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:
Traumatic Brain Injury (TBI) Waiver

C. Waiver Number:WV.0876

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 6 additional TBIW slots.
2. Add Environmental Accessibility Adaptations (EAA)Home and Vehicle for Traditional and Self-directed Service models. Maximum $1000.00 per Service Plan year.
3. Add Anyone applying for Personal Attendant having Certified Nursing Assistant (CNA) credentials providing documentation of current Certification, along with First Aid and CPR training to expedite the hiring process.
4. Case Manager visits adding option for quarterly F2F visits but monthly contact still required.
5. Removed the requirement of use of EVV for Case Managers.
6.Increase the maximum TBIW available budget to $36,600.00 per Service Plan year based on accessed need. This allows for the new service of EAA and the PERS units added in the last addendum.

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*):

Traumatic Brain Injury (TBI) 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**

Draft ID: **WV.008.02.02**

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 purpose of the Traumatic Brain Injury Waiver (TBIW) is to provide home and community-based services to West Virginia residents who are both medically and financially eligible to participate in the program. Applicants must also be at least three (3) years of age. The applicant or their legal guardian, if applicable, will choose home and community-based services rather than nursing home placement. The purpose of the TBIW is to prevent unnecessary institutionalization by providing cost-effective services in the member's home and community. 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 Medical Agency as well as an Utilization Management Contractor (UMC) for daily operations and for assessment and re-assessment. BMS retains final authority over this waiver and the administration and operation of the program.

The BMS contracts with the UMC to implement the administrative functions related to the operations of the Waiver. The UMC also assesses medical eligibility for program applicants, as well as, conducts annual re-evaluations for those receiving Waiver services. The UMC also authorizes TBIW services for eligible members. The UMC also completes initial and continuing Provider certifications.

The UMC is responsible for implementing the Quality Improvement System (QIS) for the TBIW program. The UMC reviews 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 TBIW 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 UMC 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 TBIW Quality Improvement Advisory (QIA) Council.

An TBIW 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 UMC. 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.

BMS contracts with a claims processing entity to process claims and with a sole Government sub-agent Fiscal Employer Agent (F/EA) Financial Management Services (FMS), hereafter referred to as Personal Options, to support members who choose to direct their own services through the self-directed model within the TBIW.

Individualized annual budgets are established for each member on the TBIW based upon their assessed needs as documented on their person-centered Service Plan.

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 TBIW services.

Members can choose one of two service delivery models - Traditional or Personal Options. Members choosing the Traditional Model receive their services from certified TBIW Personal Attendant and Case Management Agencies. The services available include Case Management, Personal Attendant Services, Personal Emergency Response Systems (PERS), Environmental Accessibility Adaptation (Home and Vehicle) and Transportation.

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 and Personal Emergency Respondent Systems per policy guidelines if they prefer. Members who choose Personal Options must access case management services from a certified TBIW Case Management Agency.

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.

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 TBIW 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 received and the changes made or not made are listed in the document found here: https://dhhr.wv.gov/bms/Programs/Documents/TBI%20Waiver/Waiver%20and%20Reports/2020_Draft_TBIW_Comments_and_R

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 Home and Community-Based Services

Agency:

Bureau for Medical Services

Address:

350 Capitol St., Room 251

Address 2:

City: Charleston

State: **West Virginia**

Zip: 25301

Phone: (304) 356-4868 **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:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **West Virginia**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

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:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **West Virginia**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

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 that this waiver renewal 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:
   Bureau for Medical Services

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

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. Utilization Management Contractor (UMC)Overview and Functions:

1. Individual waiver enrollment
2. Qualified provider enrollment and continuing certification
3. Provider monitoring reviews (assessments, person center service plan, employee qualifications, etc.)
4. Quality assurance and quality improvement activities and data reporting
5. Level of Care evaluation/re-evaluations
6. Prior authorization of Waiver services
7. Data Reporting
8. Management of the Managed Enrollment List (wait list) database

2. 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

3. Government Fiscal Employer/Agent (F/EA) Overview and Functions:

1. Assist 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 in members exercising employer authority;
4. Assures members workers meet employment requirements including citizenship or legal alien status as specified on the BCIS Form I-9;
5. Process of members personal attendant's timesheets and transportation invoices;
6. Operate a payroll service, (including withholding taxes from personal attendant's 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 Personal Attendant Professionals; and
10. Provide ongoing information and assistance to members and/or their program representative/legal guardian if applicable.
11. Serve as FMS for processing Community Transition Services Invoices.
No. Contracted entities do not perform waiver operational and administrative functions on behalf of the

4. Community 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:

1. Accept and follow-up with referrals from the Aging & Disability Resource Network (ADRN);
2. Conduct interviews to share information about options for returning to the community, including the availability of Waiver transition services;
3. Assess residents' transition support needs, including risk factors that may jeopardize a safe and successful transition to the community;
4. 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;
5. 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;
6. 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;

7. 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:

i. Oversee the day-to—day operations and delivery of Transition Coordination;

ii. Participate in monthly contract meetings with designated staff from the contractor and the Bureau for Medical Services (BMS);

iii. Review and approve all Transition Plans prior to the delivery of Waiver transition services;

iv. 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;

v. Provide monthly Program and data reports as specified;

vi. Provide ad hoc reports as requested by BMS, and;

vii. Attend Waiver Quality Assurance and Improvement Advisory Council meetings.

○ **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 West Virginia 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 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 Quality Management Report Template and reviewed at least monthly by BMS at the contract meetings. The Quality Management Report is also compiled and reviewed quarterly by the TBIW Quality Improvement Advisory Council. A comprehensive report summarizing the findings of provider reviews is compiled at the end of each review cycle, reviewed and analyzed by Waiver staff and presented to the QIA Council for its review and analysis.

Reports:

BMS management staff will receive and review the following contract reports:
(1) TBIW Quality Management Report on delegated functions and ad hoc reports as requested.
(2) Personal Options Vendor 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.

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	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	☒	☐

Function	Medicaid Agency	Contracted Entity
Quality assurance and quality improvement activities	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the 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 providers that submitted the validation review within timeline. Numerator- Number of providers that submitted the validation review within timeline Denominator- Number of providers whose validation review was due

Data Source (Select one):
Record reviews, 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: 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:
Percent of written complaints followed up by the UMC within established timelines
Numerator= Number of written complaints followed up on by the UMC within established

timelines. Denominator = Number of written complaints submitted to the UMC.

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

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

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

Performance Measure:
Percent of satisfaction surveys pertaining to UMC functions rated 80% or higher. Numerator= Number of satisfaction surveys pertaining to UMC functions rated 80% or higher. Denominator = Number of satisfaction surveys submitted.

Data Source (Select one):
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: 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:
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 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:
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: 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **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 with established timelines Denominator = Number of Provider reviews conducted

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: 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:
Percent of requests for prior authorizations responded to within established timelines Numerator= Number of requests for prior authorization responded to within established timelines. Denominator = Number of requests for prior authorizations.

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: 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:

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 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**
☐ **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			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☒ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☒	Brain Injury	3		☒
	☐	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:

In order to apply for the TBIW program, the applicant must be a resident of the State of West Virginia and at least 3 years of age. The applicant must have a documented Traumatic Brain Injury (TBI). A TBI is a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment or an injury caused by anoxia due to near drowning . The applicant must have deficits in five (5) Activities of Daily Living (ADLs) to meet nursing home level of care as assessed utilizing the Pre-Admission Screening (PAS) 2000. The applicant ages 18 and older must also score at a Level VII or below on the Rancho Los Amigos Levels of Cognitive Functioning Scale and applicants ages 3 through 17 must score at a Level 2 or higher on the Rancho Los Amigos Pediatric Leve of Consciousness Scale. Applicants for the Waiver can be in-patient in a licensed nursing facility, an inpatient hospital, a licensed rehabilitation facility to treat TBI or living in a community setting at the time of application.

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Specify the percentage:

○ **Other**

Specify:

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

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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 receiving TBIW services are addressed in the member's Person Centered Service Plan (SP), which is facilitated by the member's Case Manager. The SP includes Waiver services, non-Waiver services, informal supports, and emergency backup planning. The SP must address all identified needs, including risks to the member's health and safety.

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

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

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

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

☒ **Other safeguard(s)**

Specify:

A key Case Management function is to oversee the implementation of a member's services as outlined on their Service Plan. Case Managers must make monthly contact and a minimum of quarterly Face to Face visits to review the implementation of the SP and address any identified issues or concerns. If unable to reach the person by telephone, the Case Manager must make a home visit.

The member's budget is based on their assessed needs. Additional services may be requested at any time. If the review by the UMC indicates that the member's service needs have changed based on the member's condition or other factors such as a change in living arrangement or availability of informal support, the UMC may authorize an increase to the member's budget. At no time however a budget would be authorized for more than the maximum amount approved per member for this program ($36,600 per member annually).

If at any time the Waiver program cannot adequately ensure a member's health and safety, the Case Manager must make appropriate referrals to other available resources in the community. As a last resort, if a member's health and welfare cannot be assured by utilizing Waiver and/or other available community resources, the member will be referred for institutional services.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	96
Year 2	96
Year 3	96
Year 4	96
Year 5	96

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	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
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 members who are medically and financially eligible for the Traumatic Brain Injury Waiver program and who have been in a facility, such as nursing home, hospital or Institution for Mental Disease (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 Year 1,2,3, 4 and Waiver Year 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	4
Year 2	4
Year 3	4
Year 4	4

Waiver Year	Capacity Reserved
Year 5	4

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 TBIW program is reached, applicants for TBIW services are placed on a Managed Enrollment List (MEL). Upon application, financial eligibility must be determined prior to medical eligibility. Applications for entry to the program will be processed based on the date/time of their request for medical eligibility determination as capacity becomes available. Those determined both financially and medically eligible will be placed on the MEL if a funded slot is not available.

Take Me Home applicants are not subject to the same MEL requirements which requires an TBIW 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**
☒ **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 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 personal need 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 (UMC)

- ( ) **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:

The UMC staff conducting medical eligibility assessments must be a Registered Nurse, Licensed Social Worker, Licensed Professional Counselor, Certified Rehabilitation Counselor, or Licensed Psychologist with appropriate training and experience and have a Certified Brain Injury Specialist certification.

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.

BMS contracts with the following entities to perform operational and administrative functions as follows:
1. Utilization Management Contractor (UMC)Overview and Functions:

1. Individual 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. Level of Care evaluation/re-evaluations
6. Prior authorization of Waiver services
7. Data Reporting
8. Management of the Managed Enrollment List (wait list) database

2. 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

3. Government Fiscal Employer/Agent (F/EA) (Personal Options) Overview and Functions:

The UMC will complete the initial eligibility assessments utilizing the Pre-Admission Screening (PAS) and the age appropriate Rancho Los Amigos Scale. When completing assessments for children ages 3 through 18 the assessor will take into account age appropriate developmental milestones.

An applicant must have at least five (5) deficits as assessed by the Pre-Admission Screening (PAS) to qualify medically for the Waiver. These deficits are derived from a combination of the following assessment areas:
1. Decubitus (Stage 3 or 4)
2. In the event of an emergency, the applicant is mentally or physically unable to vacate a building
3. Functional abilities of individual in the home
-Eating (needs physical assistance to get nourishment)
-Bathing (needs physical assistance or more)
-Dressing (needs physical assistance or more)
-Grooming (needs physical assistance or more)
-Continence (must be incontinent)
-Orientation (must be totally disoriented, comatose)
-Transfer (requires one-person or two-person assistance)
-Walking (requires assistance) -Wheeling (must require assistance with walking in the home)
-Vision (impaired/not correctable) -Hearing (impaired/not correctable)
-Communication (understandable with aids)

4. Individual has skilled needs in one or more of the following areas:
-Suctioning
-Tracheotomy
-Ventilator
-Parental fluids
-Sterile dressings
-Irrigation's -Physical therapy
-Occupational therapy
-Speech therapy
-continuous oxygen

5. Individual is not capable of administering his/her own medications or needs prompting supervision.

6. Clinical and psychological data -Disoriented -Seriously impaired judgment -Cannot communicate basic needs -

Physically dangerous to self and others if unsupervised Applicants must also have a Traumatic Brain Injury (TBI) documented at the time of referral. A TBI is defined as a non-degenerative, non- congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment or injury caused by anoxia due to near drowning. Adult applicants must score at a Level VII or below on the Rancho Los Amigos Levels of Cognitive Functioning Scale and children age 3 through 17 must score at an Level 2 or higher on the Rancho Los Amigos Levels of Conscious Scale.

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:

INITIAL EVALUATION:
A. An applicant shall initially apply for the TBI Waiver by having a treating physician (M.D. or D.O.), physician assistant (PA), advance practice registered nurse practitioner (APRN) or specially trained neuropsychologist (here after called the referent) submit a Medical Necessity Evaluation Request (MNER) form. The referent's signature is valid for sixty days (60). The referral source for the request may be from the applicant/representative, hospital or nursing home, DHHR, the physician, social services agencies, or others from the community.
B. The Medical Necessity Evaluation Request (MNER) form asks that the referent submit the applicant's identifying information including, but not limited to, the following: 1. A statement that the individual's condition meets the entry level definition of TBI: a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment or injury of anoxia due to near drowning. 2. A description of the functional deficits directly attributable to the TBI; 3. Other pertinent medical diagnoses and comments.

C. Once a referral is received, the UMC will send a letter of verification of its receipt to the applicant/applicant's representative and the referent. If the MNER form is incomplete it will be returned to the referent for completion and resubmission, and the applicant will be notified. The UMC will send the applicant/applicant's representative the DHS-2 form with instructions for determining financial eligibility prior to scheduling an assessment for medical eligibility. When the UMC receives a completed DHS-2 from the county DHHR office indicating the applicant meets financial eligibility the UMC will attempt to contact the applicant/applicant's representative by phone to schedule a medical assessment. The UMC will follow current policy regarding requirements to contact the applicant/applicant's representative by phone. If it is determined that the applicant is not available, the referent and applicant/representative will be notified that no contact could be made. If the referral is closed because of an inability to contact the applicant/applicant's representative, a new referral will be required to re-initiate the process. If the applicant is determined financially ineligible by the county DHHR office a medical eligibility assessment will not be scheduled by the UMC and the MNER will be closed. The local DHHR office should provide a financial eligibility letter with Fair Hearing rights to the applicant.

D. If contact is made, a letter will be sent to the applicant/applicant's representative documenting that contact was made and the date of the scheduled evaluation. If the applicant has identified a court appointed legal guardian, no assessment shall be scheduled without the presence of the guardian. If the MNER form indicates that the applicant has severe dementia, no visit will be scheduled without the guardian present to assist the applicant during the evaluation.

E. The UMC staff completes the Pre-Admission Screening (PAS) and the appropriate Ranchos Los Amigos Scale. UMC staff will record observations and findings regarding the applicant's level of functioning. In those cases where there is a medical diagnosis question, the UMC staff will attempt to clarify the information with the referent. In the event that the UMC staff cannot obtain the information, they will document that supporting documentation from the referent was not received.

