CHAPTER 502 CHILDREN WITH SERIOUS EMOTIONAL DISORDER WAIVER (CSEDW)

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BACKGROUND

The Bureau for Medical Services (BMS) in the West Virginia Department of Human Services (DoHS) is the single state agency responsible for administering the Medicaid program. The West Virginia Medicaid program is administered pursuant to provisions of Title XIX of the Social Security Act and Chapter 9 of the West Virginia Code.

Medicaid offers a comprehensive scope of medically necessary physical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all state and federal requirements. Enrolled providers are subject to review of services provided to Medicaid members to determine whether the services require prior authorization. All providers of services must maintain current, accurate, legible, and completed documentation to justify the medical necessity of services provided to each Medicaid member and made available to the BMS or its designee upon request.

This Chapter sets forth requirements for payment of services provided under the Children with Serious Emotional Disorder Waiver (CSEDW) program to eligible West Virginia children and adolescents. These members may or may not be eligible for other Medicaid-covered services found in other chapters of the BMS Provider Manual. It is the responsibility of the wraparound facilitator and the child and family team to help the family or legal guardian obtain any additional services and/or support available under the West Virginia Medicaid State Plan. Any service, procedure, item, or situation not discussed in this chapter must be presumed non-covered under the waiver.

All Medicaid-enrolled providers should coordinate care if a Medicaid member receives different Medicaid services at separate locations with other providers to help ensure that quality care is taking place, and that safety is at the forefront of the member's treatment.

PROGRAM DESCRIPTION

The CSEDW is a Medicaid Home and Community-Based Services (HCBS) waiver program authorized under §1915(c) of the Social Security Act. The purpose of the CSEDW is to support children/adolescents with serious emotional disorders who are three years through 20 years of age and their families to develop and/or strengthen skills that will help them be successful in their home and communities as well as to avoid or shorten the length of stay in acute care facilities, such as a psychiatric residential treatment facility (PRTF). Services are person-centered, with plans of care created in partnership with the child/adolescent and their family/legal guardian using the National Wraparound Implementation Center (NWIC) model. These services are in addition to Medicaid State Plan coverage. All participants in the CSEDW must meet eligibility requirements as described in 502.14 CSEDW Applicant Eligibility.

The NWIC model is strengths-based, which uses the strengths of families and individuals as a starting point for growth and change, with a goal of helping waiver members and their families develop skills to cope with challenges and stabilize members in their homes. The model is also centered around the needs of the child/adolescent in CSEDW and their family/legal guardian. The child/adolescent experiencing challenging behaviors is central to the process and engaged in a plan to help develop the skills necessary to achieve stability and improve coping strategies, ideally enabling the member to achieve their personal goals. There are 10 principles of the wraparound process:

1. **Family Voice and Choice -** Family/legal guardian and child/adolescent perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members/legal guardians' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.
2. **Team-Based -**The wraparound team consists of individuals, agreed upon by the family/legal guardian and committed to the child/adolescent, through informal, formal, and community support and service relationships.
3. **Natural Supports -** The team actively seeks and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.
4. **Collaboration -** Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work toward meeting the team's goals.
5. **Community-Based -**The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child/adolescent and family integration into home and community life.
6. **Culturally Competent -**The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/adolescent, family, legal guardian, and their community.
7. **Individualized -**To achieve the goals in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.
8. **Strengths-Based -** The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child/adolescent and family/legal guardian, their community, and other team members.
9. **Unconditional -** A wraparound team does not give up on, blame, or reject children/adolescents, and their families or legal guardians. When faced with challenges or setbacks, the team continues working toward meeting the needs of the child/adolescent and family/legal guardian and toward achieving the goals in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer necessary.
10. **Outcome-Based -**The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success; monitors progress in terms of these indicators and revises the plan accordingly.

The CSEDW is a short-term highly intensive HCBS that allows children/adolescents and their families/legal guardians to receive services and support, comparable to in-patient psychiatric care. The length of enrollment in the CSEDW is based upon individual needs, with an average (continuous) enrollment of nine to 12 months. Eligibility in the CSEDW is re-established annually and reassessment must occur prior to a child/adolescent's anchor date to continue receiving services. The CSEDW is comprised of multiple services that are intended to complement but not duplicate the State Plan Amendment (SPA) or school-based health services. Every child/adolescent in the CSEDW will have a wraparound facilitator, see Section 502.18.1 Wraparound Facilitation. The wraparound facilitator works in partnership with the child/adolescent and their family/legal guardian and the rest of the wraparound team to identify and develop a plan of care that includes family voice and choice, person-centered goals, supports, and potential known barriers. The wraparound facilitator will discuss potential HCBS that can

support the child/adolescent in achieving their goals and develop the skills to help them remain in their home and community.

The Centers for Medicare & Medicaid Services (CMS) requires all HCBS Waiver programs to:

- Demonstrate that providing waiver services in the home and community will not cost the State or the CMS more than providing services alike in an institutional or hospital setting.
- Ensure the protection of health and welfare through regular contact and engagement with the child/adolescent and family/legal guardian.
- Provide adequate and reasonable provider standards to meet the needs of the target population.
- Ensure that services follow an individualized and person-centered plan of care.

502.1 BMS CONTRACTUAL RELATIONSHIPS

The BMS operates the CSEDW in conjunction with the West Virginia Specialized Youth in Foster Care §1915(b) managed care program, and utilization management will be managed by one identified managed care organization (MCO).

The BMS contracts with an administrative service organization (ASO) that acts as an agent of the BMS and administers the CSEDW program. The ASO screens potential waiver applicants during the initial eligibility determination process and provides data to the contracted medical eligibility contracted agent (MECA) to facilitate both initial evaluations and annual redeterminations of medical eligibility. The MECA recruits and trains licensed clinicians to participate in the Independent Evaluator Network (IEN). The ASO conducts education for CSEDW providers, children/adolescents, families/legal guardian, advocacy groups, and the Department of Human Services (DoHS). At times, the ASO, in collaboration with the BMS, will provide answers to policy questions. These policy clarifications are posted on the CSEDW website.

When a child/adolescent is found eligible, the ASO will notify the MCO administering the CSEDW. If a waiver slot is not immediately available, the ASO and MCO will refer the child/adolescent and family to appropriate interim services, including other Medicaid services.

The West Virginia Medicaid Management Information System (MMIS) contractor is responsible for enrollment of all Medicaid providers that then must contract with the identified MCO to provide CSEDW services. All Medicaid providers must contract with the identified MCO prior to initiating CSEDW services with enrolled members.

Please refer to the CSEDW website for ASO and MECA contact information.

502.2 MEDICAL NECESSITY

All CSEDW services covered in this chapter are subject to a determination of medical necessity defined as services and supplies that are:

- Appropriate and medically necessary for the symptoms, diagnosis, or treatment of an illness
- Provided for the diagnosis or direct care of an illness
- Within the standards of good practice
- Not primarily for the convenience of the child/adolescent or provider

- The most appropriate level of care that can be safely provided

Medical necessity must be demonstrated throughout the provision of services. For these types of services, the following five factors will be included as part of this determination:

1. Diagnosis (as determined by a physician or licensed psychologist)
2. Level of functioning
3. Evidence of clinical stability
4. Available support system
5. Appropriate level of care

Consideration of these factors in the plan of care process must be documented and reevaluated at regular plan of care updates. Nationally recognized evidence-based diagnostic and standardized instruments may be administered at the initial evaluation and as clinically indicated. The results of these measures must be available as part of the clinical record, as part of the documentation of the need for the service, and as justification for the level and type of service provided.

Providers rendering services that require prior authorization must receive authorization before rendering all services. Prior authorization does not guarantee payment for services rendered.

502.3 PROVIDER ENROLLMENT AND PARTICIPATION REQUIREMENTS

All Medicaid providers must meet the provider enrollment requirements in *Chapter 300, Provider Participation Requirements*.

To become a CSEDW provider agency, an agency must also apply for a Certificate of Need through an expedited Summary Review process and be approved by the West Virginia Health Care Authority. Then, the agency must obtain a behavioral health license through the Office of Health Facility Licensure and Certification (OHFLAC).

The CSEDW waiver service providers must also enroll with the MCO that manages the West Virginia Specialized Youth in Foster Care §1915(b) managed care program. See *Chapter 527, Section 527.9 Mountain Health Promise (Managed Care)*.

502.3.1 Comprehensive Behavioral Health Center (CBHC) And Licensed Behavioral Health Center (LBHC) Administration

CBHCs and LBHCs must develop and maintain a Credentialing Committee composed of the clinical supervisor and/or certified staff representative of the disciplines or practitioners within the agency. See *Chapter 503, Licensed Behavioral Health Centers* for duties and responsibilities of the committee. To apply for LBHC designation, contact the West Virginia Health Care Authority at 304-558-7000.

502.3.2 CSEDW Medical Eligibility Evaluator Staff Qualifications

Independent evaluators, including psychologists, supervised psychologists, licensed independent clinical social workers, and licensed professional counselors, must be licensed to practice independently and must follow the internal regulations of their accrediting body, licensing board, and/or certification board,

and be enrolled in West Virginia Medicaid. The MECA is responsible for ensuring these providers are qualified.

Psychologists on the West Virginia Board of Examiners of Psychologists approved list of supervisors may only bill for up to four supervised psychologists. Board-approved supervisors may not "trade" supervisees for billing Medicaid services.

502.3.3 CSEDW Service Providers – Staff Qualifications

These requirements apply to all CSEDW provider employees that will be providing services to any children/adolescents in CSEDW. The employing provider shall ensure that all new staff receive an orientation within the first 10 days of employment and shall document that orientation in each individual employee's personnel record. The orientation shall include an introduction to the staff person's primary job responsibilities and requirements. Staff must be age 18 or over; able to perform the job tasks as mandated by the Office of Health Facility Licensure and Certification (OHFLAC) and the BMS; have, upon hire, acceptable fingerprint-based background checks; and have been verified to not appear on the Federal Office of the Inspector General (OIG) Medicaid Exclusion List. See Section 502.4 Criminal Background Checks of this manual for specific information related to fingerprint-based background check requirements.

Documentation, including required licenses; certifications; proof of completion of training; collaborative agreements for prescriptive authority, if applicable; proof of psychiatric certification, as applicable; and any other materials substantiating an individual's eligibility to perform as a practitioner, must be kept on file at the agency location where services are provided.

In addition to orientation, the CSEDW provider employees must receive training detailed in Figure 1 within 30 calendar days of the initial employment date and annual employment anniversary date.

