5394.00	4.25	**17560167.00**	
Personal Attendant Services Personal Options Modifier	15 minute	476	5394.00	4.25	**10912062.00**	
Adult Medical Day Care Total:						**20500.00**
Adult Medical Day Care	event	205	100.00	1.00	**20500.00**	
Community Transition Services Total:						**58548.00**
				GRAND TOTAL:		**148260893.45**
				Total Estimated Unduplicated Participants:		**8500**
				Factor D (Divide total by number of participants):		**17442.46**
				Average Length of Stay on the Waiver:		322

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Transition Services	event	28	2050.00	1.02	58548.00	
Environmental Accessibility Adaptations Total:						822000.00
Environmental Accessibility - Home Traditional	event	411	500.00	1.00	205500.00	
Environmental Accessibility - Home Self-Directed	event	411	500.00	1.00	205500.00	
Environmental Accessibility - Vehicle Traditional	event	411	500.00	1.00	205500.00	
Environmental Accessibility - Vehicle Self-Directed	event	411	500.00	1.00	205500.00	
Non-Medical Transportation Total:						1273995.83
Transportation Personal Options	mile	33	1931.00	0.43	27400.89	
Transportation	mile	4066	713.00	0.43	1246594.94	
Personal Emergency Response System Total:						1150560.00
Personal Emergency Response System	monthly fee	1880	12.00	51.00	1150560.00	
Pre-Transition Case Management Total:						5826.24
Pre-Transition Case Management	15 minute	28	24.00	8.67	5826.24	
Skilled Nursing Total:						3120378.20
RN Assessment	event	5499	2.00	122.40	1346155.20	
RN Monthly	15 minute	6655	20.00	13.33	1774223.00	
				GRAND TOTAL:		148260893.45
				Total Estimated Unduplicated Participants:		8500
				Factor D (Divide total by number of participants):		17442.46
				Average Length of Stay on the Waiver:		322

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:						8868960.00
Case Management	monthly fee	8212	12.00	90.00	8868960.00	
Personal Attendant Services Total:						135043505.64
Personal Attendant Services	15 minute	3366	3802.00	4.56	58356745.92	
Personal Attendant Services Modifier	15 minute	2781	3802.00	4.56	48214530.72	
Personal Attendant Services Personal Options	15 minute	766	5394.00	4.25	17560167.00	
Personal Attendant Services Personal Options Modifier	15 minute	476	5394.00	4.25	10912062.00	
Adult Medical Day Care Total:						20500.00
Adult Medical Day Care	event	205	100.00	1.00	20500.00	
Community Transition Services Total:						59696.00
Community Transition Services	event	28	2050.00	1.04	59696.00	
Environmental Accessibility Adaptations Total:						656000.00
Environmental Accessibility - Home Traditional	event	328	500.00	1.00	164000.00	
Environmental Accessibility - Home Self-Directed	event	328	500.00	1.00	164000.00	
Environmental Accessibility - Vehicle Traditional	event	328	500.00	1.00	164000.00	
Environmental Accessibility - Vehicle Self-Directed	event	328	500.00	1.00	164000.00	
Non-Medical Transportation Total:						1303623.64
Transportation Personal Options	mile	33	1931.00	0.44	28038.12	
Transportation	mile	4066	713.00	0.44	1275585.52	
Personal Emergency Response System Total:						1173571.20
Personal					1173571.20	

GRAND TOTAL:	150315057.26
Total Estimated Unduplicated Participants:	7500
Factor D (Divide total by number of participants):	20042.01
Average Length of Stay on the Waiver:	322

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Emergency Response System	monthly fee	1880	12.00	52.02		
Pre-Transition Case Management Total:						**5940.48**
Pre-Transition Case Management	15 minute	28	24.00	8.84	**5940.48**	
Skilled Nursing Total:						**3183260.30**
RN Assessment	event	5499	2.00	124.85	**1373100.30**	
RN Monthly	15 minute	6655	20.00	13.60	**1810160.00**	
				GRAND TOTAL:		**150315057.26**
				Total Estimated Unduplicated Participants:		**7500**
				Factor D (Divide total by number of participants):		**20042.01**
				Average Length of Stay on the Waiver:		322