F. If it is determined that the applicant does not meet medical eligibility, the applicant/ applicant's representative (if applicable), the referent will be notified by a Potential Denial letter from the UMC. This letter will advise the applicant of the reason for the potential denial, listing the areas in which deficiencies were found and notice that the medical eligibility standard has not been met. A copy of the PAS, Ranchos Los Amigos, and the section of the TBI Waiver policy covering Medical eligibility will also be included with the Potential Denial letter. The applicant will be given 30 days to submit supplemental medical information to the UMC. Information submitted after the 30 day period will not be considered.

G. If no additional information is received within the timeline or the review of the supplemental information by the UMC determines that there is still no medical eligibility, the applicant/applicants representative (if applicable), referent will be notified by a Final Denial letter. The Final Denial letter will provide the reason for the denial. It will also include the applicable TBI Waiver policy manual section(s), a copy of the PAS and Rancho Los Amigos Scale, supplemental information documentation (if it has been supplied), notice of free legal services, and a Request for a Medicaid Fair Hearing form to be completed if the applicant wishes to contest the decision. The UMC will contact the applicant to offer a Pre-hearing conference to try to resolve one or more issues listed in the complaint if a request for a Medicaid Fair Hearing has been made.

H. If the applicant's medical eligibility is denied and the applicant is subsequently found medically eligible after the Medicaid Fair Hearing process, the date of eligibility can be no earlier than the effective date of the hearing decision.

I. If the applicant is determined medically eligible, a notice of approved medical eligibility is sent to the applicant, the referent, and the applicant's representative, if applicable. If a slot is available the applicant will be enrolled and assigned an Anchor Date. The Anchor Dates will serve as the fixed due date for the Annual Assessment and Service Plan development and the reevaluation of the member's medical eligibility, as well as the start date for TBIW service authorizations.

J. If the applicant is found both financially and medically eligible, and a slot is not available the applicant will be placed on a Managed Enrollment List (MEL). A Financial eligibility approval is good for 90 days. When a slot becomes available in the TBIW Program, a second notice of approved medical eligibility is sent to the referent, and applicant/applicant's representative (if applicable). If the 90 day financial eligibility approval has expired, another DHS-2 form with instructions sending the applicant to the local DHHR office to re-determine financial eligibility is sent to the applicant/ applicant's representative (if applicable) by the UMC. If the applicant is found ineligible financially the county DHHR office will send a denial letter with information regarding a Fair Hearing. The application will be closed by the UMC.

K. When an applicant on the Managed Enrollment List is informed that a funded slot is available, the UMC contacts the applicant and their representative (if applicable) and reviews the Freedom of Choice Form and their previous Service Delivery Model selection forms. If the applicant and their representative (if applicable) wish to change either or both of the selection forms then the UMC will mail new form(s).

L. Applicants are given a slot on a first on first off basis.
ANNUAL RE-EVALUATION:

A. The UMC will schedule an annual re-evaluation of the member's medical eligibility.

B. The UMC will arrange for an evaluator to visit the member in their home environment or at an agreed location in order to perform the evaluation. The annual reevaluation will be conducted utilizing the PAS and applicable Rancho Los Amigos Scale.

C. The UMC will evaluate the findings of the annual assessment to determine whether the member continues to meet medical eligibility for the TBIW.

D. If the member has identified a court appointed legal guardian, no visit shall be scheduled without presence of the guardian.

E. Once an evaluation time is arranged, the UMC shall notify the member, Case Management Agency, Personal Attendant Agency or the F/EA vendor (if applicable) and identified guardian noting the contact and date of the visit.

F. If the UMC is unable to contact the member or representative (if applicable), a letter will be sent to them and the CMA stating that the member's eligibility is in jeopardy if the evaluation cannot be performed and requesting that the member, representative or CMA contact the UMC to schedule an evaluation.

G. If the member meets the medical eligibility criteria, a Notice of Approved Continued Medical Eligibility is sent to the member, identified representative, the CMA and the F/EA (if applicable).

H. If it is determined that the member does not meet medical eligibility, the member and their representative (if applicable), CMA, Personal Attendant Agency and F/EA vendor (if applicable) a Potential Denial letter. This letter will advise the member of the reason(s) for the potential denial, listing the areas in which deficiencies were found and notice that the medical eligibility standard has not been met. A copy of the assessments and applicable TBIW policy will also be included with the Potential Denial Letter. The member will be given 30 days to submit supplemental medical information to the UMC. Information submitted after the 30 day period will not be considered.

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):*

The UMC will complete re-evaluation prior to the Members Anchor Date.

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

All records of evaluation and reevaluation will be maintained by the UMC for a minimum of 5 years.

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 medical eligibility determinations by the UMC within 45 days of receipt of the DHS-2 form Numerator= Number of initial medical eligibility determinations completed within established timelines Denominator = Number of applicants for whom initial medical eligibility determinations were due within the reporting month.

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

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

applied. Numerator= Number of initial determinations were established criteria was applied. Denominator = Number of initial determinations due within the calendar month

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(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: 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.

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**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: UMC	☒ **Annually**

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

When the UMC conducts the initial medical eligibility assessment, applicants and/or legal representative (if applicable) are provided a TBIW Program Brochure that details services available to eligible individuals. Applicants (or legal representative) are asked to sign a Consent Form indicating their choice of waiver services vs. institutional care. If determined medically eligible, applicants and/or legal representative (if applicable) receive a Service Delivery Model Selection Form which provides information on the two service model options - the Traditional Model and the Personal Options Model. The services available with each model are provided along with a listing of qualified providers in the member’s county. They also have choice of Providers for case management and Personal Attendant Agency.

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 Census 2010, 97.6% percent of West Virginians speak only English. Due to this high percentage, the TBIW addresses any needs or requests for alternative materials on an individual basis. All materials are currently available in alternate formats for individuals who cannot access standard print material. These formats include large print, audio and braille. In addition BMS and all contract staff are available to read printed materials upon request.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Case Management		
Statutory Service	Personal Attendant Services		
Other Service	Community Transition Services		
Other Service	Environmental Accessibility Adaptations		
Other Service	Personal Emergancy Response System		
Other Service	Pre-Transition Case Management		
Other Service	Transportation		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: 01 Case Management

Sub-Category 1: 01010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

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

Case management activities are indirect services that assist the member in obtaining access to needed TBIW services, other State Plan services, as well as medical, social, educational and other Services, regardless of the funding source. Case management responsibilities also include the development of the Person-centered Service Plan, completion of the member's assessment and budget development, the ongoing monitoring of the provision of services included in the Service Plan, monitoring continuing eligibility, health and welfare, and advocacy. CMs are required at make minimally quarterly face to face home visit and a monthly phone contact on the other months with the member and their court appointed legal guardian, if applicable. Case Management services must be separate from Personal Attendant services. A provider Agency may offer both services (CM & PA) but not to the same member. Exceptions can be requested by the member if there is only one willing and qualified provider in their county. Case Managers will be subject to usage of the EVV and all of it's requirements to record home visits. Conflict Free Case Management services must be separate from Personal Attendant services. Case management includes the coordination of services that are individually planned and arranged for member whose needs may be life-long. The practice of case management helps to avoid duplication and provision of unnecessary services, and to ensure a balance of services. The Case Manager serves as an advocate and coordinator of care for the member. The Case Manager must be available to respond to a member in crisis whenever needed. This involves collaboration with the member receiving TBIW, family members, friends, informal supports, and health care and social service providers.

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

1 Unit Per Month - Reimbursed at a monthly rate. There is no case load limits for case managers.

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):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

Case Managers must have current WV CARES background checks (includes OIG checks), initial and annual training requirements (Conflict Free Case Management, training on Self-directed Service Delivery Service Model, recognizing and reporting abuse, neglect and exploitation, HIPAA, Person Centered Planning, current TBIW policy manual/program forms and Service Plan development) and a valid driver's license, proof of current vehicle insurance, registration and inspection as per state law. Case management services must be provided by an individual fully licensed in West Virginia as a social worker, counselor or registered nurse and maintain professional licensure training requirement 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 the Bureau for Medical Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the BMS' Utilization Management Contractor
Agency staff is verified by the BMS' Utilization Management Contractor

Frequency of Verification:

Agency is certified annually.
Agency staff's credentials are verified initially and annually with exception of the fingerprint-based state and federal background 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:**

Service Definition *(Scope):*

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

Personal Attendant (PA) Services are defined as long-term direct care and support services that are necessary in order to enable a member to return home from a nursing facility, an in-patient rehabilitation facility, an in-patient hospital and live in or remain in their own home and community.

The Service includes:

Personal Attendant Services: Provides member's receiving TBIW direct-care assistance and supervision with Activities of Daily Living (ADLs) and Instrumental Activities (IADLs) such as eating, bathing, grooming, prompting with self-administered medications, light housekeeping and essential errands, and on-going supervision and monitoring of the member's health and safety during activities and upon completion of other PA functions. Personal Attendants are also responsible for reporting changes in the member's condition and needs. Only qualified staff employed by certified Personal Attendant Agencies or by the member that is Self-directing can provide this support. Personal Attendants will be subject to usage of the EVV and all of it's requirements. Personal Attendant Services are not intended to replace supports/services that a child would receive from the school system during a school day.

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

Personal Attendant Services are limited by the member's documented needs and individualized budget with a cap of $36,600/year. Daily billing is required by PA agency or Personal Options vendor.

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	Personal Options
Agency	Personal Attendant Agency

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 member utilizing the Personal Options program is not required to be an TBIW Provider.

Certificate *(specify):*

Not applicable.

Other Standard *(specify):*

The employee of the member utilizing the Self-directed model must have current CPR and First Aid cards along with other mandated training documentation as determined by BMS, acceptable state and federal fingerprint-based checks and Office of the Inspector General (OIG) Medicaid Exclusion List checks through the WV Clearance for Access: Registry & Employment Screening (WV CARES), be over the age of 18, have the ability to perform the tasks and be currently trained on all training requirements listed in the Self-direction section of the TBIW Policy Manual. Daily billing is required by vendor.

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 of Record utilizing the Self-directed Model is responsible for ensuring all of their employees meet all qualifications. The F/EA vendor is responsible for verifying the employee's credentials. Personal Attendants will be subject to usage of the EVV and all of it's requirements.

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 WV CARES/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:

Agency

Provider Type:

Personal Attendant Agency

Provider Qualifications

License *(specify):*

TBIW Personal Attendant Agency must be certified by the Bureau for Medical Services (BMS) through Utilization Management Contractor (UMC) initially and annually thereafter.

Certificate *(specify):*

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

Other Standard *(specify):*

Agency staff must have current CPR and First Aid cards along with other mandated training determined by BMS, have an acceptable state and federal fingerprint-based checks and acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check through the WV Clearances Access: Registry & Employment Screening (WV CARES), 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Personal Attendant Agency is responsible for ensuring all of the PERS requirements are met.
The UMC performs reviews of the program during on site reviews.
Agency is verified by the BMS' Utilization Management Contractor.
Agency staff is verified by the BMS' Utilization Management Contractor

Frequency of Verification:

Agency is certified annually. Agency staff's credentials are verified initially and annually with exception of the state and federal fingeprint-based checks which are checked every 5 years and the WV CARES/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:**

Service Definition *(Scope):*

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

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. 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.

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. The Case Manager must add the EAA on the member's Service Plan. If approved, the Provider agency 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:
• The amount of service is limited by the individualized budget of the program member
• EAA-Home is not intended to replace the responsibility of the member who receives services, their family, or their landlord for routine maintenance and upkeep of the home. These include but are not limited to:
•cleaning
•painting
•repair/replacement of roof
•windows (unless a modified window is needed that is large enough for an adult to use to exit in case of fire)
•flooring
•structural repairs
•air purifiers, humidifiers or air conditioners (unless the person has a documented respiratory/allergy condition or diagnosis)
•heating equipment or furnaces
•generators unless used for specific medical equipment (cannot be for the entire house),
•plumbing and electrical maintenance
•fences, gates or half-doors
•security systems
•adaptations that add to the square footage of the home except when necessary to complete an approved adaptation, (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair)
•Computers, communication devices, tablets, and other technologies
•landline telephones or cell phones
•swimming pools, hot tubs or spas or any accessories, repairs or supplies for these items
•railing for decks or porches
•appliances that are not adapted/modified
•yard work
•household cleaning supplies
•utility payments
•household furnishings such as comforters, linens, drapes, etc.
•furniture unless it is a lift chair for someone with documented mobility issues
•outdoor recreational equipment unless specifically adapted for the person's needs
•driveway or 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 in combination with Traditional and Self-Directed Environmental Accessibility Adaptations - Vehicle.

EAA - Vehicle:
• The amount of service is limited by the individualized budget of the member who receives services.
• $1000 available per Service Plan year in combination with Traditional and Self-Directed Environmentally Accessibility Adaptations.
• 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 Case Management 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 amount of service is limited by the individualized budget of the program member. If a member is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Personal Attendant services or 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 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):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The PAA is responsible for ensuring that providers of EAA meet qualification standards prior to processing invoices. The CM is responsible for listing the EAA on the member's Service Plan. The UMC is responsible to review for prior authorization to assure items/services are not on the exclusion list and are indicated on the Service Plan as a documented need.
The UMC will perform certification validation during reviews

Frequency of Verification:

The UMC will monitor compliance during reviews.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Personal Options

Provider Qualifications

License *(specify):*

The Personal Options Vendor will 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:

Individuals or legal representatives (if applicable) who self-direct their services are responsible for ensuring that the provider of EAA meets the qualifications/standards with assistance from the F/EA or their Case Manager. The item must not be on the exclusion list or payment will not occur.
The Personal Options vendor is responsible for validating that the item is not on the exclusion list and the
vendor qualifications prior to processing invoices.
The UMC will perform certification validation during reviews.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: 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 Emergancy 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:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A Personal Emergency Response System (PERS)is an electronic device (usually a pendant) and monitoring service that enable certain members to secure help in an emergency. PERS services shall be limited to those members who have expressed a desire to have the monitoring system in place or during the person-centered planning assessment and Service Planning meetings, 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 periods 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 members' home telephone system. PERS services shall not be used as a substitute for providing adequate supervision for the member enrolled in the the waiver.

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

A unit of service is the monthly service fee up to $50.00 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
Individual	Personal Options
Agency	Personal Attendant Agency

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:

Personal Options

Provider Qualifications
License *(specify):*

NA as members utilizing the Personal Options program are not required to be licensed TBIW providers.

Certificate *(specify):*

NA

Other Standard *(specify):*

The member participating in the Personal Options program will choose a PERS vendor with the assistance of their Resource Consultant 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 Personal Options vendor is responsible for ensuring all of the PERS requirements are met.
The UMC performs reviews of the program during on site reviews.

Frequency of Verification:

Yearly

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:

Personal Attendant Agency

Provider Qualifications
License *(specify):*

Not Applicable

Certificate *(specify):*

Not Applicable

Other Standard *(specify):*

The TBIW Personal Attendant Agency will choose one or more PERS vendor(s) to provide the service for the members that wish to receive this service. The PERS provider 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 Personal Attendant Agency is responsible for verifying all of the PERS requirements are met.
The UMC does review of program during on-site reviews.
The UMC will perform certification validation during on-site reviews of the Personal Attendant

Frequency of Verification:

Agency is certified annually.