Figure 1. Required Provider Trainings

Required CSEDW Trainings *must include a competency component (i.e., post-test with a score of 80% or above)*		
Frequency	**Responsibility**	**Required Trainings**
Upon Hire and within 10 days of hire date	All CSEDW HCBS providers	• The provider agency's mission, philosophy, and goals • The provider agency's services, policies, and procedures • The provider agency's organizational structure, including lines of accountability and authority related to the employee • Universal precautions • Documentation procedures • Conflict-Free Wraparound Facilitation Training (DoHS 301 and DoHS 305) • Fire drills and evacuation procedures (if applicable) • Procedures for medical and other emergencies • Person-specific needs, including health/welfare, medical, and home and community-based services

Required CSEDW Trainings *must include a competency component (i.e., post-test with a score of 80% or above)*		
		• Psychiatric emergency procedures and management including systematic de-escalation
Ongoing and Verified Annually	All CSEDW HCBS providers	• Cardiopulmonary resuscitation (CPR) and first aid from DoHS-approved training providers that include manual demonstration relevant to the age of the population served under the waiver • Crisis intervention and emergency intervention • Recognition and reporting suspected abuse, neglect, and exploitation • Training on member rights • Crisis planning • Emergency and disaster preparedness • Infectious disease/infection control • Person-specific needs, including health/welfare, medical, and home and community-based services • Trauma-informed care and practice • Cultural competency • Confidentiality • Direct-care ethics • High fidelity wraparound models through the West Virginia Wraparound Training Center for Wraparound Facilitators
Within One Month of Hire	Wraparound Facilitators	• First Aid and CPR • Crisis intervention and restraint • Suspected abuse and neglect • Member Rights • Crisis planning • Emergency and disaster preparedness • Infectious disease/infection control • Person-centered/person-specific needs • Trauma informed care • Cultural competency
Upon Hire and Verified Annually	Wraparound Facilitators	• CANS Certification • Providing Wraparound Services in Alignment with the National Wraparound Initiative's Principles Training • First Aid/CPR Certification • Crisis intervention and restraints • Suspected abuse and neglect • Member rights • Crisis planning • Emergency and disaster preparedness • Infectious disease/infection control • Person-centered planning/person-specific needs

Required CSEDW Trainings *must include a competency component (i.e., post-test with a score of 80% or above)*		
		• Trauma informed care • Statewide transition planning

CPR and first aid training must be renewed subsequently as required by the expiration date on the card supplied by the approved agency.

Mandatory CSEDW program training for all agency staff must be documented on the Certificate of Training form (WV-BMS-CSED-06) unless an agency has a system for tracking training that includes all information on the form. The system must be available for review by the BMS or upon request.

Additional staff qualifications are indicated under the service descriptions under provider qualifications in this chapter. All documentation for staff, including college transcripts, certifications, credentials, background checks, and documentation of training should be kept in the staff's personnel file. The BMS, its contractors, or state and federal auditors may review them at any time.

502.4 CRIMINAL BACKGROUND CHECKS

Please see *Chapter 700, West Virginia Clearance for Access: Registry & Employment Screening (WV CARES),* for fingerprint-based background check requirements.

502.5 ELECTRONIC VISIT VERIFICATION (EVV)

As required by the Cures Act, the BMS implemented an Electronic Visit Verification (EVV) system to verify in-home visits. The EVV system documents the following items:

- Individual receiving the service
- Type of service performed
- Date of the service
- Location of service delivery
- Individual providing the service
- Time the service begins
- Time the service ends

For services requiring EVV, provider employees use the system to check in at the beginning of the service. At the end of the service, the child/adolescent or family/legal guardian will use the system to verify the service has been recorded correctly. The EVV solution is secure, minimally burdensome, and does not constrain member selection of a provider or the manner of care delivery. A guide for the use of EVV is available at on the HHAeXchange's Preparing West Virginia for EVV Guide.

Use of EVV is required for the following CSEDW services:

- Out of home respite
- Independent living/skills building

Staff providing services that require EVV must obtain an individual National Provider Identifier (NPI) number to utilize the EVV system.

502.6 INCIDENT REPORTING REQUIREMENTS

All incident reporting requirements for CSEDW are adherent to state and federal guidelines and subject to change. The comprehensive and up-to-date incident reporting guidelines for this waiver are available on the CSEDW website. The CSEDW provider must also comply with any other reporting required for mandatory reporters or as part of their behavioral health license.

Incidents should be reported to the MCO according to the incident management reporting policy described in this section.

There are two types of incidents, non-critical and critical, as defined below. The CSEDW providers must report critical incidents to the MCO immediately and within 24 hours of the provider becoming aware of the occurrence. Non-critical incidents must be reported by the CSEDW providers within five calendar days of becoming aware of the occurrence:

- **Non-Critical Incidents:** Incidents that do not create an immediate risk of serious consequence or harm for waiver children/adolescents requiring immediate response from child protective services (CPS)/adult protective services (APS), law enforcement, or emergency medical personnel. Non-critical incidents are divided into two subcategories: reportable events and non-reportable events.
    - **Reportable Events:** These non-critical incidents are any unusual event or injury of unknown origin involving a waiver child/adolescent that needs to be recorded and analyzed for risk management or quality improvement purposes but does not meet the definition of abuse, neglect, or critical incident. Reportable events do not require an immediate response by law enforcement, CPS/APS, or emergency medical personnel.
    - **Non-reportable Events:** These non-critical incidents do not have the potential to impact the waiver child/adolescent's health, safety, or welfare and do **not** need to be reported. Mandated reporters and family children/adolescents should use good judgment when considering whether an event rises to the level of being reportable. If a mandated reporter is unsure whether the incident is reportable, they should complete a report. However, events where there is no need for medical attention or investigation are screened out.
- **Critical Incidents:** Incidents that are serious in nature and pose immediate risk to health, safety, or welfare of children/adolescents or others. These incidents require in-depth investigation, an expedited timeline, and, possibly, additional resources. Critical incidents include instances of suspected abuse, neglect, and exploitation.
- **Abuse, Neglect, and Exploitation Incidents:** Incidents that meet the following definitions of abuse, neglect, or exploitation:
    - Abuse means any physical motion or action (hitting, slapping, punching, kicking, pinching, etc.) by which bodily harm or trauma occurs. It includes the use of corporal punishment as well as the use of any restrictive intrusive procedure to control inappropriate behavior for purposes of punishment.

- Abuse also includes psychological abuse, which means humiliation, harassment, and threats of punishment or deprivation, sexual coercion, intimidation, whereby individuals suffer psychological harm or trauma.
- Abuse also includes verbal abuse, which means use of oral, written, or gestured language by which abuse occurs. This includes demeaning and derogatory terms to describe persons with disabilities. Verbal abuse includes, but is not limited to, yelling, or using demeaning, derogatory, vulgar, profane, or threatening language; threatening tones in speaking; teasing, pestering, molesting, deriding, harassing, mimicking, or humiliating a person in any way; and making sexual innuendo.
- Neglect means a negligent act or pattern of actions or events that caused or may have caused injury or death to a person or may have placed a person at risk of injury or death that was committed by an individual responsible for providing services. Neglect includes, but is not limited to, a pattern of failure to establish or carry out a person's individualized program plan or treatment plan that placed or may have placed a person at risk of injury or death; a pattern of failure to provide adequate nutrition, clothing, or health care; failure to provide a safe environment; and failure to maintain sufficient, appropriately trained staff.
- Exploitation means the unlawful expenditure or willful dissipation of the funds or assets designated for the benefit of an incapacitated individual.

Abuse, Neglect, and Exploitation

Anyone providing CSEDW services who suspects an incidence of abuse, neglect, or exploitation is mandated to report the incident by Behavioral Health Centers Licensure Legislative Rules (Title 64 Series 11), WV State Code §9-6-1, §9-6-9 and § 49-2-803. Reports may be made anonymously to protective services by calling 1-800-352-6513, seven days a week, 24 hours a day.

The CSEDW provider must also report suspected incidence of abuse and neglect to OHFLAC by telephone at 304-558-0050 or reports may be faxed to 304-558-2515. The OHFLAC may assist with referring the report to the proper authorities.

Death of a Child/Adolescent

The wraparound facilitation provider must submit a Mortality Notification (WV-BMS-CSED-11) to OHFLAC within 24 hours, to the ASO and MCO within seven calendar days, of the child/adolescent's death or when the CSEDW provider becomes aware of the child/adolescent's death. WV Code requires a report to the medical examiner or coroner when there is probable cause to believe that a child/adolescent has died due to abuse or neglect.

Provider Documentation of Incidents

The CSEDW providers are expected to retain evidence that an incident was reported to the MCO within required time frames to all applicable entities and that the incident report is in the child/adolescent's record for each reported incident.

Wraparound facilitators are expected to follow up with law enforcement and other entities, as needed, to support safety and to document these contacts in case notes. When there is an investigation of an incident by law enforcement, the child/adolescent and family/legal guardian are to be updated on the

investigation, as appropriate. For each incident recorded in the MCO's Incident Management System (IMS), there is a copy of the incident report in the child/adolescent's file and, correspondingly, for each incident in the child/adolescent's file, there is documentation recorded in the MCO's IMS of the incident.

502.7 CLINICAL SUPERVISION

The purpose of clinical supervision for CBHCs and LBHCs is to improve the quality of services for every member while helping ensure adherence to West Virginia Medicaid policy; therefore, the provider must have a policy for clinical supervision. See *Chapter 503, Licensed Behavioral Health Centers*, for clinical supervision requirements.

502.8 METHODS OF VERIFYING MEDICAID REQUIREMENTS

Enrollment requirements, as well as the provision of services, are subject to review by the BMS and/or its contracted agents. The BMS contracted agents may promulgate and update utilization management guidelines that the BMS has reviewed and approved. These approved guidelines function as policy. Additional information governing the surveillance and utilization control program may be found in *Chapter 100, General Information*, and is subject to review by State and federal auditors.

502.9 TRAINING AND TECHNICAL ASSISTANCE

The BMS contracted agent, the MCO, and the State-approved West Virginia Wraparound Training Center develops and conducts training as necessary for the CSEDW providers, the MECA, independent evaluators, and other interested parties to improve systemic and provider-specific quality of care and regulatory compliance. The Administrative Services Organization (ASO) provides training and technical assistance for providers on the forms used and based on the retrospective record reviews. Training is approved by the BMS and available via both face-to-face and web-based venues. Links to the CSEDW required trainings are available on the CSEDW website.

Please refer to Section 502.3.3 CSEDW Service Providers – Staff Qualifications for information on documenting required training.

502.10 CONFIDENTIALITY

An appropriate release of information form must be obtained and approved prior to sharing information in any situation other than those described here. Access to medical records is limited to the child/adolescent, family/legal guardian, authorized facility personnel, and others outside the facility whose request for information access is permitted by law and is covered by assurances of confidentiality and whose access is necessary for administration of the facility and/or services and reimbursement.
A child/adolescent may review their medical record in the presence of professional personnel of the facility and on the facility premises. The review must be conducted in a manner that protects the confidentiality of other family members and other individuals whose contacts may be contained in the record. Access to medical records is limited and should be available on a medical need-to-know basis and as permitted under federal and state law and any relevant court rulings.

Pictures of Medicaid members may be used for identification purposes only (contained in the member medical record and medication administration record). Usage for any other purposes, including public

displays, social media posts, or for promotional materials, are prohibited. All Medicaid member information must be kept locked in a secure place.

502.10.1 Health Insurance Portability and Accountability Act (HIPAA) Regulations

Providers must comply with all requirements of the HIPAA and all corresponding federal regulations and rules. The enrolled provider will provide, upon the request of the BMS, timely evidence and documentation that they comply with HIPAA. The form of the evidence and documentation to be produced is at the sole discretion of the BMS. Additional information on HIPAA may be found in *Chapter 300, Provider Participation Requirements*.