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:						**8868960.00**
Case Management	monthly fee	8212	12.00	90.00	**8868960.00**	
Personal Attendant Services Total:						**137146886.10**
Personal Attendant Services	15 minute	3366	3802.00	4.65	**59508523.80**	
Personal Attendant Services Modifier	15 minute	2781	3802.00	4.65	**49166133.30**	
Personal Attendant Services Personal Options	15 minute	766	5394.00	4.25	**17560167.00**	
Personal Attendant Services Personal Options Modifier	15 minute	476	5394.00	4.25	**10912062.00**	
Adult Medical Day Care Total:						**20500.00**
				GRAND TOTAL:		**152536228.89**
				Total Estimated Unduplicated Participants:		**7026**
				Factor D (Divide total by number of participants):		**21710.25**
				Average Length of Stay on the Waiver:		322

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Medical Day Care	event	205	100.00	1.00	20500.00	
Community Transition Services Total:						60844.00
Community Transition Services	event	28	2050.00	1.06	60844.00	
Environmental Accessibility Adaptations Total:						656000.00
Environmental Accessibility - Home Traditional	event	328	500.00	1.00	164000.00	
Environmental Accessibility - Home Self-Directed	event	328	500.00	1.00	164000.00	
Environmental Accessibility - Vehicle Traditional	event	328	500.00	1.00	164000.00	
Environmental Accessibility - Vehicle Self-Directed	event	328	500.00	1.00	164000.00	
Non-Medical Transportation Total:						1333251.45
Transportation Personal Options	mile	33	1931.00	0.45	28675.35	
Transportation	mile	4066	713.00	0.45	1304576.10	
Personal Emergency Response System Total:						1197033.60
Personal Emergency Response System	monthly fee	1880	12.00	53.06	1197033.60	
Pre-Transition Case Management Total:						6061.44
Pre-Transition Case Management	15 minute	28	24.00	9.02	6061.44	
Skilled Nursing Total:						3246692.30
RN Assessment	event	5499	2.00	127.35	1400595.30	
RN Monthly	15 minute	6655	20.00	13.87	1846097.00	
				GRAND TOTAL:		152536228.89
				Total Estimated Unduplicated Participants:		7026
				Factor D (Divide total by number of participants):		21710.25
				Average Length of Stay on the Waiver:		322

Appendix J: Cost Neutality 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:						8868960.00
Case Management	monthly fee	8212	12.00	90.00	8868960.00	
Personal Attendant Services Total:						139250266.56
Personal Attendant Services	15 minute	3366	3802.00	4.74	60660301.68	
Personal Attendant Services Modifier	15 minute	2781	3802.00	4.74	50117735.88	
Personal Attendant Services Personal Options	15 minute	766	5394.00	4.25	17560167.00	
Personal Attendant Services Personal Options Modifier	15 minute	476	5394.00	4.25	10912062.00	
Adult Medical Day Care Total:						20500.00
Adult Medical Day Care	event	205	100.00	1.00	20500.00	
Community Transition Services Total:						61992.00
Community Transition Services	event	28	2050.00	1.08	61992.00	
Environmental Accessibility Adaptations Total:						656000.00
Environmental Accessibility - Home Traditional	event	328	500.00	1.00	164000.00	
Environmental Accessibility - Home Self-Directed	event	328	500.00	1.00	164000.00	
Environmental Accessibility - Vehicle Traditional	event	328	500.00	1.00	164000.00	
Environmental Accessibility - Vehicle Self-Directed	event	328	500.00	1.00	164000.00	
Non-Medical Transportation Total:						1362879.26
Transportation					29312.58	

GRAND TOTAL:	154759732.62
Total Estimated Unduplicated Participants:	7026
Factor D (Divide total by number of participants):	22026.72
Average Length of Stay on the Waiver:	322

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Options	mile	33	1931.00	0.46		
Transportation	mile	4066	713.00	0.46	1333566.68	
Personal Emergency Response System Total:						1220947.20
Personal Emergency Response System	monthly fee	1880	12.00	54.12	1220947.20	
Pre-Transition Case Management Total:						6182.40
Pre-Transition Case Management	15 minute	28	24.00	9.20	6182.40	
Skilled Nursing Total:						3312005.20
RN Assessment	event	5499	2.00	129.90	1428640.20	
RN Monthly	15 minute	6655	20.00	14.15	1883365.00	

GRAND TOTAL:	154759732.62
Total Estimated Unduplicated Participants:	7026
Factor D (Divide total by number of participants):	22026.72
Average Length of Stay on the Waiver:	322