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 TBIW services are in place day one of the resident's transition to the community. Prior to the resident'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 completion of the Assessment for those eligible for and planning to enroll in the Traumatic Brain Injury Waiver program when returning to the community;
- Facilitate the development of the Service Plan by the selected Waiver Case Management Agency;
- Coordinate with the Personal Attendant Agency to ensure that direct-care services are in place the first day the resident returns home;
- Work with the resident to establish or verify financial eligibility for Waiver services, and;
- 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 Traumatic Brain Injury Waiver program, and;
3. Wish to transition from facility-based living to their own homes or apartments in the community consistent with the CMS Settings Rule (1915(I));
4. Require Waiver transition services to safely and successfully transition to community living, and;
5. 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 resident 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):*

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

Certificate *(specify):*

Agency must be an approved TBIW Agency.

Other Standard *(specify):*

Staff must have an acceptable background 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 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the Utilization Management Contractor.
Agency staff is verified by the Utilization Management Contractor.
The Utilization Management Contractor will perform certification validation during on-site 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:

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:**

Service Definition *(Scope):*

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

Transportation: Services are provided to members who receive TBIW 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 medical appointments and should be utilized first before accessing TBIW Transportation based on assessed need and must be for the sole benefit of the member receiving the service.

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

Transportation Miles: The maximum annual units of Transportation: Miles cannot exceed 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: Transportation

Provider Category:

Agency

Provider Type:

Personal Attendant Agency

Provider Qualifications

License *(specify):*

TBIW Agency must be certified by the Bureau for Medical Services.

Certificate *(specify):*

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

Other Standard *(specify):*

Transportation Miles: Agency staff must have current CPR and First Aid cards, have an acceptable fingerprint based check and an Office of the Inspector General (OIG) Medicaid Exclusion List check through the WV Clearance for Access: Registry & Employment Screening (WV CARES), 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 BMS' Utilization Management Contractor.
Agency staff certification is verified by the BMS' Utilization Management Contractor.

Frequency of Verification:

Agency is certified annually.
Agency staffs' credentials are verified initially and annually with the exception of the state and federal fingerprint checks which are checked every 3 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: Transportation

Provider Category:

Individual

Provider Type:

Personal Options

Provider Qualifications

License *(specify):*

Not applicable as member utilizing the Personal Options program is not required to be an TBIW Provider.

Certificate *(specify):*

Not applicable.

Other Standard *(specify):*

The Personal Options employee must have current CPR and First Aid cards, have an acceptable fingerprint based check and an Office of the Inspector General (OIG) Medicaid Exclusion List check through the WV Clearance for Access: Registry & Employment Screening (WV CARES), be over the age of 18, valid driver's license, proof of current vehicle insurance, registration and inspection per state law, the ability to perform the tasks and be currently trained on all training requirements listed in the Personal Options section of the TBIW Policy Manual.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Personal Options Vendor is responsible for ensuring all of the member's employees meet all qualifications.

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 3 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 TBIW 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 the state code: WV Code § 15-2C-1. The West Virginia State Police, Criminal Identification Bureau maintains the Central Abuse Registry. TBIW Provider agencies and for the member utilizting Personal Options the employer of record are required to request a Criminal Background Check (Central Abuse Registry) for all employees with direct access to member on the TBIW. 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 UMC 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 TBIW excluding the member's legal guardian and 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 TBIW 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 UMC 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. The UMC 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:

The Bureau for Medical Services (BMS) claims processing entity provides entities interested in becoming a TBIW Provider an enrollment packet, including a provider agreement, along with specific requirements and procedures to qualify. The enrollment process, which is continuous and ongoing, assures that all willing and qualified providers meeting the State's established provider qualifications have the opportunity to enroll. Per policy, the BMS claims processing entity has fifteen (15) business days to process the enrollment application once submitted by the prospective provider.

The prospective provider must return the provider agreement signed by an authorized representative to BMS. BMS signs the Provider Agreement and returns a copy to the prospective provider. 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 provider that it may begin providing services.
A copy is sent to the UMC. Information on the certification and enrollment process is posted on the UMC's website.

Workers and vendors providing services under the Personal Options Model, must meet established provider qualifications as specified in the service description section. The Personal Options vendor verifies that qualifications are 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:
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 per calendar month.

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

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

(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**

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:

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 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: 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:

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 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: 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:
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**	☐ **Annually**	☐ **Stratified**

Specify: UMC		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:
Percent of agency staff whose Direct Care Ethics/People Rights training is current Numerator= Number of agency staff whose Direct care Ethics/People 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: 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 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: 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:
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: 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:

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 recognition in reporting of Abuse/Neglect/Exploitation training is current Numerator= Number of agency staff whose recognition and reporting of Abuse/Neglect/Expoitation 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: 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:
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** 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:

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 UMC Quality and Utilization Review process. As individual problems are identified by the UMC 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: UMC and Quality Improvement Advisory Council (QIA is for 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 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 (SP)

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 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. UMC oversees grievances/complaints by the members and providers. A member will contact the 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 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 quality reviews conducted by the state UMC, and may periodically request additional reports from the 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 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 an agency 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 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 medical eligibility assessment, applicants/legal representative (if applicable) are provided information regarding their rights to direct and be actively engaged in the Person-Centered Service Plan development process. General information regarding person-centered planning is also provided. Program information regarding service delivery models (Traditional and Self-directed Model) is provided. Once an individual has been determined eligible for Waiver services, additional information on specific services and service providers that may be selected is made available to the member and/or legal representative (if applicable). Person-Centered Planning is the process by which the Case Manager (CM) works in collaboration with the member and/or their legal representative (if applicable)and others identified by the member and/or legal representative (if applicable) to develop the Person-Centered Service Plan (PCSP). The initial PCSP is scheduled and developed in collaboration with the member and/or their legal representative (if applicable)at a time and date convenient to them. Subsequent annual revisions to the PCSP are done in collaboration with Personal Attendant Agency staff, other service providers and informal supports as requested by the member and/or their legal representative (if applicable) at a time and date that is convenient to the member. The PCSP is developed utilizing the medical eligibility assessments (PAS and appropriate Rancho Los Amigos Scale), the Person-Centered Assessment (gathers information about the members strengths, capacities, needs, preferences, desired outcomes, health status and risk factors). By participating in the assessment process and having access to the support of the CM, Personal Attendant Agency staff, other professionals and informal supports, the member has the opportunity and tools to be actively engaged in the Person-Centered Service Plan development process. The PCSP outlines the services, type, scope, frequency and duration and responsible parties for implementing the PCSP. The CM documents the health care needs of the member on the PCSP. The UMC reviews files to ensure that services have been delivered as planned. The UMC reviews files using a review tool to ensure that Case Manager's have made a monthly contact and a minimum of a quarterly home visit. The State allows the use of an interim Service Plan during the transition process to allow the member to transition from a facility back to the community in their own home/apartment. The CM has 21 calendar days to develop a more detailed Person-Centered Service Plan.

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. Case Managers (CMs) are responsible for the development of the PCSP in collaboration with the member and/or their legal representative (if applicable). Participation in the initial PCSP development is mandatory for the member and Case Manager. The member and/or their legal representative (if applicable) may choose to have whomever else they wish to participate. Participation in subsequent reviews and annual PCSP updates are mandatory for the member, the Case Manager and Personal Attendant Agency staff. The Person-Centered Assessment must be completed within seven business days of enrollment in the program. The PCSP, which is scheduled in collaboration with the member, must be completed within fourteen business days of the Person-Centered Assessment. In order to begin services immediately and address any health and safety concerns, an Interim PCSP may be developed and implemented upon enrollment or transition to the members home/community. The Interim PCSP can be in effect up to twenty-one business days to allow time for assessments to be completed, the PCSP meeting to be scheduled and the PCSP to be developed. The case manager will provide a copy of the Person-Centered Assessment, PCSP and Budget to the member and/or their legal representative (if applicable) and to the Personal Attendant Agency.

b. The primary assessments conducted to support the PCSP development process include the Pre-Admission Screening tool (PAS) and the appropriate Rancho Los Amigos Scale. These assessments identify medical issues and functional deficits in Activities of Daily Living. The Person-Centered Assessment reviews independent living skills, medical and behavioral health status, goals and preferences, formal and informal supports, risks to health and welfare, communication, environmental issues including assistive technology needs, emergency and back-up planning, and socialization and community integration. The Rancho Los Amigos Scales are conducted to capture the cognitive functioning of an individual with TBI.

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

d. The medical eligibility assessment (PAS and appropriate Rancho Los Amigos Scale), and the Person-Centered Assessment must be completed and reviewed with the member prior to the development of the PCSP. The annual PAS, Rancho Los Amigos Scale and the Person-Centered Assessment must be completed and reviewed with the member prior to subsequent reviews and annual PCSP updates. It is the Case Manager's responsibility to ensure that all assessments are considered in the PCSP development. The PCSP document requires that these areas be addressed. As part of the Quality Improvement System (QIS), the UMC reviews files to ensure that PCSP address member's outcomes (including health care) and preferences.

e. Coordination of services begins with the PCSP development process. It is the Case Managers responsibility through collaboration with the member to ensure that all Waiver and other services are identified as part of the PCSP. The Case Manager is responsible for coordinating the implementation of the PCSP an through case review, referral, monitoring and advocacy. The CM provides the Personal Attendant agency with a copy of the PCSP. As part of the Quality Improvement System (QIS), the UMC reviews files to ensure that services have been delivered as planned.

f. Specific providers for Waiver and other services are listed on the PCSP. The Case Manager, via monthly contacts, is responsible for monitoring the implementation of the PCSP to ensure service delivery. As part of the Quality Improvement System. Staff of the UMC review files to ensure that services have been delivered as planned.

g. Case Managers are required to conduct a monthly contact and minimally quarterly F2F home visit with members to monitor PCSP implementation, identify when member's needs change and revise the PCSP to address changing needs. Additionally, PCSP's must be reviewed at least every six months and revised at that point as necessary. An annual PCSP meeting to develop a new plan is required. Case managers are expected to schedule these meetings at times and locations convenient to the member.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

The UMC completes the HCBS Consumer Assessment of Health Care Providers and Systems (CAHPS) annually. When the survey exposes a deficiency with back-up planning, the UMC reaches out to the Case Management or Personal Attendant provider for additional interview and follow-up. The results of the CAHPS are shared routinely with the Quality Improvement Council for review, and policy recommendations.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

At the time of medical eligibility determination and notification that a Waiver slot is available, applicants and/or their legal representative (if applicable) are given the opportunity to choose a Case Management Agency. Then they are offered to choose either a Personal Attendant Agency to provide all of their other TBIW services through the Traditional or to self-direct the rest of the TBIW services through the Personal Options Models. The selection forms, which list how to contact the Personal Options program and the Personal Attendant Agencies by county with contact information, are provided by the UMC. A list of both types of providers as well as Case Management Agencies are made available to people on the BMS's websites. Members/applicants may also call the UMC for a list of agencies that provide services in their community. This information is again provided at the annual re-determination of medical eligibility. Members/applicants can contact the UMC to request information in accessible formats. UMC staff will read information when requested.

The UMC reviews the options of service delivery models (Traditional or Personal Options) each year during the medical eligibility assessment. The UMC makes available choice of Case Management providers. West Virginia recognizes that the provider pool is limited and continually reaches out during statewide training venues (such as the National Association of Social Work Conference, the Association of Case Managers, the existing IDDW and Aged and Disabled Waiver and Personal Care providers) to seek new providers.

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):

Case managers are responsible for the development and oversight of the Service Plan. The UMC reviews a representative 100% of Service Plans every 12 months as part of the Quality Improvement System (QIS). Results of these reviews are compiled and reviewed by BMS during contract meetings and by the Quality Improvement Advisory Council during its quarterly meetings. Remediation plans are developed to address any identified issues/concerns.

100% of initial and annual Service Plans are submitted to and reviewed by the UMC to request prior authorization of TBI services. The UMC conducts annual on-site provider reviews for 100% of providers and 100% of program member files. The UMC conducts on-site reviews via an approved review tool that evaluates all components of documentation, member health and safety and member experience.

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 and the UMC for a minimum period of five 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 UMC are responsible for monitoring the implementation of the member's Person Centered Service Plan (PCSP). Case Managers (CMs) are responsible for monthly contact and minimally quarterly home visits 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 and the delivery of services. All critical incidents related to a member's health and safety including the ineffectiveness of back-up plans must be reported using the West Virginia Incident Management System (IMS) and as appropriate report suspicions of abuse, neglect, exploitation to Adult Protective Services (APS) or Child Protective Services (CPS). As part of the Quality Improvement System (QIS), staff of the UMC reviews 100% of Case Management files every 12 months to monitor compliance with this requirement. The UMC conducts an exit interview to review the results of each provider monitoring. UMC 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 UMC prepares draft monitoring reports which are sent to the provider for comment and return within 30 calendar days. The provider's comments are reviewed by the UMC and BMS and a final report is issued to the TBIW provider. BMS and the UMC review monitoring findings at contract meetings and develop improvement strategies as indicated in collaboration with the Quality Improvement Advisory Council. The following monitoring methods are used: Services are furnished in accordance with the PCSP- The UMC compares claims to the PCSP during on-site provider review. Members have access to waiver services identified in their PSCP (e.g., has the member encountered problems in securing services authorized in the PCSP?)- The UMC reviews Case Management notes and monthly contacts/home visit contact forms which ask the member to describe whether or not they received all the services they were supposed to during the month (indicating which services were not received), needed medical equipment or resources, etc. The Case Manager is responsible for arranging for needed services and supports. Services meet the needs of the members- The Case Manager evaluates this during the contact and documented on the contact/home visit contact form. The UMC reviews these forms during on-site provider review and determines whether or not the Case Manager has followed up. That member health and welfare is assured- During on-site provider reviews, the UMC monitors: incident report submissions, investigations and follow-up by providers, initial contact made by CM with member within 7 days of initiating direct care services, whether or not the member needed specialist and health professionals (per the Person Centered Assessment) and whether follow-up occurred, whether or not investigation follow up, PCSP meetings are conducted within timelines. The UMC also receives and reviews incident reports as they are submitted. The requirement is to submit within one business day of learning of the incident. All information is compiled and shared with the Quality Improvement Advisory Council quarterly and with BMS monthly. Members exercise freedom of choice of providers. The UMC conducts annual assessments which include education about available service models and providers, however the Case Management Agency may not provide any other TBIW services. The member is required to complete a Freedom of Choice Form in which they designate their chosen service model and provider(s). This form is also available on the state's website. The member may choose a new service model or provider at any time. Members have access to non-waiver services identified in the PCSP, including access to health services. Needed non-waiver services are captured in the Person-Centered Assessment and the member PCSP. During on-site review, the UMC evaluates whether the provider followed up on needed non-waiver services. Case Managers are responsible to make monthly contact an minimally 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 UMC) should the Case Manager not resolve their issue. The UMC assists members toward resolution. Agencies are required to have written policies and procedures to avoid conflict of interest. If the agency is the only willing and qualified provider to develop the Person Centered Service Plan and provide Personal Attendant Services there is an exception process which must be approved by BMS. The UMC reviews and measures demonstration of these policies upon on-site review to make sure there is a policy prohibiting conflict of interest in 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 state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. Specify:

a. The 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. UMC oversees grievances/complaints by the members and providers. A member will contact the 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 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 UMC, and may periodically request additional reports from the 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 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 manager 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 member's receiving services whose service plan reflected identified health and safety risks. Numerator-Number of files of member's 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: 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 and Quality Improvement Advisory Council (QIA 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 member's receiving services whose service plan reflected the member's desired outcomes Numerator-Number of files of member's 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: 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 and Quality Improvement Advisory Council (analysis only)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of files of member's receiving services whose service plan reflected assessed needs. Numerator-Number of files of member's 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: 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 and Quality Improvement Advisory Council (QIA 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 member's receiving services whose service plans were updated at least annually and revised as needed Numerator-Number of files of member's receiving serivces whose service plans were updated at least annually and revised as needed Denominator-Number of files reviewed

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

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(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 and 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 member's receiving services reviewed that reflected the type, scope, duration, amount, and frequency of services specified in the Service Plan Numerator-Number of files of member's 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):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify: 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 and Quality Improvement Advisory Council	☒ **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 member's receiving services reviewed that had a signed and current Freedom of Choice form designating a Service Delivery Model Numerator-Number files of member's receiving services reviewed with a signed and current Freedom of Choice form designating a Service Delivery Model Denominator-Number of files reviewed

Data Source (Select one):
Record reviews, 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 = 95%
☒ **Other** Specify: UMC	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(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**

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 member's receiving services reviewed with a signed and current Freedom of Choice form designating a Case Management Agency Numerator-Number of member's receiving services reviewed with a signed and current Freedom of Choice form designating a Case Management Agency 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: 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:

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 related to this assurance is collected by the UMC through the review of member's charts. Individual issues/concerns related to this assurance identified during the chart review process are addressed immediately by the UMC with providers during an exit interview. Providers are then required to submit a Plan of Correction with evidence of completion addressing identified issues. All Plans of Correction must be approved by the UMC and BMS. Services provided that are not documented on the SP or are provided by unqualified staff 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: UMC and 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.