502.10.2 Documentation and Record Retention Requirements

Documentation and record retention requirements governing the provision of all West Virgnia Medicaid services will apply pursuant to *Chapter 100, General Information*, and *Chapter 300, Provider Participation Requirements*, of the BMS Provider Manual. Providers must also comply, at a minimum, with the following documentation requirements:

- Providers must maintain a specific record for each service rendered in the child/adolescent record including, but not limited to:
    - Name
    - Address
    - Birth date
    - Medicaid identification number
    - Pertinent diagnostic information
    - A current Plan of Care signed by the provider in ink or in an electronic documentation system that includes a time and date stamp
    - Name of service provider
    - Credentials of staff providing the service
    - Service provided
    - Service code
    - Documented description of services provided
    - Date of service
    - Accurate start and stop time of service delivery
    - Signature and credential of the provider in ink or in electronic documentation system that includes a time and date stamp
- All required documentation must be maintained for at least five years in the provider's file and subject to review by authorized BMS personnel or the BMS contracted agent. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years, whichever is greater.
- Failure to maintain all required documentation may result in the disallowance and recovery by the BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to the BMS upon request.
- Providers must also comply with the specific documentation requirements for the program or service procedure, as described in this manual.

- The BMS recognizes that some providers use an electronic system to create and store documentation, while other providers choose to use a hard copy-based system. Regardless of the system the provider is using, those using an electronic-based system will require an electronic signature with a time date stamped on the documentation. Each service code in this manual describes the required documentation. All requirements must be met no matter the modality of system choice. Any document that is printed must have a handwritten signature and be dated.

502.11 QUALITY IMPROVEMENT SYSTEM (QIS)

The BMS is responsible for building and maintaining the CSEDW QIS. The CSEDW provider is responsible for participating in all activities related to the QIS. The CSEDW QIS is used by the BMS and the ASO as a continuous system that measures system performance, tracks remediation activities, and identifies opportunities for system improvement. Achieving and maintaining program quality is an ongoing process that includes collecting and examining information about program operations and outcomes, and then using the information to identify strengths and weaknesses in program performance. This information is used to form the basis of remediation and improvement strategies.

The QIS is designed to collect the data necessary to provide evidence that the CMS quality assurances are being met and to help ensure the active involvement of interested parties in the quality improvement process.

502.11.1 Centers for Medicare & Medicaid Services Quality Assurances

The CMS mandates the CSEDW program to meet the following six quality assurances:

1. **CSEDW Administration and Oversight:** The State Medicaid agency is actively involved in the oversight of the CSEDW and is ultimately responsible for all facets of the CSEDW program.
2. **Level of Care:** Children/adolescents enrolled in the CSEDW have needs consistent with an institutional or hospital Level of Care.
3. **Provider Qualifications: The** CSEDW providers are qualified to deliver services/supports.
4. **Plan of Care:** A child/adolescent has a Plan of Care that is appropriate to their needs and preferences and receives the services/supports specified in the Plan of Care.
5. **Health and Welfare:** A child/adolescent's health and welfare are safeguarded.
6. **Financial Accountability:** Claims for CSEDW services are paid according to state payment methodologies specified in the approved waiver.

Data is collected and analyzed for all the Quality Assurances and sub-assurances based on West Virginia's Quality Performance Indicators, as approved by the CMS. The primary sources of discovery include the CSEDW provider reviews, service utilization from claims reporting, the MCO reporting, incident management reports, complaints and/or grievances of children/adolescents who receive services or the family/legal guardian OHFLAC reviews, abuse and neglect reports, administrative reports, oversight of delegated administrative functions, and interested party input.

502.11.2 Quality Improvement Advisory Council

The Quality Improvement Advisory (QIA) Council comprised of individuals, who formerly utilized CSEDW services, children/adolescents who currently are utilizing CSEDW services or parents/legal guardians,

service providers, advocates, and other interested parties of people with serious emotional disorders. The council aims to have a minimum of 15 members, with at least five being actively involved in the program. The ASO facilitates the creation of the QIA Council and is responsible for membership and recruitment. The ASO provides information for the council based upon annual reviews. No member of the council may financially benefit from activities sanctioned by the group.

The QIA Council plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies. The QIA Council's role is to advise and assist the BMS, the MCOs, and the ASO staff in program planning, development, and evaluation consistent with its stated purpose. In this role, the QIA Council uses the CSEDW Performance Indicators as a guide to:

- Recommend policy changes
- Recommend waiver priorities and quality initiatives
- Monitor and evaluate policy changes
- Monitor and evaluate the implementation of waiver priorities and quality initiatives
- Serve as a liaison between the waiver and interested parties
- Establish committees and work groups consistent with the QIA Council's purpose and guidelines
- Share positive and negative feedback on the program based on member experience

502.12 PROVIDER REVIEWS

Monitoring the quality and performance of the CSEDW includes provider reviews conducted by the ASO as determined by a defined 12-month review cycle.

The ASO performs on-site and desk documentation provider reviews, staff interviews, telephone satisfaction surveys with children/adolescents who receive services and/or their parent/legal guardian, to validate certification documentation and address the CMS quality assurance standards. Targeted on-site CSEDW provider reviews and/or desk reviews may be conducted by OHFLAC and/or the ASO in follow-up to incident management reporting, complaint data, corrective action plan, etc.

Prior to beginning the provider reviews, the ASO will identify the time frame for review for each provider based upon the time frame elapsed since the last review. The ASO will request a universe of children/adolescents served (and employees providing CSEDW services) over the sample time-period from the provider. The ASO will request CSEDW claims data reports from the MCO for the 10% representative sample of selected employees and children/adolescents. During the review, the ASO will compare the claims data to the provider and employee records and include any discrepancies between provider records and claims in their findings.

Upon completion of each provider review, the ASO conducts a face-to-face exit summation with staff as chosen by the provider to attend. Within two weeks of the exit summation, the ASO will make available to the provider a draft exit report and a corrective action plan (CAP) to be completed by the CSEDW provider. If there are no potential disallowances identified, then a CAP is not necessary. If potential disallowances are identified, the CSEDW provider will have 30 calendar days from receipt of the draft exit report to send any necessary information/documentation, comments related to disallowances, and the completed CAP back to the ASO. If a CAP is not submitted within the 30-day comment period, BMS may place a hold on payments for services. After the 30-day comment period has ended, the BMS will review the draft report, and any comments submitted by the CSEDW provider and issue a final report to the

CSEDW provider's executive 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 CSEDW services. A cover letter to the CSEDW provider's executive director will outline the following options to effectuate repayment:

- Payment to the BMS or designee within 60 calendar days after the BMS notifies the provider of the overpayment
- Placement of a lien by the BMS or designee against further payments for Medicaid reimbursements so that recovery is effectuated within 60 calendar days after notification of the overpayment
- A recovery schedule of up to a 12-month period through monthly payments or the placement of a lien against future payments

If the CSEDW provider disagrees with the final report, the CSEDW provider may request a document/desk review within 30 calendar days of receipt of the final report pursuant to the procedures in *Chapter 100, General Information*, of the West Virginia Medicaid Provider Manual. The CSEDW provider must still complete the written repayment arrangement within 30 calendar days of receipt of the final report, but scheduled repayments will not begin until after the 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.

The letter must be addressed to:

Bureau for Medical Services
Legal Department
350 Capitol St., Room 251
Charleston, WV 25301-3706

If no potential disallowances are identified during the ASO review, then the CSEDW provider will receive a final letter and a final report from the BMS and designee.

For information relating to additional audits that may be conducted for services contained in this chapter, please see *Chapter 800, Program Integrity*, of the BMS Provider Manual that identifies other state/federal auditing bodies and related procedures.

CAP

In addition to the draft exit report sent to the CSEDW providers, the ASO will also send a draft CAP electronically. CSEDW providers are required to complete the CAP and electronically submit a CAP to the ASO for approval within 30 calendar days of receipt of the draft CAP from the ASO. The BMS may place a hold on claims if an approved CAP is not received by the ASO within the specified time frame. The CAP must include:

- How the deficient practice for the provider cited in the deficiency will be corrected
- What system will be put into place to help prevent recurrence of the deficient practice
- How the provider will monitor to help ensure future compliance and who will be responsible for monitoring
- The date the CAP will be completed
- Any provider-specific training requests related to the deficiencies

502.12.1 Self-Audit

The CSEDW providers have an ethical and legal duty to ensure the integrity of their partnership with the Medicaid program. This duty includes an obligation to examine and resolve instances of noncompliance with program requirements through self-assessment and voluntary disclosures of improper use of state and federal resources. A self-audit must be conducted when:

- The provider becomes aware there was a noncompliance issue, and/or
- A self-audit is assigned by the BMS or the Office of Program Integrity (OPI).

Providers must use the approved format for submitting self-audits to the OPI. Failure to submit an assigned self-audit may result in the MCO withholding Medicaid payments until the self-audit is submitted. Providers are required to send completed Self Report and Standard Repayment Provision forms in an electronic format to OPI. This information is not to be submitted to the program manager.

- For information concerning other audit authorities relevant to services provided under this chapter or sanctions available to the BMS, please see *Chapter 800, Program Integrity*. Forms necessary to complete a self-audit can be found on the OPI website.

502.13 OTHER ADMINISTRATIVE REQUIREMENTS

The provider is responsible for maintaining compliance with the BMS policies and procedures pertaining to documentation and case record review as well as the following:

- All documentation completed must be maintained in the individual record, whether electronic or written, and must be legible.
- Staff must use uniform guidelines for case record organization, so similar information will be found in the same place from case record to case record and can be quickly and easily accessed. Copies of completed release of information forms and consent forms must be filed in the case record.
- Records must contain complete identifying information.
- The Plan of Care must comply with all Child and Family Team (CFT) planning requirements and must contain service goals and objectives, which are derived from a comprehensive assessment and must stipulate the planned service activities and how they will assist in goal attainment, including frequency, scope setting, and duration of CSEDW services.
- Planning for transitioning out of CSEDW services must begin from the first meeting.
- Prior to the retrospective review, all records requested must be presented to the reviewers completing the retrospective review.
- If requested, the providers must provide copies of Medicaid member records within one business day of the request.
- Providers must facilitate the records access that is requested as well as equipment that may need to be utilized to complete the Comprehensive Retrospective Review Process.
- Providers must provide a point of contact throughout the Comprehensive Retrospective Review Process.
- In addition to the documentation requirements described in this chapter, the CSEDW service providers must comply with the documentation and maintenance of records requirements

described in *Chapter 100, General Information; Chapter 300, Provider Participation Requirements* and 64 CSR 11, Behavioral Health Centers Licensure.