The self-directed service model, Personal Options, is available to every eligible TBIW member. This option provides each member with the opportunity to exercise choice and control over the self-directed services they receive and the employees and organizations who provide them (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). The self-directed services over which member receiving TBIW services will have the opportunity to exercise choice and control are:

• Personal Attendant Services
• Transportation
• Personal Emergency Response System
-Environmental Accessibility Adaptations (Home and Vehicle)

Under the Personal Options model, the member is the common law employer of the qualified Personal Attendant worker he or she hires directly. The contracted 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 budget funds, processing and paying qualified Personal Attendant worker (payroll and vendors), providing orientation at the time of enrollment with the Personal Options vendor and ongoing training and support to the member and their Personal Attendant Professionals.

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

The member choosing the Personal Options Model is allocated an annual budget based on his/her assessments and person-centered outcomes documented on their Service Plan. Services under the Personal Options Model must be for the sole benefit of the member receiving TBIW services. The member receiving services function as the common law employer (employer of record) of their Personal Attendant workers who provide services.

Case Management is provided by qualified staff employed by a TBIW Case Management Agency. The member may choose which CM Agency provides these 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 Worksheets
2) Executing provider agreements on behalf of BMS
3) Assuring the adherence to Federal and State laws and regulations
4) Verifying National Criminal Information Checks of prospective employees per TBIW policy
5) Verifying employee qualifications (including that the potential employee is not the member's legal guardian, spouse or parent of a minor child)
6) Verifying employee’s time records
7) Verifying that services are within approved limits(compliance with the member's Service Plan)
8) Monitoring of underpayments and overpayments
9) Assisting the member in revising Spending Plans as necessary
10) Recognizing and reporting critical incidents
11) Verifying an employee's citizenship status
12) Providing for payment of member's employee's benefits where applicable
13) Verifying with proper documentation initial/ongoing 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 enrolled in the Personal Options model. This support is an administrative activity and is reimbursed as such. Resource Consulting provides the member receiving TBIW services 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, assistance and referral
2) Explaining and assisting the member with the completion of the employer packet paperwork (i.e. IRS Form 2678, IRS Form 2848, IRS Form 8821, WV State Tax Department Form WV/2848, etc.). The Resource Consultant submits the

completed employer packet to the Personal Options Financial Operations Unit
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 Attendant workers
6) Maintaining/providing training modules for the member's employees
7) Verification of required training for the member's employees
8) Monitoring quality and health and safety through required monthly calls and face-to-face contact at least every six months. Resource Consultants monitor more frequently as needed based on the member's needs and/or requests
9) Recognizing and reporting critical incidents (which are then investigated by the Personal Options vendor, UMC, APS, CPS, Medicaid Fraud, police, etc. as appropriate). All critical incidents are entered into the West Virginia Incident Management System (WVIMS)by the Personal Options vendor. Personal Options and the UMC to analyze for trends
10) Providing information on employee benefits when applicable
11) Participate in the development of the member's Service Plan 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 and/or requested in revisions to the their Spending Plan
14) Providing training to the member receiving services on providing employee training on proper documentation for Personal Attendant Services (i.e. Personal Attendant Worksheets)

Personal Options Resource Consultants do not provide case management services.

The Personal Options vendor also operates a call center for the member or their employees to access needed information about the program. Customer service representatives support the primary role of the Resource Consultant and payroll specialists by performing the following functions:

1) Assisting the member/employer with inquiries related to budgeting, employer responsibilities, paperwork such as tax forms, employee background checks, 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 Worksheets, and invoices, providing additional training and helpful hints to ensure accurate and timely payments
4) Placing courtesy calls and mail 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. Prior to the award of a funded slot, an applicant and their legal representative (if applicable) will meet with the UMC and receive education on the Self-directed Model. The UMC will discuss the member's responsibilities and potential liabilities. When the member's annual re-determination assessment is conducted by the UMC, the member and their legal representative (if applicable) will again receive education regarding Self-direction. The member may ask their Case Manager about the program during routine monthly contacts and the minimally required quarterly home visits and information about Self-direction is available on the BMS website. BMS, the UMC and the F/EA staff are always available to answer questions and provide technical assistance.

b. The UMC is responsible for furnishing this information during the educational component of the initial meeting and annually during the re-determination assessment. The educational component will provide the applicant/member and their representative (if applicable) with information on the self-directed model, the roles and responsibilities of each of the key stakeholders related to the delivery and receipt of Self-directed services (i.e., member, legal and non-legal representatives (if applicable), F/EA vendor, UMC, CM, and BMS); and traditional service options available to them in order to support their choice service models. The UMC is also responsible for fielding questions from the member 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 government FMS vendor are also available to provide information upon request.

c. The member and their legal representative (if applicable) will receive this information at their initial and annual eligibility assessment to determine medical eligibility conducted by the UMC.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A spouse or the parent of a minor child under the age of 18 through their parent or legal representative may appoint a "Program Representative" to assist with the responsibilities of self-directing their services. The spouse, child's parent or legal guardian may serve as the Program Representative. Adults without a legal guardian may choose to appoint a Program Representative to assist them. Neither a spouse, parent of a minor child, legal representative nor an appointed Program Representative may be a paid service provider for the member receiving services.

The appointed program representative is:
•restricted to acting on the member's behalf and in a manner that reflects the member's wishes to the extent possible;
•must complete and sign a Program Representative Appointment Form; and
•must perform the required Program Representative's tasks which include hiring/supervising workers, approving Personal Attendant's Timesheets, Worksheets and transportation invoices.

The Personal Options vendor will ensure that the Program Representative is acting in the best interest of the member and fulfilling his/her responsibilities. The Case Manager or Personal Options vendor staff may submit a complaint with the UMC office to review the Program Representative's ability to act in the best interest of the member. They also must report to the UMC any exploitation of the self-directed services that appear to benefit someone other than the member. BMS will make the final decision on whether a member must transfer over to the Traditional Model.

The Personal Options vendor and/or the UMC staff have the right, after consultation with BMS, to terminate the assistance and support provided to the member receiving services by their Program Representative at any time with documented evidence of abuse, neglect and exploitation of the member.

The Program Representative can be identified at the initial enrollment session or at any time, if:
1. the member indicates they would like assistance with fulfilling the employer duties such as verifying timesheets, verifying and initialing the personal attendant document daily and other responsibilities as needed or requested by the member.
2. the Resource Consultant determines that the member would benefit from additional assistance, they recommend a program representative be identified, trained and signed with the Appointment of Program Representative form.

The Program Representative participates in monthly calls, quarterly visits, 6 month visits, or other meetings as requested by the member, the Resource Consultant or the Case Manager.

The Program Representative is never a paid employee.

The Resource Consultant recommends a change in the Program Representative if the Program Representative is unable to fulfill their role.

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
Transportation	☒	☒
Personal Emergancy Response System	☒	☒
Environmental Accessibility Adaptations	☒	☒
Personal Attendant Services	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☒ **Governmental entities**

☐ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The sole Government sub-agent Fiscal/Employer Agent (F/EA) Financial Management Service (FMS) vendor model (Personal Options) is used by the WV Bureau of Medical Services to perform delegated agent tasks procured through a Request for Proposal process and the execution of a contractual agreement with BMS. The Government F/EA FMS and sub-agent operates under §3504 of the IRS code, Revenue Procedure 80-4 and Proposed Notice 2003-70, applicable state and local labor, employment tax and workers' compensation insurance and Medicaid program rules, as required and exploitation of the member.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The Government Fiscal/Employer Agent (F/EA) is compensated through an administrative fee established by a competitive procurement (RFP) on a per member/per month (PMPM) basis.

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

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

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [ ] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [x] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [ ] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- [x] **Other**

Specify:

Provide Information and Assistance (I&A) services related to member/legal/non-legal representative orientation and skills training.
Make available to the member/legal/non-legal representative and their Case Manager the member's spending plan and budget utilization data.

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

BMS will execute a contractual agreement with the Government F/EA FMS vendor known as the Personal Options vendor that has been selected through a Request for Proposal process. The contractual agreement will identify the role and responsibilities of the Personal Options vendor. The contractual agreement will outline the specific requirements for the Personal Options vendor to successfully complete a Readiness Review prior to being approved by BMS to perform as the sub-agent to the Government F/EA FMS provider. The contract will stipulate the oversight methodologies to be implemented by BMS to ensure fiscal responsibility and accountability is achieved by the Personal Options vendor. These methods will include, but not be limited to, the collection and processing of time-sheets, the disbursement of payments, completing proper with-holdings from workers' pay, reporting with-holdings as required by federal and state laws, make available statements (written or electronic) for each member's budget authorization, distributing annual individual satisfaction surveys and completing end of year tax processing. BMS will complete an annual review of the fiscal integrity of the Personal Options vendor and review the satisfaction survey results.

If BMS finds that the Personal Options vendor is not meeting the requirements agreed upon, it may recommend the following options:

- Provide a letter of recommendation to the Personal Options vendor for passing their review and permit the contract to continue
- Provide a letter of completion to the Personal Options vendor for completing their review with technical assistance being provided
- Require a Plan of Correction be completed while continuing to provide Personal Options services.
- Require a Plan of Correction be completed, as well as, disallowances of noted Personal Options vendor administrative reimbursements due to review findings.
- Require a Plan of Correction to be completed with all Personal Options vendor administrative reimbursements being suspended until all identified deficits have been corrected
- Generate notice to discontinue contract initiate transfer support to individuals using the Personal Options program.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

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

Case Managers (CMs) assist the member receiving services upon request with information or links to information related to Personal Options Model, including the benefits and responsibilities of choosing this option. CMs will receive training including a scripted presentation regarding the Personal Options Model. This information will be reviewed with the member/representative during their annual re-evaluation by the UMC to ensure unbiased presentations are being provided.
Case Management activities specific to the Personal Options model include, but are not limited to:
1. Informing the member of the availability of the Personal Options Model.
2. Explaining general rights, risks, responsibilities and the member's right to choose the Personal Options Model.
3. Assist in determining if a Program Representative is desired and/or needed by the member.
4. Providing or linking the member/Program Representative with program materials in a format that they can use and understand.
5. Explaining person-centered planning and philosophy to the member/Program Representative.
6. Linking the member with the Personal Options vendor for completion of the necessary paper work to enroll in this program.
7. Explaining to the member the roles and supports that will be available.
8. Reviewing and discussing the member's budget, including the budget available for participant-direction.
9. Ensuring that the member/Program Representative know how and when to notify the Case Manager about any operational or support concerns or questions.
10. Monitoring the member's risk management activities.
11. Ensuring a seamless transition into the Personal Options Model if chosen.
12. Coordinating services provided by traditional provider agencies if involved.
13. Notifying the UMC and the Personal Options vendor of concerns regarding potential issues which could lead to a member's disenrollment.
14 Notifying the UMC of concerns about the status of the health and welfare of 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
Case Management	☐
Transportation	☐
Pre-Transition Case Management	☐
Personal Emergancy Response System	☐
Community Transition Services	☐
Environmental Accessibility Adaptations	☐
Personal Attendant Services	☐

☒ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

a) Supports for the member choosing the Self-Directed Model are furnished by the Personal Options vendor. The Personal Options vendor is paid a Per Member/Month (PMPM) administrative fee. The PMPM is comprised of a Fiscal Agent Support fee and a Support Broker (Resource Consultant) fee. The Resource Consultant provides the information and assistance activities.

b) Supports are procured through an Request for Proposal (RFP) and contract process.

c) Supports are available to:
-provide general information and assistance on the self-direction opportunity
-assist with the development of the Spending Plan based from the desired outcomes listed in the person-centered Service Plan
-provide practical skills training such as hiring, managing and terminating workers, problem solving, training employee's in required program documentation and conflict resolution
-maintain and provide required training competency based training modules for Personal Attendant workers
-maintain a roster of qualified Personal Attendant workers and assist in the verification of qualified employees
-provide information on employee benefits if applicable
-monitor quality through monthly telephone contact and face-to-face contact with the member at least every six months
-assist with required program paperwork
-verifying potential employees are not a parents of a minor child, legal guardians or spouses of the member receiving services

d) Bureau for Medical Services (BMS) oversight of the Personal Options vendor includes:
-Monthly contract meetings
-Monthly review of program activity reports
-Monthly review of tax information
-Quarterly review of complaints and grievances report
-Results of the annual Customer Satisfaction Surveys

In addition, as part of the Quality Improvement System (QIS), staff of the UMC audit the Personal Options vendor every 12 months.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

The state has a designated protection and advocacy organization (Disability Rights of West Virginia) available to provide independent advocacy services. Other resources (non-state agencies) include Legal Aid of West Virginia and Mountain State Justice.

Disability Rights of West Virginia can be reached by calling: 1-800-950-5250 or visiting the website at: https://www.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:

The member who chooses the Personal Options Model and/or their legal representative (if applicable) can opt to transfer from the Personal Options Model to the Traditional Model at any time. The member's voluntary transfers will ordinarily be effective the first day of the next month, except in cases of emergency. The Personal Options vendor will work with the UMC and Case Management Agency and Personal Attendant Agency to assist the member with a seamless transition to the traditional service delivery model.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The Case Manager and Personal Options vendor must develop a report to the UMC outlining the reasons the Personal Options vendor is requesting termination the member from Personal Options. Issues such as the verification of Medicaid fraud, inability to maintain safe staffing supports, inability to keep the spending plan within the budget would require the CM and/or Personal Options vendor to notify the UMC to review any member for involuntary removal from Personal Options. An additional concern that may be reported is the exploitation of the member for the representative's benefit rather than the member's. This would be reported to the Adult/Child Protective Services and the Office of Program Integrity (OPI) for review and they would pass on to the Medicaid Fraud Control Unit. If a member has demonstrated an inability to self-direct their services they may be required to select a representative. If the member refuses to select a representative they will be required to transfer to the Traditional Model.

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 agencies (Adult/Child Protective Services). Each member utilizing Personal Options must have emergency and contingency plans developed within their SP. These plans must address the issues of whether related staffing and transportation issues, natural disaster effects to their support system, illness/epidemic/pandemic effects to supports and the back-ups for each situation. All paid and natural supports must be outlined in each member's SP. The Case Management agency is responsible for the oversight of program implementation, health, safety and welfare of each member.

The Case Manager will ensure that no break in vital services will occur and that a timely revision of the SP occurs.

All Personal Options staff are trained in person-centered planning and philosophy. The Personal Options vendor is trained to provide a person-centered approach to serving all members. The vendor frequently serves members who have challenges that preclude them from being served in traditional programs. Members are not involuntarily terminated from the program; they are transferred to the traditional program to receive services. They may return to Personal Options if the non-compliant or risky behavior stops.

When there is the possibility of involuntary transfer from Personal Options, the member is informed of the reasons, potential actions that need to be initiated to remain on the program and the timeline for demonstration of the actions. Reasons for involuntary transfer to traditional are: non-compliance with program requirements; inappropriate behaviors with employees; inability to hire employees in an expected time period; schedule management budget mismanagement; and alleged Medicaid Fraud.

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		40
Year 2		40
Year 3		40
Year 4		40
Year 5		40

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 Personal Attendant worker is responsible for obtaining and paying for the National Crime Information Check (NCIC) as specified by policy.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

The method to conduct background checks does not vary 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. For Personal Options:
The Personal Options member/Employer of Record is responsible for ensuring all of their employees complete a state and federal fingerprint-based check 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**

- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

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

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the state's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The Participant-Directed Budget is based on the member's assessments and desired outcomes. Personal Attendant, Community Transition, Personal Emergency Response Systems, Environmental Accessibility Adaptations (Home and Vehicle) and Transportation Services are documented in the Service Plan and are reflected in the member's self-directed budget and will not reflect the costs of the Traditional Services (Case Management). Self-Directed services will be monetized based on the amount, duration and frequency established in the Service Plan (SP) but may not exceed the cap per member per year of TBIW services.

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 individual budget. The member's individual budget is based on assessed needs and monetized based on results of the assessment process. The member's individual budget (less the cost of FMS and I and A) is claimed as service match accordingly.

The above information is made available to the public by posting this waiver application on the West Virginia Department of Health and Human Resources, Bureau for Medical Services website for a 30 day comment period. Notices of this public comment period were published in the state's largest newspaper, sent to TBW providers to be shared with members and posted in prominent place in the office of the TBIW provider and posted on the WVDHHR FaceBook page. The CMS approved TBIW application is posted on the BMS website for future reference.

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.

Once a member has been enrolled in the program and a Service Plan has been developed by the service planning team the UMC conducts a Care Management Review and provides the necessary authorizations for services outlined in the member's Service Plan. The UMC will also provide the Case Manager's Request for Service Authorization Form which includes the member's budget amount. The UMC provides a written authorization notice to the Personal Options vendor including the approved units for self-directed services. The Personal Options vendor completes the Spending Plan with the member who has enrolled with the Personal Options vendor and Program Representative (if applicable).

Per policy, the member and/or their legal representative(if applicable) have the opportunity to request an increase in their self-directed services at any time, however, at no time may the services exceed the maximum TBIW budget per member per year ($36,600).

Case Managers are responsible for submitting an updated Service Plan reflecting any service changes. The Service Plan must be submitted to the UMC and include assessment/documentation sufficient (reflecting the member's current needs) to support the request. If approved, the member's service authorizations will be adjusted accordingly. The member's Case Manager and the Personal Options vendor will be notified by the UMC.

If denied, the member/legal representative (if applicable) is offered the opportunity to request a Fair Hearing. After requesting a Fair Hearing, the member and their legal representative will be offered a pre-hearing conference unless the member has obtained legal counsel. If legal counsel has been obtained, then BMS' legal counsel will consult with the member's legal counsel only.

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 self-directed budget into monthly spending plans based upon input from the member/Program Representative. This safeguards premature depletion of the self-directed 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 or their Program Representative to develop and monitor the monthly spending plans. The Resource Consultants will ensure the member/representative is aware of under-utilization and/or any attempts to over spend the monthly spending plan. The member enrolled in Personal Options may request their CM to revise their Service Plan if necessary.

If there is a complaint about the services by the Personal Options vendor, BMS researches the issue, contacts the vendor and requests documentation related to the issue. The complainant is contacted and a resolution is shared. The vendor is informed of the decision and the vendor completes necessary action.

There is a grievance procedure with the Personal Options vendor. The procedure has 2 levels within the process. Level One requires a meeting with the Vendor staff to determine if resolution can be made. Level Two requires a meeting with BMS where a decision is determined.

All members are educated on the procedure during the enrollment session and they are provided grievance procedures and documents to complete if necessary.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

The member receiving TBIW services and their legal representative (if applicable) and their case managers are notified in writing of Medicaid Fair Hearing rights when:

1. The member receiving TBIW services does not meet medical eligibility requirements for the Waiver (initial and re-evaluation assessment). They are notified by the UMC at the time of determination. The UMC maintains all records of medical eligibility denials.

2. The member's services have been reduced during a Service Plan development meeting. They are notified by the UMC. The UMC maintains all records of annual re-evaluations.

3. The member's request for an increase of services is denied. They are notified by the UMC at the time of denial. The UMC maintains all records of requests for a service change and decisions.

4. The member's TBIW case has been closed (per established policies and procedures). They are notified by the UMC at the time of closure. The UMC maintains all records of case closures. If the member is denied due to financial ineligibility the local DHHR Office will send notice of the denial and fair hearing rights.

The UMC maintains all applicable records of medical eligibility, service denials and closures with the exception of a member's financial ineligibility.

All notifications of Medicaid Fair Hearing rights includes information that services will continue throughout the Medicaid Fair Hearing process if applicable policy is followed when making the request. Information on available advocacy support is also provided. The member is also provided the opportunity for a Pre-Hearing Conference after they have filed a Medicaid Fair Hearing request to attempt to resolve the issue(s) with BMS through the UMC. If the member has retained legal counsel, then the UMC will not conduct a pre-hearing conference, however BMS legal counsel and the member's legal counsel may communicate as needed prior to the hearing.

The Member Handbook is provided to and reviewed with applicants and members during eligibility assessments (annual for members) by the UMC. This Handbook includes information about Fair Hearing and pre-hearing conference. Additionally, if an applicant is denied eligibility or if a member is denied eligibility or experiences a reduction in service, the Notice of Decision letters include a Fair Hearing request form, instructions for completion and also outline hearing rights and available advocacy resources.

If at any time the Waiver program cannot adequately ensure a member's health and safety, the Case Manager must make appropriate referrals to other available resources in the community. As a last resort, if a member's health and welfare cannot be assured by utilizing Waiver and/or other available community resources, the member will be referred for institutional services. Should a referral be made for institutional services the member would have Fair Hearing rights described below.

If an applicant is denied eligibility or if a member is denied eligibility or experiences a reduction in service, the Notice of Decision letters include a Fair Hearing request form, instructions for completion and also outline hearing rights and available advocacy resources.

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 Utilizaton Management Contractor

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

A member who is dissatisfied with the services received from a provider agency has the right to file a grievance. All TBIW Provider agencies have a written grievance procedure. The UMC will explain the grievance process to all applicants/members at the time of initial application/re-evaluation. Applicants/members and/or their legal representative (if applicable) will be provided with a generic Grievance Form at that time with instructions to send their grievance to the Provider their grievance is with. Members receive information about the grievance process in their TBIW Handbook. Service providers will only afford members with a grievance procedure for services that fall under the particular service provider's authority; for example, a Case Management Agency will not conduct a grievance procedure for Personal Attendant Service Agency activities, nor will a Personal Attendant Service Agency conduct a grievance procedure for Case Management Agency activities.

A member may by-pass the level one grievance and file a level two grievance with the UMC if he/she chooses.

The grievance procedure consists of two levels:

A. Level One:
The TBIW Provider has 10 business days from the date they receive a Grievance Form to hold a meeting with the member and/or legal representative (if applicable), in person or by telephone. The meeting will be conducted by the agency director or their designee with the member and/or their legal representative (if applicable). The agency has five business days from the date of the meeting to respond in writing to the grievance. If the member is dissatisfied with the agency decision, he/she may request that the grievance be submitted to the UMC for a Level Two review and decision.

B. Level Two:
If a TBIW Provider is not able to address the grievance in a manner satisfactory to the member and the member requests a Level Two review, the UMC will, within 10 business days of the receipt of the Grievance Form, contact the member and/or their legal representative (if applicable) and the TBIW Provider to review the Level One decision. Level Two decisions will be based on Medicaid policy and/or health and safety issues. The UMC will provide notice of the decision in writing to the member and/or legal representative (if applicable), the Provider agency and the Bureau for Medical Services (BMS).

The TBIW grievance process is intended to resolve complaints not subject to the Medicaid Fair Hearing process such as member's allegations of Provider noncompliance with Waiver policy and/or non-implementation of the member's current Service Plan.

The grievance process is not utilized to address decisions regarding medical or financial eligibility, a change in service(s) or case closure.

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).

TBIW Providers must have policies and procedures for thoroughly reviewing, investigating, and tracking all incidents involving the risk or potential risk to the health and safety of the members they serve. Providers are responsible for taking appropriate action on both an individual and systemic basis. All providers are required to report and track incidents through the web-based West Virginia Incident Management System (WVIMS). Providers shall classify all incidents as:

• Allegation of abuse, neglect, or exploitation - must be reported to Adult Protective Services (APS) per WV Code 9-6-1 or Child Protective Services (CPS) per WV Code 49-6A-2.
• Critical incident - a high likelihood of producing real or potential harm to the health and welfare of the member.
• Simple incident - unusual events occurring to a member that cannot be characterized as a critical incident and does not meet the level of abuse or neglect.

Any incidents involving a member utilizing TBIW services must be reported to the UMC by email or entered into the WVIMS within the next business day of learning of the incident. The TBIW Provider's Director or designated staff will immediately review each Incident Report and determine whether the incident warrants a thorough investigation. Investigations must be initiated within 24 hours of learning of the incident. A completed Incident Report must be entered into the WVIMS within fourteen (14) calendar days of the incident. At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the provider shall immediately notify APS or CPS as mandated by State Code. Providers are responsible to investigate all incidents, including those reported to APS or CPS. The Provider will inform the member and/or their legal representative (if applicable)in writing the results of an investigation.

Providers are required to regularly review and analyze incident reports to identify health and safety trends. Identified health and safety concerns and remediation strategies must be incorporated into the Provider's Quality Management Plan.

Providers must conduct a thorough investigation on any incident involving the risk or potential risk to the health and safety of the program members. Incidents have been classified by policy (BMS) and Providers are required to use this classification when determining their response. Classification of incidents include: Abuse, Neglect, and/or Exploitation, Critical Incidents and Simple Incidents.

All Critical Incidents must be investigated by the Provider, all incidents involving abuse, neglect and/or exploitation must be reported to WV DHHR Bureau for Children and Families Protective Services (Adult/Children).

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.

Information that defines abuse, neglect and exploitation and how to notify the appropriate authorities is provided by the UMC to the applicant and/or legal representative (if applicable) at their initial medical eligibility assessment as well as to the member and/or their legal representative (if applicable) at their annual medical eligibility re-evaluation.

The UMC will review/educate the member about recognizing and reporting abuse, neglect and exploitation annually during the eligibility assessment. The member will sign-off that they have received and understand the information reviewed.

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.

TBIW Provider Directors (or designated staff) must immediately review each Incident Report and determine whether the incident warrants a thorough investigation. Investigations are required to be initiated within twenty-four (24) hours of learning of the incident. Providers will be required to enter all Incident Reports into the WVIMS.

At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the Provider shall immediately notify APS or CPS as mandated by State Code. The member/legal representative may request to review APS or CPS investigation findings at any time, however, those mandated investigative agencies must follow WV state code regarding who can be informed of their investigative results. TBIW Providers are responsible to investigate all incidents, including those reported to APS or CPS. Per policy, when there has been an allegation of abuse, neglect or exploitation, TBIW Providers must:
1) Take immediate necessary steps to ensure the health and safety of the member while investigating the incident
2) Revise the emmber's Service Plan if necessary to implement additional supports, and
3) Implement necessary system's changes including additional Personal Attendant professional training that might be helpful in preventing future incidents.

Providers are required to review periodically their incident data to identify and address systemic issues and concerns.

The UMC generates a monthly report which is reviewed by the Bureau for Medical Services (BMS) and management staff of the UMC at regular contract meetings. The UMC monitors Provider incidents. The UMC will monitor Provider incidents in real time via the WVIMS.

Providers will be required to review their incident data and identify and address systemic issues and concerns quarterly per policy. The UMC will monitor compliance with this policy during annual on-site provider reviews.

Providers are required to report within 24 hours of learning of the incident. They are required to immediately initiate an investigation of critical incidents and complete their investigation within 14 calendar days.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The UMC is responsible for the monitoring and oversite of the operation of the WVIMS and is responsible for real time monitoring of Provider incident investigations. Every incident submitted must be reviewed by the UMC to ensure that appropriate and timely steps are taken by the Providers. A report is generated monthly which is reviewed by BMS and management staff of the UMC at regular contract meetings to identify and address system issues and concerns and prevent re-occurrences. Quarterly reports are also reviewed by the Quality Improvement Advisory Council.

As part of the Quality Improvement System (QIS), the UMC reviews a representative sample of files annually, including (as applicable) compliance with Incident Management policies. This data is also reviewed and analyzed by BMS, UMC and the Quality Improvement Advisory Council.

Appendix G: Participant Safeguards

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

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

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

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

WV does not permit the use of restraints or restrictive interventions on this program. 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) or Child Protective Services (CPS). APS or CPS is required to investigate these allegations. Providers also have a responsibility per policy to investigate and to report the incident directly the WV Incident Management System (WVIMS.