- Documentation of services provided in this manual must demonstrate only one staff person's time is billed for any specific activity provided to the child/adolescent.
- An electronic signature is an acceptable form of submission if it contains a time and date stamp.
- Provider training between the CSEDW providers is not considered as a direct medical service and cannot be reimbursed. The cost for those activities is considered administrative and has already been included in the service rate.
- Some services allow for telehealth delivery and are listed in Section 502.20 Telehealth Modalities and Service Provisions.
- Wraparound facilitation is in part an indirect service and can be reimbursed for activities including, but not limited to coordination and CFT contacts. Allowed activities for reimbursement are included in the service definition.
- Providers must subcontract with licensed individual, or group practices of the behavioral health profession as defined by the OHFLAC, if contracting occurs.
- Providers must maintain evidence of implementing a utilization review and quality improvement process, which includes ongoing verification that services have been provided and the quality of those services meets the standards of the CSEDW program and all other applicable licensing and certification bodies.
- Providers must provide an assigned agency CSEDW contact person whose duties include:
    - Oversight of agency staff implementing the Plans of Care in the CSEDW program
    - Monitoring service utilization throughout the service year
    - Verifying that services delivered are reflected both in the Plan of Care and CSEDW agency electronic records/reporting systems and are not being over- or underutilized based on the current juncture in the service year
    - Communicating with the BMS, the MCO, and the ASO
- Providers must implement the CSEDW QIS as further defined under Section 502.11.2 Quality Improvement Advisory (QIA) Council.
- Conflict-free wraparound facilitation must be provided when the same entity is assisting both a child/adolescent and their family/legal guardian to gain access to services and providing services. There must be appropriate safeguards and "firewalls" in place to mitigate risk of potential conflict. Additionally, the entity has the "firewalls" in policies and practice to ensure that those establishing access to services are not the same staff providing the services. Staff that determine access and those that provide the services are separated by different supervision, oversight, and decision-makers.
- Providers must maintain written policies and procedures to avoid conflict of interest (if the agency is providing wraparound facilitation and other services) that must include at a minimum:
    - Education of wraparound facilitators on general conflict of interest/professional ethics with verification
    - Annual signed conflict of interest statements for all wraparound facilitators and the wraparound facilitation agency director
    - Process for investigating reports on conflict of interest
    - Process for reporting to the BMS
    - Process for complaints to professional licensing boards for ethics violations
- If a wraparound facilitator agency asks for an exception to exceed the maximum caseload capacity of 15 children/adolescents due to staff vacancy, the wraparound facilitator must ensure

their caseload includes at least 10 active members before placing anyone on a waitlist. The wraparound facilitator must also notify the MCO within 48 hours of learning of the need to exceed the maximum by providing the following in writing to the MCO:
    - The number of children/adolescents per wraparound facilitator whose caseload exceeds 15 children/adolescents (e.g., wraparound facilitator name, number of children/adolescents)
    - The agency plan, including timelines for hiring and training new wraparound facilitators
    - The agency's backup plan to cover emergencies that occur due to exceeding the maximum caseload capacity
- Children/adolescents who are on hold do not count toward the wraparound facilitator's caseload capacity of 15. A wraparound facilitator must have a caseload of 10 active cases and may have up to five cases on hold that they previously supported. The on-hold cases must be reviewed every 90 days. If a child/adolescent received a service and is on hold, then the wraparound facilitator must maintain the case within their caseload.
- Staff training documentation must include training topic, date, the beginning time of the training, the ending time of the training, the location of the training, the signature of the instructor, and the signature of the trainee. Internet training must include the person's name, the name of the online training provider, and a certificate of completion or other documentation showing successful completion. All documented evidence of training for all staff who deliver CSEDW services must be kept on file and available upon request.
- Prior to using an online training provider to meet training requirements, the name, web address, and course names must be submitted to the ASO for review. The ASO will respond in writing whether the training meets training criteria.
- Wraparound facilitators are also required to receive initial training in conflict-free wraparound facilitation.
- Wraparound facilitators are also required to receive introduction, engagement, and intermediate training through the West Virginia Wraparound Training Center
- The agency must maintain documentation that any staff person who provides transportation services via personal vehicle abides by local, state, and federal laws regarding maintaining current vehicle licensing, insurance, registration, and inspections. All required forms for program documentation are maintained on the CSEDW website.

502.14 CSEDW APPLICANT ELIGIBILITY

Eligibility for the CSEDW must be established prior to enrollment in the program and includes both medical and financial eligibility criteria. The applicant must:

- Meet the CSEDW medical eligibility
- Be at least three years through age 20 years
- Apply for or already be enrolled in West Virginia Medicaid at the time of eligibility or once the CSEDW Certificate of Approval is obtained
- Be a resident of West Virginia, even if presently living out of state in a facility, and be able to provide proof of residency upon waiver application
- Choose HCBS over services in an institutional setting
- Choose to enroll with the identified MCO
- Choose CSEDW over Assertive Community Treatment (when criteria are met)

The CSEDW medical eligibility is described in Section 502.14.1 Medical Eligibility. At the time of application review, the ASO determines if the applicant has active West Virginia Medicaid or will need to apply for Medicaid coverage.

Effective September 1, 2022, applicants who have an institutional Level of Care need and meet program medical eligibility requirements, but do not meet financial eligibility requirements, are able to utilize the special HCBS Waiver group (§435.217 Group) of the Social Security Act to enroll in West Virginia Medicaid for the duration of their enrollment in the CSEDW. Effective January 1, 2024, children/ adolescents in the 217 Group are eligible for continuous Medicaid eligibility for 12 months from their last financial application or redetermination. Should their CSEDW enrollment terminate prior to the 12-month period, they will continue to be eligible in the 217 Group for non-CSEDW Medicaid covered services for the remainder of that 12-month period. Once a child/adolescent is found medically eligible for the CSEDW, they or their legal guardian must return to the local county DoHS office with the letter of approval to apply for West Virginia Medicaid under the child/adolescent's income only. The ASO will follow up with the child/adolescent and/or family/legal guardian weekly to assist them.

Applicants are required to provide the ASO with proof of residency prior to starting the assessment process. Documents required to prove West Virginia residency of a prospective member include a valid driver's license, Medicaid card, vehicle registration, valid passport and/or a utility bill. If an applicant recently moved to West Virginia, permission is required to move forward through the assessment process. This permission can be granted by the BMS program manager for the CSEDW on a case-by-case basis.

Individuals must reside in a home and community-based setting. Those currently receiving services in a facility, whether in or out of state, may become fully enrolled for services once transitioned home. The West Virginia DoHS case workers are not required to provide proof of residency for individuals in the State's custody. It is not a requirement that the prospective child/adolescent is in foster care to apply for this waiver.

502.14.1 Medical Eligibility

To be medically eligible, the applicant must require the Level of Care and services provided within a PRTF setting as evidenced by required evaluations and other information requested by the independent evaluator or the MECA and corroborated by narrative descriptions of functioning and reported history. To be eligible for the CSEDW, an applicant must have:

- Eligible diagnosis
- Functional impairment
- Otherwise require PRTF Level of Care

Initial medical eligibility is determined by MECA through review of an Independent Evaluation Report completed by a member of the IEN, which must include background information, a mental status examination, functional behavior, and any other documentation deemed appropriate.

West Virginia defines the term "children with a serious emotional disorder" as children/adolescents with a serious emotional disorder who are three years of age through 20 years of age and who currently have or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of

sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Disease (ICD) or equivalent that is current at the date of evaluation and results in functional impairment that substantially interferes with or limits the child/adolescent's role or functioning in family, school, and/or community activities.

502.14.2 Diagnosis

An eligible diagnosis is defined as a diagnosable mental, behavioral, or emotional disorder that meets the current DSM diagnostic criteria. These disorders include any mental disorders listed in the DSM except for "V" codes, substance use, and developmental disorders, which are excluded unless they co-occur with another diagnosable serious emotional disorder.

The applicant must also demonstrate an impairment in functioning that is due to an eligible diagnosis to meet eligibility requirements.

502.14.3 Functional Impairment

The applicant must have a substantial impairment in functioning, which is defined as a Youth Total score of 90 or above on the Child and Adolescent Functional Assessment Scale (CAFAS) and the Preschool and Early Childhood Functional Assessment (PECFAS), The child/adolescent must demonstrate an ability to engage in activities of daily living but lack adequate emotional or behavioral stability to meet the demands of daily living. The child/adolescent must be able to actively engage and participate in services offered through the CSEDW. The CAFAS/PECFAS must reflect elevated scores as noted above. The presence of substantial impairment must be supported not only by relevant test scores, but also the narrative descriptions contained in the documentation submitted for review and other relevant information (e.g., previous psychological testing, Individualized Education Program (IEP), treatment records, discharge summaries, etc.).

The following CAFAS/PECFAS subscales must equal at least a total score of 90:

- School/day care/work role performance
- Home role performance
- Community role performance
- Behavior toward others
- Moods/emotions
- Self-harmful behavior
- Substance use (CAFAS only)
- Thinking/communication

Additionally, ratings on the most current Behavior Assessment System for Children (BASC), must reflect T-scores greater than 60 in two or more of the clinical scales. The criteria must be supported by additional documentation provided (e.g., previous psychological evaluations, IEP, facility records, etc.).

502.14.4 PRTF Level of Care

PRTFs provide full-time psychiatric treatment for children and adolescents with complex mental health conditions who are under the age of 21 (more information is available in *Chapter 531, Psychiatric*

Residential Treatment Facility Services). PRTFs serve individuals with mental, emotional, or behavioral problems who do not require emergency or acute psychiatric care but whose symptoms and needs are not able to be managed in their home or community and require supervision/intervention on a 24-hour basis. The CSEDW approval does not indicate that a child would be approved for PRTF placement, and that insurance approval would still be required. To be eligible for CSEDW, the applicant must meet the criteria and require a hospital Level of Care defined as an inpatient psychiatric facility for individuals ages 21 and under as provided in 42 CFR §440.160. The applicant must also be at imminent risk of placement in a PRTF.

Imminent risk of placement in a PRTF is defined as:

- Residing in a PRTF within the past six months; **or**
- Through evaluations and documentation submitted to the MECA, it is determined that there is a reasonable indication that the applicant is in danger of being placed in a PRTF within the next 30 days.
- Is at imminent risk of harm due to behavior(s) that are likely to cause physical harm to them self or others. The applicant must indicate the need for PRTF as evidenced by suicidal or homicidal ideation, physical aggression toward others, self-injurious behavior, seriously risky behavior (running away, sexual aggression, or substance use).

502.14.5 Level of Care Instruments

- A CAFAS)/PECFAS is completed by the ASO and sent to the MECA for all applicants.
- The applicant must have an independent evaluation completed by an enrolled psychologist, supervised psychologist, licensed independent clinical social worker, or licensed professional counselor who is licensed to practice independently that includes the most recent version of the BASC for children/adolescents living at home or in a community setting.
- For children placed in out of state residential placements, the facilities current treatment plan and/or psychiatric evaluation may be substituted for the independent evaluation.

502.14.6 Eligibility Determination Process

An applicant may obtain an Application for CSEDW Services form (WV-BMS-CSED-01) from the MCO, CSEDW providers, the ASO, on the CSEDW website or by contacting the West Virginia Children's Crisis and Referral Line at 844-Help4WV and allowing an application to be sent to the Assessment Pathway (information for submission via the ASO is located in the application). All applicants must follow the eligibility process outlined below to determine medical eligibility for waiver services:

1. The process begins with the applicant contacting the ASO or submission of the application from the applicant to the ASO (information is located on the application).
2. Once the child/family has scheduled the Independent Evaluation, the ASO will obtain a signed Freedom of Choice form for the applicant child/family's selected Independent Evaluation provider.
3. The ASO assists with completion of the application, if needed.
4. Upon receipt of the application, the ASO time and date stamps the application.
5. The ASO makes contact using information found on application within 72 hours of receipt of the application to explain the CSEDW eligibility process and service options.

6. The ASO assists the applicant with completing the CAFAS/PECFAS assessment to determine if a CSEDW Independent Evaluation is warranted.
7. The ASO provides the applicant and/or family/legal guardian with the Freedom of Choice form (WV-BMS-CSED-02) which documents the applicant's decision to select institutional and HCBS. This form must be signed by the applicant and/or their family/legal guardian.
8. If the applicant and/or family legal guardian selects HCBS, then the ASO assists with selecting an IE within the geographical area or otherwise convenient for the applicant and/or family/legal guardian. The ASO contacts the Independent Evaluation at once to schedule an evaluation.
    a. If the IE is unable to schedule and complete a report within 14 days, then the ASO will work with the applicant and/or family/legal guardian to choose another Independent Evaluation with availability and ability to complete the report within 14 days.
9. Once the independent evaluation is scheduled, the ASO will discuss interim services. If interested and not already receiving interim services, the applicant's information (with their consent) will be sent to the appropriate Bureau for assignment of interim services.
10. The Independent Evaluation provider reviews the submitted documentation and reviews assessments obtained through the independent evaluation and sends it to the MECA within 14 calendar days of the kept the Independent Evaluation appointment.
11. The MECA makes a final medical eligibility determination within seven calendar days of receipt of the completed Independent Evaluation which includes the BASC (most recent edition). If a West Virginia resident is presently residing in an out-of-state PRTF, the MECA reviews documentation submitted from that out-of-state PRTF which includes the following: treatment plans, discharge summaries, history and physical, psychological and/or psychiatric evaluations, etc. in order to determine eligibility. The CAFAS completed by the ASO is submitted to the MECA as well.
12. The MECA notifies the ASO of the medical eligibility determination.
13. The ASO notifies the applicant and/or family/legal guardian of the medical eligibility determination and sends a certified copy of the decision to the home address provided in the application.
14. The ASO will also offer the family the option to select a wraparound facilitation agency and complete a Freedom of Choice form (WV-BMS-CSED-02) for CSEDW services.
15. When an applicant is determined eligible, the ASO notifies the MCO of the determination. The MCO works with the child/adolescent and family/legal guardian to select a preferred or first available wraparound facilitation agency.
16. If an applicant is Medicaid-eligible and approved for medical eligibility by the MECA and a CSEDW slot is available, then the applicant is enrolled into the CSEDW program.
17. If a waiver slot is available, the MCO then contacts the wraparound facilitation agency selected by the waiver enrollee to assign a wraparound facilitator.
18. If the waiver member is already receiving wraparound services, the ASO will contact the current wraparound facilitation agency to inform the agency that the child has been approved for CSEDW services.
19. If a slot is not available, then the applicant will be placed on a Member Eligibility List until a slot allocation is available.

The applicant's right to a medical eligibility determination within 90 calendar days may be forfeited if the applicant fails to schedule and keep a timely appointment or does not provide additional documentation requested by the IEN provider to complete the independent evaluation. Additional supporting documentation may include, but is not limited to the following:

- The IEP for school-aged children, and adolescents (if applicable)

- Psychiatric and psychological evaluations
- Outpatient therapy notes and progress notes
- Records from inpatient psychiatric hospitalizations, partial hospitalizations, or residential placements
- Any other additional documentation deemed necessary by the IEN provider or MECA to complete the independent evaluation

502.14.7 Right to Appeal

If a child/adolescent is determined to not meet medical eligibility criteria by the MECA, a written Notice of Decision, a Request for Medicaid Fair Hearing form, and a copy of the independent evaluation is sent by certified mail by the ASO to the address listed on application. This denial of medical eligibility may be appealed through the Medicaid Fair Hearing process by submitting the Request for Medicaid Fair Hearing form to the Board of Review within 90 calendar days of receipt of the Notice of Decision. The Notice of Decision letter also allows a request to be made for a second medical evaluation. For children/ adolescents currently receiving CSEDW services, unless the medical eligibility determination is appealed or a second evaluation is requested, services will end within 14 calendar days of the Termination letter.

If a second medical evaluation is requested, then it must be completed by a different member of the IEN within 60 calendar days of the request. Requests for a second evaluation received by the ASO are date stamped upon receipt. The ASO will assist the child/adolescent and family/legal guardian by providing options available with a different IEN provider and scheduling the second evaluation. If the child/ adolescent is determined to be medically eligible following the second medical evaluation, and a slot is available, then the child/adolescent is enrolled into the CSEDW program. If the child/adolescent is determined to be medically eligible, but a slot is not available, then the child/adolescent will be placed on a Managed Enrollment List until a slot is available.

If the child/adolescent is again determined by the MECA to not meet medical eligibility criteria following the second medical evaluation, then a written Notice of Decision, a Request for Medicaid Fair Hearing form, and a copy of the second independent evaluation will be sent through certified mail by the ASO to the address on file. This second denial of medical eligibility may be appealed through the Medicaid Fair Hearing process by submitting the Request for Medicaid Fair Hearing form to the Board of Review within 90 calendar days of receipt of the Notice of Decision and a Medicaid Fair Hearing will be scheduled. See Section 502.14.6 Eligibility Determination Process, for more information.

A request for a pre-hearing conference may be made at any time prior to the Medicaid Fair Hearing. At the pre-hearing conference, the child/adolescent and/or the family/legal guardian and a representative from the MECA will review the information submitted for the medical eligibility determination and the basis for the denial.

The child/adolescent and/or family/legal guardian shall have the right to access their independent evaluation used by the MECA in making the eligibility decision, and copies shall be provided free of charge by the BMS. If the denial of initial medical eligibility is reversed by the hearing officer, the child/adolescent will be placed on the Managed Enrollment List based on the date of the hearing officer's decision. When/if a slot is available, the child/adolescent will be enrolled in the program.

Any child/adolescent denied medical eligibility may reapply to the CSEDW program at any time.

502.15 ENROLLMENT

If a child/adolescent is assigned to an MCO other than the Specialized Foster Care/CSEDW MCO while they are on the Managed Enrollment List, they are required to transfer to the Specialized Foster Care/ CSEDW MCO when a slot becomes available. Those who are not willing to enroll with the identified MCO are not eligible to enroll in the CSEDW program.

Children/adolescents may only be enrolled in and receive services for one waiver at a time though they may be receiving services on one waiver while on a waiting list for another waiver.

502.15.1 Slot Allocation

Once eligibility is established and waiver services are approved after completing the required Freedom of Choice forms, the child/adolescent is considered enrolled in the CSEDW. Slot allocation for the CSEDW program is dependent upon the following:

- The chronological order by date of the ASO's receipt of the fully completed initial application (WV-BMS-CSED-01) and approval of eligibility from the MECA
- The date medical eligibility is established because of a Medicaid Fair Hearing decision

If a slot is not available at the time of enrollment, the child/adolescent is placed on a Managed Enrollment List in chronological order. The ASO will work with the child/adolescent and/or family/legal guardian to identify interim support service until a waiver slot is available. Children/adolescents can receive other Medicaid or grant-funded services while they are on the waiting list. When a slot becomes available, the child/adolescent and/or family/legal guardian is informed and may proceed with the enrollment process for the CSEDW program.

The MCO will then notify the wraparound facilitation agency selected by the child/adolescent and/or family/legal guardian. A wraparound facilitator with the chosen wraparound facilitation agency will contact the child/adolescent and/or parent/legal guardian to begin engagement in the Plan of Care development process prior to the seven-day meeting taking place.

The child/adolescent must access CSEDW direct-care services within 365 calendar days of when the slot becomes available, or the child/adolescent will be discharged from the program. For current children/adolescents receiving waiver services, the BMS may approve a pause in waiver services. A pause in waiver services may be requested by the child/adolescent and/or family/legal guardian based on the immediate needs, including but not limited to medical treatment or extended time out of their service area or the state. All children/adolescents are assigned a wraparound facilitator and must meet as defined in their Plan of Care but at a minimum monthly, as indicated by the acuity level, detailed in Section 502.18.1.1 Child/Adolescent Acuity Levels. At a minimum they must receive one additional supportive waiver service in alignment with their Plan of Care and goals per month to remain enrolled in the waiver, if all eligibility criteria are maintained.

The MCO will send a referral to the chosen wraparound facilitation provider and other providers chosen to deliver services. The wraparound facilitation provider may reject the referral only if one or more of the following is true:

- It appears to have been received in error
- The wraparound facilitation provider is at maximum service capacity and unable to accept referrals until additional wraparound facilitators are hired (must be verified by the MCO)
- The wraparound facilitation provider is unable to meet the current medical and/or behavioral needs

502.15.2 Choice of Single Wraparound Facilitation Provider

At the time of enrollment, the annual redetermination assessment, and at any time it is requested by the child/adolescent and/or family/legal guardian, a list of CSEDW provider agencies will be provided for review. The child/adolescent and/or family/legal guardian must be given an opportunity to choose one approved wraparound facilitation provider and must indicate this choice on a BMS-approved CSEDW Freedom of Choice form (WV-BMS-CSED-02). A signed copy of this form must be retained in the record and must serve as an enrollment, disenrollment, or re-enrollment of the child/adolescent with the provider. The BMS reimburses only for wraparound facilitation services provided by the Medicaid-enrolled provider. A new wraparound facilitation provider can be requested at any time. The effective date of the change of providers will be the first day of the month following the change unless otherwise approved by the BMS or designee.

The child/adolescent retains all rights afforded to them under the law, and the lists below are intended to be limited to their rights and responsibilities as a child/adolescent participating in the CSEDW program. Each child/adolescent is informed of these rights by their CSEDW wraparound facilitation agency upon enrollment and at least annually thereafter.

502.15.3 Member Rights

Children/adolescents and/or their family/legal guardians have the right to:

- Choose between HCBS as an alternative to institutional care by the ASO through the completion of a Freedom of Choice form (WV-BMS-CSED-02) upon enrollment in the program, at any time during the program and at least annually thereafter
- Choose their CSEDW providers
- Choose the time, day, and modality services are rendered
- Choose the type, modality, and number of services they choose to participate in
- Change their mind about any service type and modality at any time, given that the telehealth limitations are followed
- Address dissatisfaction with services through the CSEDW provider's grievance procedure
- Access the Medicaid Fair Hearing process
- Be free from abuse, neglect, and financial exploitation
- Be notified and attend all their CFT meetings, including significant life event meetings
- Choose who they wish to attend their CFT meetings in addition to those attendees required by state regulations and policy.
- Obtain advocacy if they choose to do so

- Have voice/choice in services and all CFT meetings
- File a complaint with the ASO regarding the results of their reassessment
- Have all assessments, evaluations, medical treatments, and Plans of Care explained to them in a format they can understand, even if they have a legal guardian making the final decisions regarding their health care
- Make decisions regarding their services
- Receive reasonable accommodations afforded to them under the Americans with Disabilities Act (ADA)

502.15.4 Participation Responsibilities

The child/adolescent and/or their family/legal guardian (if applicable) have the following responsibilities:

- To be present and engaged during CFT meetings
- In certain circumstances, the family/legal guardian or other team members may participate by teleconferencing as permitted by policy
- It is best practice for children/adolescents aged 11 or older, when appropriate, to be present and engaged during the CFT meeting
- To understand that this is an optional program and that not all needs may be met through the services available within this program
- To actively participate and be engaged in services offered consistently
- To participate and supply up-to-date information in the annual assessments for determination of medical eligibility
- To comply with all CSEDW policies, including allowing home visits by the wraparound facilitator and other entities
- To actively implement the portions of the Plan of Care for which they have accepted responsibility
- To maintain a safe home environment for all service providers and CFT members
- To notify their wraparound facilitator immediately if the child/adolescent's living arrangements change, or the child/adolescent's needs change
- To notify the wraparound facilitator or another member of the CFT immediately if the child/adolescent is hospitalized, there is an incident (critical or noncritical), or if the child/adolescent experiences a significant life event

Failure to comply with these responsibilities may jeopardize the child/adolescent continuation of CSEDW services. If the child/adolescent's behaviors continue to escalate or put the child/adolescent at risk of harm to themselves or others, or the child/adolescent and/or family/legal guardian is not participating in services, then a referral may be made for further evaluation and consideration for other services. If the child/adolescent continues to meet medical eligibility and actively participates in treatment, waiver services can continue.