WV does not permit the use of restraints or restrictive interventions on this program, however, all providers are mandatory reports and, as such, WV requires TBIW providers to have policies and procedures for thoroughly reviewing, investigating, and tracking all incidents involving the risk or potential risk to the health and safety of the members they serve. The provider is responsible for taking appropriate action on both an individual and systemic basis in order to identify potential harms, or to prevent further harm, to the health and safety of all members served, Anyone providing services to a member on the TBIW who suspects an allegation of abuse, neglect, or exploitation must report the incident to West Virginia Centralized Intake immediately by calling 1-800-352-6513,which is available 7 days a week, 24 hours day. This initial referral must then be followed by a written report, submitted to the local Department of Health and Human Resources where the alleged victim resides, within 48 hours following the verbal referral. An Adult Protective Services (APS) or Child Protective Services (CPS) Worker MAY be assigned to investigate the alleged abuse, neglect and/or exploitation. The TBIW provider, member or legal representative may also report suspected sexual assault and/or sexual abuse, serious physical abuse or exploitation to your local law enforcement agency by calling 911. Any incident attributable to the failure of TBIW provider staff to perform his/her responsibilities that compromises the health or safety of the member receiving TBIW services is considered to be neglect and must be reported to Adult or Child Protective Services. Incidents shall be classified by the provider as one of the following:

Critical incidents are occurrences with a high likelihood of producing real or potential harm to the health and welfare of the member receiving ADW services or incidents which have caused harm or injury. It could also include any type of suspected criminal activity. For the purpose of this system, critical incidents do not result from abuse/neglect/exploitation. These incidents may include, but are not limited to, the following:

a. Attempted suicide, or suicidal threats or gestures.
b. Suspected and/or observed criminal activity by the member receiving TBIW services, member's families, health care providers, concerned citizens, and public agencies that compromise the health or safety of the member.
c. An unusual event such as a fall or injury of unknown origin requiring medical intervention or first aid if abuse and neglect is not suspected.
d. A significant interruption of a major utility, such as electricity or heat in the member's residence that compromises the health or safety of the member.
e. Environmental/structural problems with the member's home, including inadequate sanitation or structural damage that compromises the health or safety of the member.
f. Fire in the home resulting in relocation or property loss that compromises the health or safety of the member.
g. Unsafe physical environment in which the personal attendant and/or other agency staff are threatened or abused, and the staff's welfare is in jeopardy.
h. Disruption of the delivery of TBIW services, due to involvement with law enforcement authorities by the member and/or others residing in the member's home that compromises the health or safety of the member.
I. Medication errors by a member or his/her family caregiver that compromises the health or safety of the member, such as medication taken that was not prescribed or ordered for the member, and failure to follow directions for prescribed medication, including inappropriate dosages, missed doses, or doses administered at the wrong time.
j. Disruption of planned services for any reason that compromises the health or safety of the member receiving TBIW services, including failure of member's emergency backup plan.
k. Any other incident judged to be significant and potentially having a serious negative impact on the member receiving TBIW services.
l. Any incident attributable to the failure of TBIW provider staff to perform his/her responsibilities that compromises the member's health or safety is considered to be neglect and must be reported to Adult or Child Protective Services (APS).

Simple incidents are any unusual events occurring to a member receiving TBIW services that cannot be characterized as a critical incident and does not meet the level of abuse or neglect. Examples of simple incidents include, but are not limited to, the following:

a. Falls or other incidents that does not require minor first aid or medical intervention.
b. Minor injuries of unknown origin with no detectable pattern.
c. Dietary errors with minimal or no negative outcome.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

Providers are mandatory reporters and as such are required to report any incidents of the use of restrictive interventions directly to Adult Protective Services (APS) or Child Protective Services (CPS). APS/CPS 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)until such time it becomes available they must report to the UMC.

WV does not permit the use of restraints or restrictive interventions on this program, however, all providers are mandatory reports and, as such, WV requires TBIW providers to have policies and procedures for thoroughly reviewing, investigating, and tracking all incidents involving the risk or potential risk to the health and safety of the members they serve. The provider is responsible for taking appropriate action on both an individual and systemic basis in order to identify potential harms, or to prevent further harm, to the health and safety of all members served, Anyone providing services to a member on the TBIW who suspects an allegation of abuse, neglect, or exploitation must report the incident to West Virginia Centralized Intake immediately by calling 1-800-352-6513, which are available 7 days a week, 24 hours day. This initial referral must then be followed by a written report, submitted to the local Department of Health and Human Resources where the alleged victim resides, within 48 hours following the verbal referral. An Adult Protective Services (APS) or Child Protective Services (CPS) Worker MAY be assigned to investigate the alleged abuse, neglect and/or exploitation. The TBIW provider, member or legal representative may also report suspected sexual assault and/or sexual abuse, serious physical abuse or exploitation to the local law enforcement agency by calling 911. Any incident attributable to the failure of TBIW provider staff to perform his/her responsibilities that compromises the health or safety of the member receiving TBIW services is considered to be neglect and must be reported to Adult or Child Protective Services. Incidents shall be classified by the provider as one of the following:
Critical incidents are occurrences with a high likelihood of producing real or potential harm to the health and welfare of the member receiving TBIW services or incidents which have caused harm or injury. It could also include any type of suspected criminal activity. For the purpose of this system, critical incidents do not result from abuse/neglect/exploitation. These incidents may include, but are not limited to, the following:

a. Attempted suicide, or suicidal threats or gestures.
b. Suspected and/or observed criminal activity by the member receiving TBIW services, member's families, health care providers, concerned citizens, and public agencies that compromise the health or safety of the member.
c. An unusual event such as a fall or injury of unknown origin requiring medical intervention or first aid if abuse and neglect is not suspected.
d. A significant interruption of a major utility, such as electricity or heat in the member's residence that compromises the health or safety of the member.
e. Environmental/structural problems with the member's home, including inadequate sanitation or structural damage that compromises the health or safety of the member.
f. Fire in the home resulting in relocation or property loss that compromises the health or safety of the member.
g. Unsafe physical environment in which the personal attendant and/or other agency staff are threatened or abused, and the staff's welfare is in jeopardy.
h. Disruption of the delivery of TBIW services, due to involvement with law enforcement authorities by the member and/or others residing in the member's home that compromises the health or safety of the member.
I. Medication errors by a member or his/her family caregiver that compromises the health or safety of the member, such as medication taken that was not prescribed or ordered for the member, and failure to follow directions for prescribed medication, including inappropriate dosages, missed doses, or doses administered at the wrong time.
j. Disruption of planned services for any reason that compromises the health or safety of the member receiving TBIW services, including failure of member's emergency backup plan.
k. Any other incident judged to be significant and potentially having a serious negative impact on the member receiving TBIW services.
l. Any incident attributable to the failure of TBIW provider staff to perform his/her responsibilities that compromises the member's health or safety is considered to be neglect and must be reported to Adult or Child Protective Services.

Simple incidents are any unusual events occurring to a member receiving TBIW services that cannot be characterized as a critical incident and does not meet the level of abuse or neglect. Examples of simple incidents

include, but are not limited to, the following:

a. Fall or other incident that does not require minor first aid or medical intervention.
b. Minor injuries of unknown origin with no detectable pattern.
c. Dietary errors with minimal or no negative outcome.

○ **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 mandatory reporters and as such are required to report any incidents of the use of restraints and restrictive interventions directly to Adult Protective Services (APS)or Child Protective Services (CPS). APS or CPS is required to investigate these allegations. Providers also have a responsibility per policy to investigate and to report the incident directly to the UMC or the WV Incident Management System (WVIMS)when available).

WV does not permit the use of seclusion in this program, however, all providers are mandatory reports and, as such, WV requires TBIW providers to have policies and procedures for thoroughly reviewing, investigating, and tracking all incidents involving the risk or potential risk to the health and safety of the members they serve. The provider is responsible for taking appropriate action on both an individual and systemic basis in order to identify potential harms, or to prevent further harm, to the health and safety of all members served, Anyone providing services to a member on the TBIW who suspects an allegation of abuse, neglect, or exploitation must report the incident to West Virginia Centralized Intake immediately by calling 1-800-352-6513, which are available 7 days a week, 24 hours day. This initial referral must then be followed by a written report, submitted to the local Department of Health and Human Resources where the alleged victim resides, within 48 hours following the verbal referral. An Adult Protective Services (APS) or Child Protective Services (CPS) Worker MAY be assigned to investigate the alleged abuse, neglect and/or exploitation. The TBIW provider, member or legal representative may also report suspected sexual assault and/or sexual abuse, serious physical abuse or exploitation to the local law enforcement agency by calling 911. Any incident attributable to the failure of TBIW provider staff to perform his/her responsibilities that compromises the health or safety of the member receiving TBIW services is considered to be neglect and must be reported to Adult or Child Protective Services. Incidents shall be classified by the provider as one of the following: Critical incidents are occurrences with a high likelihood of producing real or potential harm to the health and welfare of the person receiving TBIW services or incidents which have caused harm or injury. It could also include any type of suspected criminal activity. For the purpose of this system, critical incidents do not result from abuse/neglect/exploitation. These incidents may include, but are not limited to, the following:

a. Attempted suicide, or suicidal threats or gestures.
b. Suspected and/or observed criminal activity by the member receiving TBIW services, member's families, health care providers, concerned citizens, and public agencies that compromise the health or safety of the member.
mc. An unusual event such as a fall or injury of unknown origin requiring medical intervention or first aid if abuse and neglect is not suspected.
d. A significant interruption of a major utility, such as electricity or heat in the member's residence that compromises the health or safety of the member.
e. Environmental/structural problems with the member's home, including inadequate sanitation or structural damage that compromises the health or safety of the member.
f. Fire in the home resulting in relocation or property loss that compromises the health or safety of the member.
g. Unsafe physical environment in which the personal attendant and/or other agency staff are threatened or abused, and the staff's welfare is in jeopardy.
h. Disruption of the delivery of TBIW services, due to involvement with law enforcement authorities by the member and/or others residing in the member's home that compromises the health or safety of the member.
i. Medication errors by a member or his/her family caregiver that compromises the health or safety of the member, such as medication taken that was not prescribed or ordered for the member, and failure to follow directions for prescribed medication, including inappropriate dosages, missed doses, or doses administered at the wrong time.
j. Disruption of planned services for any reason that compromises the health or safety of the member receiving TBIW services, including failure of member's emergency backup plan.
k. Any other incident judged to be significant and potentially having a serious negative impact on the member receiving TBIW services.
l. Any incident attributable to the failure of TBIW provider staff to perform his/her responsibilities that compromises the member's health or safety is considered to be neglect and must be reported to Adult or Child Protective Services.

Simple incidents are any unusual events occurring to a member receiving TBIW services that cannot be characterized as a critical incident and does not meet the level of abuse or neglect. Examples of simple incidents include, but are not limited to, the following:

a. Fall or other incident that does not require minor first aid or medical intervention.
b. Minor injuries of unknown origin with no detectable pattern.
c. Dietary errors with minimal or no negative outcome.

○ **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 files reviewed with National Crime Information Center (NCIC) checks returned with satisfactory results within timelines Numerator= Number of agency staff reviewed with NCICs returned with satisfactory results within timelines Denominator= Number of agency staff files reviewed

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

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:
Percent of agency staff files reviewed with monthly OIG exclusion list checks returned with satisfactory results Numerator= Number of agency staff files reviewed with OIG exclusion list checks with satisfactory results Denominator= Number of agency staff files reviewed.

Data Source (Select one):

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

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

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

Performance Measure:
Percent of files of members 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 member or the legal representative Numerator= Number of files of member receiving services with that signed acknowledgement Denominator= Number of files reviewed

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

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

Performance Measure:
Percent of files of members receiving services that have a document signed by the member or legal representatives acknowledging they know how to report abuse, neglect, exploitation or other critical incidents. Numerator= Number of files of members receiving services with that signed document Denominator= Number of files of members receiving services reviewed

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

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

(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**

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:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Percent of reported critical and abuse/neglect/exploitation incidents resolved within fourteen days Numerator= Number of reported critical and abuse/neglect/exploitation incidents marked resolved within fourteen days Denominator= Number of reported critical and abuse/neglect/exploitation incidents entered into the WVIMS for any given period

Data Source (Select one):
Record reviews, 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: 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:
Percent of unexplained, suspicious and untimely deaths for which review/investigation resulted in the identification of preventable causes Numerator: Number of unexplained, suspicious and untimely deaths for which

review/investigation resulted in the identification of preventable causes Denominator: Total number of deaths

Data Source (Select one):
Mortality reviews
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(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**

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

Performance Measure:
Percent of mortality reports of members receiving services reported by Case Manager that coincide with cause of death on death certificate. Numerator-Number of mortality reports of members receiving services that coincide with the cause of death on the death certificate. Denominator-Number of mortality reports submitted.

Data Source (Select one):
Mortality reviews
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **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 reported critical and abuse/neglect/exploitation incidents followed-up on by providers with established timelines. Numerator-Number of reported critical & abuse/neglect/exploitation incidents followed-up on by the provider with timelines. Denominator-Number of reported critical & abuse/neglect/exploitation incidents.

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: 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:

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 members receiving services reviewed with a current and appropriate backup/crisis plan in their file Numerator: The number of files of members 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	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(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 files of members receiving services reviewd whose Serivce Plan reflected a members health care needs were coordinated. Numerator: The number of files of members receiving services reviewed whose Service Plan reflected a members 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 =
☒ **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:

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 for unexplained and/or unexpected 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.

All information related to this assurance is collected and monitored by the UMC. The UMC will collect and monitor this assurance using the WVIMS. The UMC will collect and monitor this assurance using results of Provider reviews, BMS Fiscal Agency data, and mortality reviews. Providers issues/concerns such as failure to meet requirements are addressed immediately upon identification by the UMC. Providers may be required to submit Plans of Correction addressing identified issues that must be approved by the UMC.

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 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 UMC is responsible for monitoring the quality of Waiver services and implementing and evaluating quality improvement strategies. The Waiver'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 CMS assurances and sub-assurances. Specific data sources include provider monitoring, claims data, incident management reports, contract oversight meetings and reports, and other stakeholder feedback and input.

The primary mechanism for involving stakeholders in the Waiver's quality improvement initiative is the Quality Improvement Advisory (QIA) Council. The Council is comprised of people who currently or formerly received TBIW services and/or their legal representatives (if applicable) of the program, Waiver providers, advocates and other interested stakeholders. The Council serves as a forum for members and/or their legal representative (if applicable) 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 with the QIA Council in order to identify trends and to monitor the effectiveness of quality improvement activities.

Quality improvement priorities are identified through data analysis and stakeholder input and are incorporated in the annual Quality Management Plan. Updates on the goals and objectives of this plan are reviewed at each meeting and guide the efforts of the Council and staff. The Quality Management Plan is evaluated at the annual QIA Council meeting and is revised if necessary to reflect current quality issues.

The UMC receives reported incidents within 24-hours of the provider becoming aware of the incident. The UMC reviews these reports and initially follows up with the provider to provide technical assistance (review timelines and policy). The UMC verifies any investigations are completed by the provider within timeline (and that any appropriate referrals have been made to Protective Services, law enforcement etc.). The UMC compiles information monthly and reports to BMS. Quarterly, information is reviewed by the Quality Improvement Advisory Council for possible suggested policy/procedural changes.

The UMC generates monthly reports to identify and monitor incident trends.

The UMC provides and reviews the Member Handbook with applicants and members during the UMC's eligibility assessment. The handbook includes information on the toll-free hotline. The UMC follows the Complaint and Investigation protocol to investiage the concerns that members/people have communicated via the toll-free complaint line.

The purpose of the TBI Waiver Quality Improvement Advisory (QIA) Council (hereafter known as the Council) is to provide guidance and feedback to the Department of Health and Human Resources Bureau for Medical Services (BMS) and its contracted UMC in the development of an ongoing quality assurance and improvement system for the TBI Waiver Program. To this end, the Council's charge is to work with staff to develop and strengthen the TBI Waiver program's ability to:
-Collect data and assess member experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for quality improvement,
-Act in a timely manner to remedy specific problems or concerns as they arise and

-Use data and quality information to engage in actions that lead to continuous improvement in the TBI Waiver program.