502.15.5 Grievances and Complaints

A child/adolescent and their family/legal guardian has the right to obtain oral and written information on the CSEDW provider agency's complaints and grievance policies. If the child/adolescent and/or family/ legal guardian is dissatisfied with the quality of services, type of service, modality of service, or the provider of service, it is recommended that they follow the CSEDW provider agency's grievance process.

If the issue is not resolved at this level, the child/adolescent and/or family/legal guardian may file provider complaints directly to the Secretary's office (DoHS). The OHFLAC outlines the process within the behavioral health regulations in Section 4.7, Complaint Investigations.

Regarding the MCO, a complaint is defined as an expression of dissatisfaction made about an MCO decision or services received from the MCO when an informal grievance is filed; some complaints may be subject to appeal. Complaints are handled through the MCO Provider Services Department and reported to the BMS quarterly, though reporting can be more frequent if necessary.

Grievance is defined as an expression of dissatisfaction, either in writing (formal) or orally (informal), regarding any aspect of service delivery provided or paid for by the MCO, other than those MCO actions that are subject to appeal. The term grievance also refers to the overall system that includes grievances and appeals handled at the MCO level and access to the State Fair Hearing process.
The MCO will complete an investigation into all grievances received and report the results to the BMS and to the child/adolescent and/or their family/legal guardian.

502.16 ANNUAL REDETERMINATION OF WAIVER ELIGIBILITY PROCESS

Federal and state mandates require that all child/adolescent presently enrolled in the CSEDW program, as well as those on the Managed Enrollment List, have their eligibility redetermined annually. In West Virginia, the date by which this must be completed is referred to as the child/adolescent anchor date. To remain in the CSEDW benefit program, the child/adolescent must continue to meet the eligibility criteria as previously defined. Medical eligibility requires input from the CFT.

Continued medical eligibility requires the child/adolescent to meet eligibility criteria, including having a substantial impairment as described in Section 502.14.3 Functional Impairment of this manual.
The ASO, in coordination with the CFT, will conduct the annual reevaluation to determine ongoing eligibility. The re-evaluation may be conducted up to 90 calendar days prior to the anchor date. To ensure timely reevaluation the ASO must make, at minimum, three reasonable attempts to contact the family or legal guardian within 30 calendar days to schedule the CAFAS/PECFAS assessment and complete it in a timely manner. Following the assessment, the ASO will promptly submit all pertinent information to the MCO, which may include the Plan of Care, the CANS, and any other relevant documentation. The MCO is responsible for reviewing the submitted information to ensure that provider billing aligns with the child's/adolescent's level of acuity as determined by the assessment.

An anchor date, also known as the annual date, is the date by which the medical eligibility must be redetermined to continue participating in the CSEDW program. The anchor date is established by the anniversary date, that is the first day of the month following the date when initial medical eligibility was established by the MECA and is assigned by the ASO. For example, if found eligible June 5, the anchor date will be July 1 of the following year and every year thereafter.

Prior to completing the annual redetermination, the CFT should conduct a review of relevant documentation. This documentation could include, but is not limited to, the following:

- Incident reporting within the current eligibility period
- Service utilization
- Psychological evaluations

- Progress reports provided by the school, facility, etc.
- Progress on the Plan of Care
- The IEP
- The behavior plan or positive behavior support plan
- Psycho-social assessment

After completing the review of the CFT-determined relevant materials, the following documentation should be completed:

- Updated CAFAS/PECFAS
- Updated, completed Freedom of Choice form (WV-BMS-CSED-02)
- The Needs Domains of the CANS conducted by the CANS-certified wraparound facilitator

The wraparound facilitator is responsible for coordinating the Child and Family Team's (CFT) input, obtaining necessary forms, and submitting them to the ASO 45 calendar days prior to the anchor date.

If the child/adolescent has family member/legal guardian who did not attend the annual reassessment and complete the Freedom of Choice form (WV-BMS-CSED-02), then it is the responsibility of the wraparound facilitator to obtain the signature, in ink or in an electronic documentation system that provides a time and date stamp, of the child/adolescent and/or family/legal guardian prior to or at the CFT meeting.

The Child's Adolescent Needs and Strengths (CANS) Needs Domains, completed by the wraparound facilitator, and the CAFAS/PECFAS will be reviewed by the Medical Eligibility Contracted Agent (MECA). A child/adolescent who shows "no evidence of need/no need for action," as defined by the CANS, may not require continued eligibility for the CSEDW program, and eligibility for the CSEDW program will be terminated if the CAFAS/PECFAS total score is also less than 90 overall. Those who are no longer achieving the goals in the wraparound plan need further evaluation from the team to reach agreement that a formal wraparound process is no longer necessary.

The ASO, the child/adolescent, and/or family/legal guardian, and any other members of the CFT that the child/adolescent wishes to be present may attend the annual reassessment. All present at the CFT meeting shall sign an acknowledgment that they participated in the assessment and were given the opportunity to review and concur with the answers recorded during the assessment. The child/adolescent and/or family/legal guardian shall notify the ASO through their wraparound facilitator within five calendar days of the assessment date if they disagree or refuse to sign the assessment, and the ASO shall resolve the issue by contacting the child/adolescent and/or family/legal guardian to come to an agreement on the answers on the assessment. If there is still a dispute regarding the answers on the assessment, then the issue can be appealed through a Medicaid Fair Hearing. The Assessment Data Modification Request (WV-BMS-CSED-13) Form must be fully completed and must cite the items in question.

Reimbursement for participating in the annual assessment is not a billable activity for the CFT. It is a reimbursable activity for the wraparound facilitator.

502.16.1 Medical Redetermination Eligibility Appeals

If a child/adolescent is determined not to be medically eligible, then the ASO sends by certified mail to the address on file a written Notice of Decision (termination), a Request for Hearing form that includes free legal resources, and the results of the reassessment. This notice is also sent to the wraparound facilitator and MCO. The termination may be appealed through the Medicaid Fair Hearing process if the Request for Hearing Form is submitted to the Board of Review within 90 calendar days of receipt of the Notice of Decision. If the team wishes to continue existing services throughout the appeal process, the Request for Hearing Form must be submitted within 14 calendar days of the receipt of the Notice of Decision. If the Request for Hearing Form is not submitted within 14 calendar days of the Notice of Decision, reimbursement for all CSEDW services will cease.

After filing a request for a Medicaid Fair Hearing, a request can be made for a second medical evaluation (IE). The second medical evaluation must be completed within 60 calendar days by a member of the IEN. The wraparound facilitator, upon notification of the eligibility decision, must begin the discharge process by arranging for a Transfer/Discharge CFT meeting to develop a backup plan for transition because reimbursement for CSEDW services will cease on the 14th calendar day after receipt of the written Notice of Decision letter if a Request for Hearing form is not received.

If medical eligibility is denied based on the second medical evaluation, a written Notice of Decision, a Request for a Fair Hearing form, and a copy of the second medical evaluation will be sent by certified mail from the Administrative Services Organization (ASO). The wraparound facilitator and MCO will also receive a notice. This decision may be appealed by going through the Medicaid Fair Hearing process if the Request for Hearing Form is submitted to the Board of Review within 90 calendar days of receipt of the Notice of Decision.

A pre-hearing conference may be requested at any time prior to the Medicaid Fair Hearing, and the ASO will schedule. If the child/adolescent and/or family/legal guardian has obtained legal counsel, the BMS legal counsel will conduct the pre-hearing. At the pre-hearing conference, the child/adolescent and/or their family/legal guardian along with a representative from the MECA will review the information submitted for the medical eligibility determination and the basis for the termination.

If the denial of medical eligibility is upheld by the hearing officer who is a member of the Department's Board of Review authorized to conduct hearings and render decisions on behalf of the Board of Review, services that were continued during the appeal process must cease on the date of the hearing decision. If the child/adolescent is eligible financially for Medicaid services without the CSEDW program, other services may be available. If the child/adolescent is not eligible financially for Medicaid services without the CSEDW program, other grant-funded services may be offered. If the termination based on medical eligibility is reversed by the hearing officer, services will continue with no interruption.

The child/adolescent and/or family/legal guardian shall have the right to access their medical evaluation used by the MECA in making the eligibility decision, and copies shall be provided free of charge.

502.17 PERSON-CENTERED PLAN OF CARE

Participation in wraparound services is a collaborative process led by the CFT. The CFT should ideally be composed of people who have a strong commitment to the child/adolescent and their family/legal guardian's well-being. Choices about who is invited to participate in the CFT should be driven by the

child/adolescent and their family/legal guardian's perspectives. Ideally, the team should primarily include the natural support identified by the child/adolescent and/or their family/legal guardian when appropriate. The Plan of Care is a living document that empowers the child/adolescent and/or their family/legal guardian to help develop the skills to be successful in their homes and communities. Plans of Care must be developed collaboratively through a shared decision-making process. The child/adolescent and/or their family/legal guardian works with the wraparound facilitator and the identified CFT to choose services and supports that best meet the identified needs and goals. Collaboration between the CFT helps to identify potential barriers to care and develop a plan in the event of a crisis. The Plan of Care development process is rooted in what is most important to the child/adolescent and involves them directly with their community, network of connections, and close personal relationships to look at the innovative ways to attain specific life goals. Resources are considered in how they will support the child/adolescent in achieving their identified goals.

Team members are invited to attend and often do not have a professional relationship with the child/adolescent (e.g., coworkers, family, and community members). Meetings typically should not occur at a provider's office; rather they take place at the child/adolescent home or community setting if privacy can be established.

The CSEDW providers must follow nationally recognized evidence-based practices currently utilized by the BMS. All services, including time and location, must be determined by the child/adolescent and/or their family/legal guardians. These meetings are meant to be interactive with all team members and can involve nontraditional means of visualizing goals and the various steps to achieve them beyond clinical record keeping.

502.17.1 Child and Family Team (CFT)

The CFT is composed of personal and professional supports including but not limited to representatives of each professional discipline (key representatives from school, child welfare, and juvenile justice agencies), provider and/or program providing services to that member (inter- and intra-agency, all peer partners (e.g., family advocates, family support partners, youth support partners, etc.), the MCO care coordinator (if requested) and anyone not listed who the member choses to participate. that have been identified by the child/adolescent and/or their family/legal guardian. Ideally, natural supports and family/legal guardians will represent more than 50% of the CFT. If natural supports are not consistently attending CFT meetings, then there is evidence of ongoing and persistent efforts to identify and engage them.

The wraparound facilitator is responsible for facilitating the development of and subsequent updates to the Plan of Care document; the child/adolescent wraparound facilitation agency cannot provide any additional CSEDW services unless an exception is approved by the BMS program manager due to a lack of providers available in the child/adolescent geographic area or a need for a provider who speaks the language of the child/adolescent and/or family/legal guardian or who is closely aligned with the family's culture. It is important to remember that, although coordination of the Plan of Care process is the responsibility of the wraparound facilitator, development, modification, and implementation of the Plan of Care is the responsibility of the CFT.

All meeting participants are invited based on voice and choice. It is best practice for the current treatment team, including physical health and behavioral health supports to attend in person for all CFT meetings,

including Plan of Care development, transfer meetings, when a child/adolescent is changing agencies, and discharge meetings for graduation or Level of Care change.

The wraparound facilitator must document the following information to bill for any CFT meetings:

- The invitation to members of the CFT, as identified, and all attempts to include service providers in care planning discussions.
- The meeting minutes for the CFT meeting and any updates to the Plan of Care discussed and agreed upon by the CFT team.
- The case record notes from the CFT meeting and agreed upon next steps.
- The updates of the Plan of Care with agreed-upon changes discussed during the CFT meeting.
- The wraparound facilitator must share the Plan of Care with the providers that could not attend. In turn the team members that could not attend should provide a summary of the progress or recommendations for the member prior to the meeting.
- The attempts by the wraparound facilitator to obtain feedback and signatures from all providers unable to attend the meeting in person.

The wraparound facilitator will have 10 business days to obtain signoff from the providers unable to attend the CFT meeting in person and will provide the MCO with an updated Plan of Care within 14 calendar days of the meeting being held.

Although the Plan of Care is driven by needs, goals, and preferences, the wraparound facilitator, in conjunction with the CFT, informs the child/adolescent and the family/legal guardian of the available resources that may be included in the Plan of Care. CSEDW services will emphasize the importance of combining natural supports from the community with professionals to create a Plan of Care that supports the child/adolescent and the family/legal guardian. West Virginia utilizes a strengths-based model, which views the child/adolescent and family/legal guardian as the expert on their strengths and needs. These strengths and needs are then used to guide the Plan of Care development in combination with the information gathered during enrollment. The person-centered Plan of Care captures:

- The strengths, needs, preferences, and desired outcomes of the child/adolescent
- Outlines the frequency, scope and duration of all services and supports
- Both formal and informal

To be person-centered, services must be culturally appropriate, child/adolescent guided, and relevant to identified needs. The child/adolescent and/or family/legal guardian have the right to refuse support offered at any time. The child/adolescent and/or family/legal guardian have the right to choose when the services take place and by what modality.

502.17.2 Child and Adolescent Needs and Strengths (CANS)

The CANS is a person-centered, consensus-based functional needs assessment for the child/adolescent with serious emotional disorders and their families/legal guardians. The CANS provides the wraparound facilitator and CFT with information about the child/adolescent needs, strengths, interests, and available/current natural supports. Details provided in the Strengths and Needs Report will help the wraparound facilitator and CFT expand on information already known about the child/adolescent or

identify areas that require further exploration or assessment for the ongoing development of the Plan of Care.

The wraparound facilitator is responsible for completing the CANS within 30 days of a child/adolescent's assignment date and entering it into the system within three calendar days of the assessment. An identified "significant life event" is determined by the CFT that may alter the child/adolescent's existing level-of-care status, and prior to the six-month CFT meeting.

502.17.3 Plan of Care Requirements

Initial Plan of Care Meeting

The initial Plan of Care (please see Section 502.17 Person-Centered Plan of Car) must be completed within seven calendar days of CSEDW enrollment assignment date. The Plan of Care includes the assignment date which is the date the child/adolescent is assigned to the wraparound facilitation services agency. If the child/adolescent already receives services from the wraparound facilitation agency through interim wraparound, the existing Plan of Care is reviewed for consideration of any additional CSEDW services that would be beneficial and revised within this period. The plan must be completed by the CFT team.

The initial Plan of Care describes the services and/or supports the child/adolescent can receive until the assessment process is complete and the master Plan of Care is developed. This initial Plan of Care must consist of the following at a minimum:

- Description of any further assessments or referrals that may need to be performed
- A listing of immediate interventions to be provided along with objectives for the interventions
- An initial crisis plan which must include a safety plan for any natural disaster
- A date for development of a master Plan of Care if not being completed at this meeting. The designated date must be appropriate for the planned length of service but at no time will that exceed 30 calendar days from the date of waiver enrollment assignment date.
- The signature of the child/adolescent and/or family/legal guardian, wraparound facilitator, and other persons participating in the development of the initial plan, each person's credentials, and start/stop times in ink or in an electronic documentation system with time and date stamp are required.
- The Plan of Care goals and objectives must be based on problems identified in the initial assessment or in subsequent reassessment(s) during the treatment process.

Master Plan of Care

- The master Plan of Care is developed within 30 calendar days of waiver enrollment assignment date (unless completed at the seven-day meeting) and must include:
    - A statement or statements of the person-centered positive and outcome-oriented goal(s) for identified services and supports, in general terms
    - A therapy plan
    - Crisis plan which must include a safety plan for any natural disaster
    - A Family Story includes strengths/needs and culture discovery completed within the first 20 calendar days after assignment
    - Any assessment-driven home and community-based services recommendations

- A listing of specific objectives that the service providers, child/adolescent, and/or family/legal guardian hope to achieve or complete. It is expected that objectives be specific, measurable, realistic, and capable of being achieved in the time available in the projected duration of the program or service
- The technique(s) and/or services (intervention) to be used in achieving the objective
- Identification of individuals (with their names and roles identified) responsible for implementing the services and their frequency of intended delivery
- The interventions as well as the methods chosen to address the person's assessed behavioral need(s)
- Discharge criteria
- A transition plan for adolescents over 15
- A date for review of the plan of care which includes time considerations for the expected duration of services.
- The signature of the child/adolescent and/or family/legal guardian, wraparound facilitator, and other persons participating in the development of the master plan, each person's credentials, and start/stop times in ink or in an electronic documentation system with time and date stamp are required.
- Discharge planning, with all discharge reports being filed upon case closure

Monthly Plan of Care Review

- Wraparound facilitators are responsible for the development and updates of the Plan of Care and must confirm that all updates are person-centered and approved by the team. The Plan of Care is a living document and will change over time as goals are met or if a new service/support is identified. The Plan of Care goals and objectives must be based on problems identified in the initial assessment or in subsequent reassessment(s) during the treatment process. The CFT will meet at a minimum monthly to review and discuss the current Plan of Care and update as needed. The CFT, as identified by the child/adolescent and/or their family/legal guardian, is invited to all Plan of Care meetings and are provided with relevant case updates. Plan of Care development is a billable service by the wraparound facilitator. See Section 502.17.4 Plan of Care Development, for clarification and description of exceptions.

Significant Life Event meeting

- A significant life event is any significant impact/change to the child/adolescent and their daily living situation. These events are individualized and unique, meaning what is considered significant will change as the child/adolescent develops skills and grows through their waiver enrollment. It is important for the wraparound facilitator to watch this development, monitor for significant life event, document, and engage the CFT within seven calendar days of a significant life event.
- After a significant life event, the Plan of Care must be reviewed with the child/adolescent and their family/legal guardian (if appropriate) to assess if the current services and support meet the current needs. When an intervention proves to be ineffective, the plan of care must reflect consideration by the team of changes in the intervention strategy.

The following safeguards must be in place to ensure that the Plan of Care development is conducted in the best interest of the child/adolescent and family/legal guardian when a wraparound facilitation provider has been approved to provide both wraparound facilitation and other HCBS:

- Conflict-free wraparound facilitation must be provided when the same entity is both assisting a child/adolescent and family/legal guardian to gain access to services and providing services to that young person and family/legal guardian, there must be appropriate safeguards and "firewalls" in place to mitigate risk of potential conflict. Additionally, the entity has the "firewalls" in policies and practice to ensure that those establishing access to services are not the same staff providing the services. Staff that determine access and those that provide the services are separated by different supervision, oversight, and decision-makers.
- The Plan of Care may be updated at any time. All updates must be signed by the child/adolescent if age appropriate (able to understand and contribute to their own Plan of Care) and/or their family/legal guardian.

502.17.4 Plan of Care Development

If a child/adolescent is served by multiple behavioral health providers, all providers must be invited to participate in the initial CFT. If a Plan of Care has already been completed, the CFT is convened to review the plan and consider whether any additional services available are needed. All CFT members must receive adequate notice of meetings, which is defined as at least seven calendar days prior to the treatment team meeting.

The wraparound facilitator is responsible for scheduling and coordinating treatment team meetings, monitoring the implementation of the Plan of Care, and for initiating treatment team meetings as the needs dictate. Justification for the presence of each person participating in the meeting is the responsibility of the wraparound facilitator. Participation may vary depending on the nature of involvement and contribution to the team process. Plan of Care meetings must be scheduled at times and places that facilitate the inclusion of the child/adolescent and their family/legal guardian. It is important to remember that, although coordination of the plan of care process is the responsibility of the wraparound facilitator, development of the plan of care is the responsibility of the CFT.

Only the wraparound facilitator can bill for the Plan of Care meetings. Other service providers may not bill for participation by any of their staff in the Plan of Care process. The agency coordinating the Plan of Care meeting also cannot bill for participation of staff from other agencies. Participation by family/legal guardians is not billable.

The CSEDW providers must make the proper distinction between plan of care and other activities related to wraparound facilitation. The wraparound facilitator may be involved in the development of individual program plans, such as residential plans, day treatment plans, work training plans, educational plans, as called for by the master Plan of Care. These types of activities are included under wraparound facilitation services. Only wraparound facilitators may be reimbursed for the coordination and participation in the annual reassessment, six-month progress review, redetermination meetings, as well as gathering all updates from each provider to present during this meeting.