The Council will work with BMS and the UMC to ensure that the TBI Waiver supports the desired outcomes outlined in the six (6) focus areas of the Quality Framework developed by the Centers for Medicare and Medicaid Services (CMS).

The role of the Council is advisory in nature and therefore, it has no authority in administering the TBI Waiver Program. Its function is to advise and assist BMS in program planning, development, and evaluation consistent with its stated purpose. In this role, the Council shall:
-Review findings from evidence-based discovery activities,
-Recommend program priorities and quality initiatives,
-Recommend policy changes,
-Monitor and evaluate the implementation of TBI Waiver priorities and quality initiatives,
-Monitor and evaluate policy changes,
-Serve as a liaison between the TBI Waiver program and its stakeholders and
-Establish committees and work groups consistent with its purpose and guidelines.

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.

The TBIW 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 complaints, administrative reports, oversight of delegated administrative functions, and stakeholder input.

Provider Reviews:

The primary means of monitoring the quality of Waiver services is provider reviews conducted by staff of the UMC.

Prior to enrolling as a TBIW Provider, agencies interested in providing Waiver services are reviewed by the UMC to ensure that all Licensure and/or Certification standards are met. All new providers are reviewed after the first six (6) months in order to identify and address any issues or concerns.

Providers are required to submit evidence to the UMC annually to document continuing compliance with all Licensure and/or Certification requirements as specified in the TBIW 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 may be issued until appropriate documents are submitted and approved by the UMC. Providers receiving a Provisional Certification are required to have an on-site review by the UMC prior to full re-certification. A percentage of Providers are randomly selected each year for an on-site review to validate certification documentation. Targeted on-site provider reviews may be conducted based on Incident Management Reports and complaint data.

A statewide representative sample of files are reviewed every 12 months. Files are reviewed by staff of the UMC. Monitoring tools have been developed to ensure that the critical data necessary to monitor CMS assurances are collected. A random sample, ensuring that at least one member's chart from each Provider site is reviewed, will be identified with the guidance of CMS technical assistance contractors.

West Virginia Incident Management System (WVIMS):

Another key source for monitoring the quality of TBIW services is the online West Virginia Incident Management System (WVIMS). Waiver Providers are required to use the online application to report and track all incidents including 1) Simple Incidents, 2) Critical Incidents, and 3) Abuse, Neglect, and Exploitation. The online system gives providers the ability to generate agency specific reports to identify and monitor trends. The WVIMS also provides the UMC the capability to monitor reported incidents in "real time" in order to ensure that timely, appropriate steps are taken by providers. The UMC generates periodic reports to identify and monitor trends statewide.

The UMC also operates a toll-free hotline allowing members 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:

-UMC - Monthly Program Report, Monthly Activity Report, semi-monthly Tracking Report, and ad hoc reports as requested.
-Personal Options- Monthly Program report and ad hoc reports as requested.
-Claims processing entity - regular claims data reports and ad hoc reports as requested.

Contract Oversight Meetings:

BMS management staff conducts monthly oversight meetings with each of its contractors to monitor performance and address identified issues/concerns.

The quality management data collected through discovery methods is compiled using the Quality Management Report Template and reviewed at least monthly by BMS and the UMC at its contract meetings. The Quality

Management Report is also compiled and reviewed quarterly by the QIA Council.
A comprehensive report summarizing the findings of provider reviews is compiled at the end of each review cycle, reviewed and analyzed by Waiver staff and presented to the QIA Council for its review and analysis.

The Quality Improvement Advisory (QIA) 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 Management Plan are continuously monitored by the QIA 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).*

A statewide representative sample of TBI files is reviewed every 12 months to verify documentation of services billed. Provider reviews are conducted by staff of the UMC to ensure the integrity of payments that have been made for waiver services. When provider documentation does not support services billed, providers are required to submit Plan of Correction which must be approved by the UMC and BMS. Providers are required to reimburse the Bureau for Medical Services for any services billed without supporting documentation or provided by unqualified staff. The Medicaid Program (which would include the TBIW) is audited annually under the West Virginia Statewide Single Audit. The State of West Virginia Statewide Single Audit is conducted by Ernst & Young, LLP. The claims submitted by providers for services provided under the TBIW will be processed through the MMIS, just as any other claim. During the single audit process the auditors select a sample of claims processed through the MMIS for testing; since the TBIW claims are processed through the MMIS, they would be included in the population of all claims that are selectable for testing during the single audit process.

The audit procedures performed by Ernst and Young for waiver providers is to validate:
Authorization of Provider services
Delivery of Provider services
Payment of Provider services

The audit procedures for waiver provider services are included in Ernst and Young sample selection methodology for all provider payments.

The Ernst and Young audit procedures are an additional layer of review – in addition to the UMC contractor processes to verify accurate service provision and expenditures.

WV Code §16-5F-1 requires submission of an annual audit report to the WV Healthcare Authority for certain healthcare providers.

100% of providers are reviewed annually. 100% of member files are reviewed upon on-site provider review. 50% of member claims are reviewed and compared to Service Plans, assessments, and documentation to substantiate services are billed in compliance with policy standards.

If a fraudulent provider is uncovered, the UMC refers the case to Office of Program Integrity who then refers to the Medicaid Fraud Control Unit for follow-up.

The UMC does verify service documentation and staffing qualifications as part of the provider review.

The UMC submits to OPI a list of members to be reviewed (100% sample). OPI pulls a sample of TBI Waiver claims representing 6-months of services for each member to be reviewed.

The UMC expects the provider to submit outstanding document (ex. Evidence of provider qualifications, training, policies, etc.). Upon the provider's next annual on-site review, the UMC verifies whether or not the provider has successfully implemented their Plan of Correction.

All fraudulent activity is referred to Office of Program Integrity (OPI), who refers to the Medicaid Fraud Control Unit.

WV relies on the fiscal agent to monitor the appropriate exclusions databases upon enrollment and re-enrollment validation. The fiscal agent compares providers against the Medicare Exclusion Database and the General Services Administration's Excluded Parties List System. The fiscal agent also checks the HHS/OIG List of Excluded Individuals/Entities monthly.

The Bureau for Medical Services is responsible for the UMC's performance.

BMS is responsible to examine all Provider Review Reports generated by the UMC. BMS, OPI, UMC, and any other entity deemed necessary by BMS meet as a Review Committee to consider provider's comments related to a Provider Draft Disallowance Report. BMS is responsible to make the final determination for any recommended disallowance resulting from the UMC provider review during the Review Committee. BMS is responsible to forward the finalized Provider Review Reports to the Provider with instructions for repayment.

Types of Activities to ensure the integrity of services payments:

1.) Licensing Process: All TBI W Providers must meet initial and continuing Certification Reviews. All TBIW Providers must be enrolled with Molina and receive a provider number from Molina. TBI W Case Managers must be licensed in WV as a Social Worker, Counselor, or Registered Nurse and employed by a TBI Waiver Case Management Agency enrolled with Medicaid. Professional credentials are verified during Provider on-site reviews by the UMC.

2.) Compliance Process: Upon completion of each provider quality review, the UMC conducts a face-to-face exit summation with the agency director. Following the exit summation, the UMC will make available to the provider a draft Review Report and if necessary a Draft Plan of Correction to be completed by the TBI Waiver provider. If potential disallowances are identified, the TBI Waiver provider will have 30 days from receipt of the draft Review Report to send comments back to the UMC. After the 30 day comment period has ended, BMS will review the draft Review Report and any comments submitted by the TBI Waiver provider and issue a Final Review Report to the TBI Waiver provider's Director.

The final report reflects the provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of TBI Waiver Services. A cover letter to the TBI Waiver provider's Director will outline the following options to effectuate repayment:
(1) Payment to BMS within 60 days after BMS notifies the provider of the overpayment; or
(2) Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment; or
(3) A recovery schedule of up to a 12 month period, through monthly payments or the placement of a lien against future payments.

If the TBI Waiver provider disagrees with the final disallowance report, the TBI Waiver provider may request a document/desk review within 30 days of receipt of the final report pursuant to the procedures in Common Chapter 800, General Administration of the West Virginia Medicaid Provider Manual. The TBI Waiver provider must still complete the written repayment arrangement within 30 days of receipt of the Final Disallowance Report, but scheduled repayments will not begin until after Ithe document/desk review decision. The request for a document/desk review must be in writing, signed and set forth in detail the items in contention.

3.) What is the process of prior authorization of services to ensure the integrity of services payments?
The UMC receives the Service Request from the member's assigned Case Management Agency (CMA). A complete Service Request must include:
The Medicaid Traumatic Brain Injury Waiver Services Prior Authorization Cover Sheet
Copy of the signed Service Plan
Copy of the most current, signed Member Assessment
Completed budget
The UMC will examine the clinical information (Member Assessment and Service Plan) submitted by the CMA and the associated prior authorization service request. The UMC conducts a care management review to ensure the following:

- *Verifying medical eligibility of member*
- *Verifying financial eligibility of member*
- *Quality review of submitted Member Assessment*
- *Quality Review of submitted Member's Service Plan*
- *Calculate spending and unit limits (See worksheet for instructions)*
- *Determine the budget is within service and annual limits*
- *Determine if prorated budget is required due to anchor date alignment*

A positive care management review will result in the creation of the Prior Authorization Notice (PAN). The PAN includes the following information Service Type, Units approved, dollar amount based on approved units, date ranged and authorization numbers for each unit obtained from the Molina system.

4.) How are providers prioritized to be audited to ensure the integrity of services payments?
100% of providers are reviewed annually. 100% of member files are reviewed upon on-site provider review. 50% of member claims are reviewed and compared to Service Plans, assessments, and documentation to substantiate services are billed in compliance with policy standards.
5.) What are the surveillance and utilization review activities to ensure the integrity of services payments?
On-site Provider Reviews are conducted annually by the UMC using a standardized review tool that is based on TBIW program policies. Review activities include a comparison of claims to the Service Plan and service notes (Case Management and Personal Attendant). Services that: were not included on the Service plan, did not have appropriate supporting documentation, were provided by unqualified staff, or were included on an invalid Service Plan, to a member who was not medically or financially eligible or those provided outside of policy limits or definitions are recommended for a potential disallowance.

5.) What are the surveillance and utilization review activities to ensure the integrity of services payments?
On-site Provider Reviews are conducted annually by the UMC using a standardized review tool that is based on TBIW program policies. Review activities include a comparison of claims to the Service Plan and service notes (Case Management and Personal Attendant). Services that: were not included on the Service plan, did not have appropriate supporting documentation, were provided by unqualified staff, or were included on an invalid Service Plan, to a member who was not medically or financially eligible or those provided outside of policy limits or definitions are recommended for a potential disallowance.

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:
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	***Frequency of data***	***Sampling Approach****(check*

data collection/generation *(check each that applies):*	***collection/generation*** *(check 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:* *UMC*	☒ ***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 processed claims that were denied per MMIS edits. Numerator: Number of processed claims that were denied per MMIS edits. Denominator: The 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 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***

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

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

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

The data and information generated through onsite provider quality reviews is collected on Discovery and Remediation report and reviewed monthly with BMS.
Any Provider scoring less than 100% compliance on post payment review items is subject to potential disallowance and must develop a Plan of Correction to achieve compliance. Provider's Plan of Corrections must be approved by the UMC and is monitored during review cycles. Remediation actions are reviewed during Contract Management meetings with BMS and UMC.

Monthly review of the Discovery and Remediation report findings by BMS allows for discussion and identification of systematic and/or provider compliance issues. Remediation steps are discussed and developed and are addressed through technical assistance and/or training for Providers conducted by BMS and the UMC.

Post-payment financial reviews are conducted annually by the UMC during the Provider quality review. 100% of providers and 100% of member files are reviewed. 50% of the provider claims are reviewed to ensure that the claims are properly supported by documentation of the TBI waiver services provided. Any claims/services delivered with no or insufficient documentation is recommended for a potential denial and a Plan of Correction must be developed to address the deficiencies.

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 the review and analysis of claims data provided by the claims processing entity. Evidence collected via claims data is reviewed and analyzed by BMS and the claims processing entity in order to identify any system issues.

ii. Remediation Data Aggregation

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

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

The current rate structure for the TBIW services is based on services in the existing approved IDDW and Aged and Disabled Waiver. The rate for Case Management was based on the established rate in the existing approved IDDW, and has been developed to reflect service definitions, provider requirements, operational service delivery and administrative considerations. The following components were used to determine the current TBIW rates: Bureau for Labor Statistics wage information; employee related expenses; productivity adjustment factor; and administrative overhead. This methodology was applied to those HCPCS Level II codes and were last updated in November 2006. The rate for Personal Attendant Services is based on the existing rate for Personal Attendant service in the Aged and Disabled Waiver was increased as follows at the direction of Department Administration following negotiations with providers; in August 2009 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 April 2020 the rate will increase from $3.75 to $4.25 for the Traditional Model. In January 2021, the rate will increase to assist providers with increased administrative costs for providing the service, including the implementation of EVV, staff recruitment, training and personal protective equipment. Mileage reimbursement for Transportation is based on the approved mileage rate as published by the West Virginia Division of Purchasing, Travel Management Office. The described rate methodology is consistently applied to all waiver services. The current rate methodology provides consistency with the provisions of section 1902(a)30(A) and 42 CFR section 447.200-205. The state of West Virginia does not use a formula to base increase for inflation. BMS will post payment rates on the Agency website so that waiver participants and providers will be aware of the cost of waiver services. There is an annual update of the calculation of factors described in question 60 below based on the established methodology (however funding limitations are a consideration in implementation of any rate increases). A methodology to evaluate changes in the factors described in the response to question 60 for reimbursement rates was developed in 2010, with annual updates being calculated each year since 2012. However funding limitations are a consideration in implementation of any rate increases, and as additional funds become available increases to rates have been implemented as described in the application for Personal Attendant Services. The $36,600 individualized budget was originally based on the available funding dedicated to the TBI Waiver and the anticipated members to be served during the initial 3 years. Budget updates would be subject to availability of additional funding, balancing the needs of the population to be served and the number of members. There is an annual update calculation of the factors described in the response to question 60 that comprise the rate calculations, which are performed by staff in the DHHR Office of Accountability and Management Reporting, Rate Setting Unit. This information is in shared with the Bureau for Medical Services for inclusion in the evaluation of the overall Medicaid budget and funding available for the TBI Waiver. When rates are changes, the TBIW providers are notified and it is posted on the BMS website and also on the TBIW web page. Rates and rate methodologies are included in the Waiver application, which is posted on the DHHR-BMS website for a public comment period. Rates are available on the DHHR-BMS website as well as the TBIW webpage. WV Code §16-5F-1 requires submission of an annual audit report to the WV Healthcare Authority for certain healthcare providers. Factors included in the rate methodology include Wages (based on Bureau for Labor Statistics for similar occupations and mixes of occupations to those providing Waiver services); Inflation (Consumer Price Index); Payroll Taxes; Employee Benefits; Administrative (allowing for both non-billable administration for direct-care providers and for administrative support staff); Mileage; and Capital/Technology. An annual update calculation of rates is performed (although funding limitations are a consideration in implementation of rate increases). Geographical fees are not a component of the rate determination. 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 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)

The rate for the newly added Personal Emergency Response System service is based on historical cost of this individual pendant through the Money Follows the Person demonstration grant.

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:*

Authorization is processed through a third party contractor and claims are directly submitted to the Medicaid fiscal agent for payment. Providers bill the state's claims payer directly. There is a provider portal and the provider can enter their claims directly into that portal. Direct data entry is available or claims can be uploaded. Once a provider is enrolled, then they complete a trading partner agreement that allows the use of electronic filing. The provider may also use a clearing house to bill for their claims. The provider may also send paper claims to the claims payer. Timely filing is one year. The UMC receives reviews and authorizes all service requests for the TBIW program. The UMC issues a Prior Authorization Notice (PAN) to the provider that includes the following information: Service Type, Units, Dollars, PA Number and Date Range and Service Type. The Provider uses this information when submitting claims to the claims payer.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Each claim is subjected to a series of edits to ensure that the person is eligible on the date of service, that the provider has a valid enrollment status and that the service is eligible for payment. If the claim passes these initial edits, further assurances are provided through prior authorization of waiver services based on the person's approved Service Plan. Post-payment review activities are conducted to ensure that services were provided.

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 in attached document (executive summary excerpt 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.

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:

The source of funding is dedicated general revenue appropriated by the legislature annually.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

- (●) ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*
- ( ) ***Applicable***

Check each that applies:

- [ ] ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

Check each that applies:

- [ ] ***Health care-related taxes or fees***
- [ ] ***Provider-related donations***
- [ ] ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

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	22351.01	10903.00	33254.01	57396.00	8406.00	65802.00	32547.99
2	23469.61	11448.00	34917.61	59440.00	9078.00	68518.00	33600.39
3	23448.78	12020.00	35468.78	61556.00	9804.00	71360.00	35891.22
4	23448.78	12621.00	36069.78	63747.00	10588.00	74335.00	38265.22
5	23448.78	13252.00	36700.78	66017.00	11435.00	77452.00	40751.22

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	96	100
Year 2	96	100
Year 3	96	100
Year 4	96	100
Year 5	96	100

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.*

It is estimated that waiver member's will stay on the waiver a full year when added and will remain indefinitley thereafter.

The 372 Report for the period 1/31/13 represents data for the initial year of the TBI Waiver; all members included in that year's reporting enrolled at some point during that period, however the State does not believe that partial year of participation is representative of what would be expected when more of the available Waiver slots have been filled. It is anticipated that over the first few years of the Waiver there would be a gradual increase in the ALOS and that when the Waiver is mature the ALOS would be closer to 365 days, or similar to the experience on the A/D Waiver and the I/DD Wavier (325.7 and 357.3 respectively for the most recent 372 report, period ended 6/30/13).

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:*

Estimated based on services to be provided under the waiver at existing rates projected based on estimated usage per participant. Methodology for the estimates provided remained the same. Estimates are based on estimated usage per participant using 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 (average cost of acute care services per person) for a similar population in the approved Aged/Disabled Waiver, utilizing nursing facility level of care, using the latest data available for SFY 2014. 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 estimate is trended forward for each year in the Waiver application based on the current (2015) average member budget of $29,000, trended forward for years 2016-2020 at an estimated annual increase of 5%. The actual expenditure data available for the TBI Waiver at the time of preparation of the application was limited due to low enrollment for historical periods, therefore the State relied upon the current actual average per member budget to calculate the estimates for the application.

In the acute care comparison, the Factor G' is less than the Factor D'. The members in the TBI Waiver are Nursing Facility level of care, however the members that have participated in this Waiver to date have shown a higher level of acute care expenditures than those on the State's other waiver with Nursing Facility level of care (Aged/Disabled Waiver) as well as the average per member cost for acute care services that is experienced for members in a Nursing Facility. For example, the table below provides a comparison of the per member acute care costs for these two waivers since the initial year of the TBI Waiver, along with the Nursing Facility average per member acute care costs:

	TBI	ADW	NF
2013	8,116	6,904	6508
2014	11,662	7,276	7207

Based on the limited data available for the TBI Waiver, it appears that the utilization of acute care services is higher for members participating in the TBI Waiver than either the A/D Waiver or members in Nursing Facilities, resulting in the projections (trended forward from actual data) for Factor D' higher than Factor G'.

The Case Management and Transportation services are forecast at the maximum allowed units per member for each year in the application, which is the reason the utilization for those services does not change over the waiver period. Additional details of the calculation for each individual service are shown in the accompanying workpaper.

The most recent 372 report filed was for the period 1/31/13, in which there were only 7 unduplicated participants. Since the historical utilization data available was limited to a partial year of utilization for those 7 participants, the State sought more recent information to forecast the members that may choose Personal Options and used the number of participants for which the Financial Management Service (FMS) indicated were using Personal Options to calculate the forecast amounts in the application.

Factor D' was updated for Years 4 and 5 to better reflect actual usage.

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:*

Institutional (nursing facility) care average per person- projections based on 6-30-14 claims data.

The estimate for Factor G' was calculated from the prior periods' actual acute care costs for the A/D Waiver population, and the source data is from the same data reports that are used to prepare the 372 reporting. The costs for the Factor G' are pulled from claims data in the MMIS by identifying the members during the reporting period with claims for Nursing Home services, then by running a report to aggregate the acute care (non-Nursing Home) claims paid for those members. The average acute care costs per member were then trended forward for the estimate included in the Waiver application using the average of increases experienced from the most recent years available (2010 through preliminary 2014 data).

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:*

Services in addition to institutional (nursing facility) services provided to people (ie acute care services, etc)

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	
Community Transition Services	
Environmental Accessibility Adaptations	
Personal Emergancy Response System	
Pre-Transition Case Management	
Transportation	

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:						86710.00
G9002 U2	event	92	3.00	174.00	48024.00	
T1016 UB	15 minute	92	50.00	8.41	38686.00	
Personal Attendant Services Total:						2025861.00
Personal Attendant Services	15 minute	24	4849.00	4.25	494598.00	
Personal Options Personal Attendant Services	15 minute	16	6582.00	3.75	394920.00	
Personal Attendant Services Modifier	15 minute	24	4849.00	4.25	494598.00	
Personal Attendant Services Personal Options Modifier	15 minute	26	6582.00	3.75	641745.00	
Community Transition Services Total:						2050.00
Community					2050.00	
GRAND TOTAL:						2145696.76
Total Estimated Unduplicated Participants:						96
Factor D (Divide total by number of participants):						22351.01
Average Length of Stay on the Waiver:						365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transition Services	event	1	2050.00	1.00		
Environmental Accessibility Adaptations Total:						8000.00
Environmental Accessibility - Home Traditional	event	4	500.00	1.00	2000.00	
Environmental Accessibility - Home Self-Directed	event	4	500.00	1.00	2000.00	
Environmental Accessibility - Vehicle Traditional	event	4	500.00	1.00	2000.00	
Environmental Accessibility - Vehicle Self-Directed	event	4	500.00	1.00	2000.00	
Personal Emergancy Response System Total:						13200.00
Personal Emergancy Response System	monthly rate	22	12.00	50.00	13200.00	
Pre-Transition Case Management Total:						204.00
Pre-Transition Case Management	15 minute	1	24.00	8.50	204.00	
Transportation Total:						9671.76
Transportation	1 mile	16	918.00	0.42	6168.96	
Personal Options Transportation	1 mile	12	695.00	0.42	3502.80	
				GRAND TOTAL:		2145696.76
				Total Estimated Unduplicated Participants:		96
				Factor D (Divide total by number of participants):		22351.01
				Average Length of Stay on the Waiver:		365

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:						192096.00
G9002 U2					192096.00	
				GRAND TOTAL:		2253082.76
				Total Estimated Unduplicated Participants:		96
				Factor D (Divide total by number of participants):		23469.61
				Average Length of Stay on the Waiver:		365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	event	92	12.00	174.00		
T1016 UB	15 minute	0	1.00	1.00	0.00	
Personal Attendant Services Total:						2025861.00
Personal Attendant Services	15 minute	24	4849.00	4.25	494598.00	
Personal Options Personal Attendant Services	15 minute	16	6582.00	3.75	394920.00	
Personal Attendant Services Modifier	15 minute	24	4849.00	4.25	494598.00	
Personal Attendant Services Personal Options Modifier	15 minute	26	6582.00	3.75	641745.00	
Community Transition Services Total:						2050.00
Community Transition Services	event	1	2050.00	1.00	2050.00	
Environmental Accessibility Adaptations Total:						10000.00
Environmental Accessibility - Home Traditional	event	5	500.00	1.00	2500.00	
Environmental Accessibility - Home Self-Directed	event	5	500.00	1.00	2500.00	
Environmental Accessibility - Vehicle Traditional	event	5	500.00	1.00	2500.00	
Environmental Accessibility - Vehicle Self-Directed	event	5	500.00	1.00	2500.00	
Personal Emergancy Response System Total:						13200.00
Personal Emergancy Response System	monthly rate	22	12.00	50.00	13200.00	
Pre-Transition Case Management Total:						204.00
Pre-Transition Case Management	15 minute	1	24.00	8.50	204.00	
Transportation Total:						9671.76
Transportation	1 mile	16	918.00	0.42	6168.96	
Personal Options Transportation	1 mile	12	695.00	0.42	3502.80	

GRAND TOTAL:	2253082.76
Total Estimated Unduplicated Participants:	96
Factor D (Divide total by number of participants):	23469.61
Average Length of Stay on the Waiver:	365

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:						192096.00
G9002 U2	event	92	12.00	174.00	192096.00	
T1016 UB	15 minute	0	1.00	1.00	0.00	
Personal Attendant Services Total:						2025861.00
Personal Attendant Services	15 minute	24	4849.00	4.25	494598.00	
Personal Options Personal Attendant Services	15 minute	16	6582.00	3.75	394920.00	
Personal Attendant Services Modifier	15 minute	24	4849.00	4.25	494598.00	
Personal Attendant Services Personal Options Modifier	15 minute	26	6582.00	3.75	641745.00	
Community Transition Services Total:						2050.00
Community Transition Services	event	1	2050.00	1.00	2050.00	
Environmental Accessibility Adaptations Total:						8000.00
Environmental Accessibility - Home Traditional	event	4	500.00	1.00	2000.00	
Environmental Accessibility - Home Self-Directed	event	4	500.00	1.00	2000.00	
Environmental Accessibility - Vehicle Traditional	event	4	500.00	1.00	2000.00	
Environmental Accessibility - Vehicle Self-Directed	event	4	500.00	1.00	2000.00	
Personal Emergancy Response System Total:						13200.00
Personal Emergancy Response System	monthly rate	22	12.00	50.00	13200.00	
Pre-Transition Case Management Total:						204.00
Pre-Transition Case Management	15 minutes		24.00	8.50	204.00	

GRAND TOTAL:	2251082.76
Total Estimated Unduplicated Participants:	96
Factor D (Divide total by number of participants):	23448.78
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1				
Transportation Total:						9671.76
Transportation	1 mile	16	918.00	0.42	6168.96	
Personal Options Transportation	1 mile	12	695.00	0.42	3502.80	
		GRAND TOTAL:				2251082.76
		Total Estimated Unduplicated Participants:				96
		Factor D (Divide total by number of participants):				23448.78
		Average Length of Stay on the Waiver:				365

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:						192096.00
G9002 U2	event	92	12.00	174.00	192096.00	
T1016 UB	15 minute	0	1.00	1.00	0.00	
Personal Attendant Services Total:						2025861.00
Personal Attendant Services	15 minute	24	4849.00	4.25	494598.00	
Personal Options Personal Attendant Services	15 minute	16	6582.00	3.75	394920.00	
Personal Attendant Services Modifier	15 minute	24	4849.00	4.25	494598.00	
Personal Attendant Services Personal Options Modifier	15 minute	26	6582.00	3.75	641745.00	
Community Transition Services Total:						2050.00
Community Transition Services	event	1	2050.00	1.00	2050.00	
Environmental Accessibility Adaptations						8000.00
		GRAND TOTAL:				2251082.76
		Total Estimated Unduplicated Participants:				96
		Factor D (Divide total by number of participants):				23448.78
		Average Length of Stay on the Waiver:				365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Environmental Accessibility - Home Traditional	event	4	500.00	1.00	2000.00	
Environmental Accessibility - Home Self-Directed	event	4	500.00	1.00	2000.00	
Environmental Accessibility - Vehicle Traditional	event	4	500.00	1.00	2000.00	
Environmental Accessibility - Vehicle Self-Directed	event	4	500.00	1.00	2000.00	
Personal Emergancy Response System Total:						13200.00
Personal Emergancy Response System	monthly rate	22	12.00	50.00	13200.00	
Pre-Transition Case Management Total:						204.00
Pre-Transition Case Management	15 minutes	1	24.00	8.50	204.00	
Transportation Total:						9671.76
Transportation	1 mile	16	918.00	0.42	6168.96	
Personal Options Transportation	1 mile	12	695.00	0.42	3502.80	
				GRAND TOTAL:		2251082.76
				Total Estimated Unduplicated Participants:		96
				Factor D (Divide total by number of participants):		23448.78
				Average Length of Stay on the Waiver:		365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						192096.00
G9002 U2	event	92	12.00	174.00	192096.00	
T1016 UB	15 minute				0.00	
				GRAND TOTAL:		2251082.76
				Total Estimated Unduplicated Participants:		96
				Factor D (Divide total by number of participants):		23448.78
				Average Length of Stay on the Waiver:		365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		0	1.00	1.00		
Personal Attendant Services Total:						2025861.00
Personal Attendant Services	15 minute	24	4849.00	4.25	494598.00	
Personal Options Personal Attendant Services	15 minute	16	6582.00	3.75	394920.00	
Personal Attendant Services Modifier	15 minute	24	4849.00	4.25	494598.00	
Personal Attendant Services Personal Options Modifier	15 minute	26	6582.00	3.75	641745.00	
Community Transition Services Total:						2050.00
Community Transition Services	event	1	2050.00	1.00	2050.00	
Environmental Accessibility Adaptations Total:						8000.00
Environmental Accessibility - Home Traditional	event	4	500.00	1.00	2000.00	
Environmental Accessibility - Home Self-Directed	event	4	500.00	1.00	2000.00	
Environmental Accessibility - Vehicle Traditional	event	4	500.00	1.00	2000.00	
Environmental Accessibility - Vehicle Self-Directed	event	4	500.00	1.00	2000.00	
Personal Emergancy Response System Total:						13200.00
Personal Emergancy Response System	monthly rate	22	12.00	50.00	13200.00	
Pre-Transition Case Management Total:						204.00
Pre-Transition Case Management	15 minutes	1	24.00	8.50	204.00	
Transportation Total:						9671.76
Transportation	1 mile	16	918.00	0.42	6168.96	
Personal Options Transportation	1 mile	12	695.00	0.42	3502.80	

GRAND TOTAL:	2251082.76
Total Estimated Unduplicated Participants:	96
Factor D (Divide total by number of participants):	23448.78
Average Length of Stay on the Waiver:	365