Documentation: The following documentation is required for substantiation:

- The Plan of Care must include the following: the cover sheet with demographics, goals and dreams, a summary of any assessments leading to qualification for waiver services and the results of those evaluations, any medications, identification of waiver services and non-waiver services as well as natural supports, the therapy plan, behavior support plan, crisis plan, and signature page.
- The behavior support portion of the plan includes clinical opinions related to the behavior, other significant issues with documentation of follow-up, and the clinical reason for and intended benefit of any direct observation.
- The Plan of Care signature page must include original, dated signatures (with names, titles, and credentials) of all participating members of the treatment team, the child/adolescent, and/or family/legal guardian and must include the actual time all individuals listed participated by listing the start and stop times of their participation in ink or in an electronic documentation system. The expectation is that the representative from each CSEDW service that is being provided to the member will attend the meeting and sign the plan. If that individual cannot attend the reason must be documented in the Plan of Care and a summary of the services offered by that individual must be submitted in place of in person attendance within 48 hours of the CFT meeting and sign that they have received and agree with the Plan of Care within 10 business days of the CFT meeting. That team member cannot miss every meeting and is expected to be present unless there is a valid reason for their absence. For example, the therapist must attend when the service is requested or provided. If they are unable to attend, the reason why must be documented, and a summary must be sent to the wraparound facilitator within 48 hours of the meeting. The therapist must then sign they have received and agree with the Plan of Care within 10 business days.
- Staff may participate for different lengths of time, depending on the nature of their involvement and contribution to the team process. The Plan of Care signature page, along with the rationale for disagreement (if applicable), is to be placed in the clinical record along with the completed Plan of Care or Plan of Care update and Plan of Care meeting minutes.
- Each staff person participating in the Plan of Care session must include the agency they are representing on the signature page.
- Separate documentation must also be included in their agency's clinical record in the form of an activity note that states the purpose for participating in the meeting, their signature, in ink or in an electronic documentation system, and credentials, the location, date, and the actual time spent participating in the session by listing their start and stop times.

Every effort should be made to include the child/adolescent in meetings regarding their care. If the child/adolescent and/or family/legal guardian is unable to attend the scheduled Plan of Care meeting, the MCO may grant an exception to allow the meeting to proceed at the scheduled time without their participation. The reason for the absence must be documented in the clinical record. If the child/adolescent is unable to attend, the child/adolescent and/or family/legal guardian must review and sign the Plan of Care within seven calendar days. Documentation of the MCO's approval for the child/adolescent and/or family/legal guardian's absence from the Plan of Care meeting must be included in the plan. If there is an emergency for the wraparound facilitator or the therapist that necessitates a delay in the Plan of Care meeting, the wraparound facilitator should submit a request to the MCO for an extension of the time frame.

The Plan of Care will include service provision based on specific goals in agreement with the CFT. If between regular Plan of Care sessions, the child/adolescent requires access to a service not previously

mentioned on the Wraparound Facilitation section of their Plan of Care, the wraparound facilitator will convene a significant life event CFT meeting to address adding the needed service to the plan.

Many services, including CFT meetings, can be provided via telehealth 50% of the time. These services must comply with service definitions and Section 502.20 Telehealth Modalities and Service Provision. This delivery method is reimbursable for the wraparound facilitator, as it is considered a face-to-face meeting. In extenuating circumstances, CFT members may participate by teleconferencing (i.e., telephone). The wraparound facilitator must obtain signatures within 10 business days for any CFT member who attended the meeting via telehealth or teleconference and must forward copies of the Plan of Care to all participating CFT members and the MCO care manager within 14 calendar days of the meeting. If the clinical record does not include a valid signature page with required signatures, in ink or in an electronic documentation system, the plan of care will be invalid, and subsequently, no services provided under its auspices will be billable. Please see *Chapter 519.17 Practitioner Services, Telehealth Services,* for more information on telehealth requirements.

502.17.5 Seven-Day CFT Meeting

This meeting is mandatory once a wraparound facilitation agency is assigned. This is the initial meeting that occurs within the first seven calendar days of the wraparound facilitator being assigned. The provider receiving the referral must include discussion of CSEDW services as well as other support services the child/adolescent needs to live successfully in the community. This Plan of Care document must reflect a full range of planned services: Medicaid, non-Medicaid, and natural supports. This meeting must be documented on the Initial Plan of Care (WV-BMS-CSED-14) by the wraparound facilitator. If all CSEDW services can be finalized at this meeting and the full range of planned services are finalized and documented, then this Plan of Care can act as the master Plan of Care. Requirements for participation, notice, documentation requirements and billing requirements are the same for all CFT meetings.

502.17.6 30-Day CFT Meetings

The master Plan of Care must be finalized within 30 calendar days of waiver facilitator enrollment. The master Plan of Care is completed in 30 calendar days (WV-BMS-CSED-14) and completed by the wraparound facilitator who identifies the comprehensive array of services necessary to fully support the child/adolescent who receives CSEDW services. The current services, barriers and identified goals in the Plan of Care are reviewed at a minimum every 30 calendar days by the CFT to help ensure the Plan of Care is accurate and addressing all identified needs. This is a living document and needs to be reviewed on a regular ongoing basis depending on the need of the individual and may need updated more often than every 30 calendar days. If a new service/support need is identified or the Plan of Care needs to be revisited the goals and progress on those goals that are being facilitated by each CSEDW provider. These reviews are documented in the Home Visit form (WV-CMS-CSED-03) for the visit and attached to the Plan of Care. A copy is also forwarded to the MCO care manager. The assignment date sets the clock for scheduling all subsequent CFT meetings. The Plan of Care must be reviewed and updated at significant life event meetings. Requirements for participation, notice, documentation requirements, and billing requirements are the same for all CFT meetings. Telehealth is allowed for attendance at these meetings. Providers attending via telehealth must work with the CSEDW provider to sign the Plan of Care within 10 business days after the CFT meeting.

If the child/adolescent continues to meet medical eligibility and the child/adolescent and/or family/legal guardian actively participates in treatment, waiver services may continue. If the child/adolescent is hospitalized or placed in a residential treatment facility due to a crisis that puts themselves or others at imminent risk of harm, the services can be placed on hold during that time so that they can return home with waiver support, provided they access services within 365 calendar days.

502.17.7 Transfer Process

All children/adolescents in CSEDW have the right to transfer wraparound facilitation and other services from the existing provider to another chosen provider at any time for any reason. Transfers must be addressed in the Plan of Care, approved by the child/adolescent and/or family/legal guardian and a representative from the receiving provider, as evidenced by their signatures on the Plan of Care signature sheet in ink or in an electronic documentation system with a time and date stamp. The wraparound facilitator should work with the CFT to coordinate the meeting and ensure the completion of the transfer. A CFT meeting is held when a transfer occurs from one CSEDW provider to another. When the child/adolescent transfers from one agency to another, the transfer-from agency is responsible for coordinating the meeting and documenting the transfer. The child/adolescent and/or family/legal guardian, as well as the transfer-to agency, must agree to the transfer. The transfer-from agency must also submit a transfer and attach a Transfer form (WV-BMS-CSED-15) to the MCO within seven calendar days. The transfer-from agency must send the resulting Plan of Care to the transfer-to agency within 14 calendar days. Exceptions for participation may be granted for the child/adolescent and/or family/legal guardian by the MCO if necessary. If the resulting Plan of Care is found to be invalid because members of the CFT did not attend, or necessary services were not addressed during the transfer, then the authorizations may be rolled back to the transfer-from agency until a valid CFT meeting is held.

The wraparound facilitator is required to notify the MCO of the transfer within two business days:

- The transferring agency is responsible for the notification by submitting the Transfer form (WV-BMS-CSED-15). This form must include the last date of service provided.
- The transferring agency is expected to have the full medical file, including all Plans of Care, current, with all updates notes and required signatures prior to completing transfer to the new agency.
- The transferring agency is still required to provide all needed referrals and services until the transfer to the new agency with all documentation is completed.
- Lack of notification of the transfer will affect the registration of services to the correct service provider(s) and subsequent payment of claims for services.

502.17.8 Discharge Process

A child/adolescent may discharge from CSEDW for the following reasons:

- Goals are met, and the child/adolescent wants to step down to less intensive services
- The needs of the child/adolescent can no longer be met by CSEDW
- The child/adolescent can no longer safely remain in the home or community. Such occurrences include, but are not limited:
    - The direct-support worker and/or other agency staff are threatened or abused, and the staff's welfare is in jeopardy.

- The child/adolescent or other household members repeatedly demonstrate sexually inappropriate behavior; display verbally and/or physically abusive behavior; and/or threaten the direct-support staff or other agency staff with guns, knives, or other potentially dangerous weapons, including menacing animals or verbal threats to harm the direct care staff and/or other agency staff. The child/adolescent or other household members display abusive use of alcohol and/or drugs and/or other illegal activities in the home.

An incident report should be filed by a provider in any of the situations above. See Section 502.6 Incident Reporting Requirements. If the environment is determined to be unsafe because of an investigation following an incident report, then discharge will occur.

- The child/adolescent turns 21 and a transfer to other services has occurred
- Loss of medical eligibility through the annual redetermination process
- Loss of financial eligibility
- Members have not accessed services in 365 days. The child/adolescent and/or family/legal guardian no longer desires or requires services
- Relocation to another state

In the case in which services are not utilized for 365 calendar days due to cancellations, etc. The agency should document the dates and times of cancellation; if there is a recognizable pattern, please contact the assigned MCO care manager for guidance related to discharge initiation.

The wraparound facilitator works with child/adolescent and/or family/legal guardian to achieve a level of independence that allows for more active engagement in their home and communities so that CSEDW services are no longer needed. The duration of enrollment is determined by the child/adolescent's goals, taking into consideration their needs and preferences and ability to engage in and manage their own care and services. From the point of engagement, wraparound facilitators need to discuss the process of moving forward toward graduation from the CSEDW and transitioning to less intense services.

It is the responsibility of the wraparound facilitator to notify the child/adolescent and/or family/legal guardian that if they again have difficulties with maintaining care and stability in their home or community, they can reapply for CSEDW and receive supports if they meet eligibility criteria. In cases where a wraparound facilitator is faced with the potential discharge of a child/adolescent who has not reached their goals (e.g., member choice), steps must be taken to ensure a safe transition from the CSEDW. Discharge planning must be a collective process consisting of the child/adolescent and family/legal guardian, the CFT, the MCO care manager and any other support identified. All communication must be mutual in nature to ensure responsibilities are clearly defined amongst the CFT.

The discharge process must include, but is not limited to:

1. Discussion with the child/adolescent and/or family/legal guardian and CFT, discharge planning should be part of the Plan of Care process to include ongoing evaluation of their ability to self-manage successfully in their home or community.
2. Direct communication on the discharge process between child/adolescent and/or family/legal guardian and the CFT.

3. Support the child/adolescent and/or family/legal guardian right to make an informed decision related to program discharge.
4. Document in the child/adolescent and/or family/legal guardian Plan of Care reason(s) for discharge, all communication related to the reason(s) for discharge and responses and steps taken to complete the discharge process.
5. Update the child/adolescent and/or family/legal guardian Plan of Care to include child/adolescent disposition, status of goals, discharge/safety plan, and any referrals made/needed, as appropriate.
6. The discharge plan of care must include a discharge/safety plan, any referrals made by the wraparound facilitator for new providers/services and contact information for the CFT and all referred services. The most recent Plan of Care must include contact information for care and service providers, including contact information for the MCO.
7. Notify the child/adolescent and/or family of their Fair Hearing rights, as applicable.

This meeting is held when a discharge is processed.

Successful discharge from the waiver program should be the goal of the CFT. Services are designed to be intensive short-term services, with the end results being the child/adolescent and/or family/legal guardian having the tools and knowing the steps to remain in their home and community setting successfully.

During the discharge meeting, there should be clearly documented information for the child/adolescent and/or family/legal guardian on follow-up appointments, use of natural supports in the area, list of resources needed, and contact information for the West Virginia Children's Crisis and Referral Line, at 1-844-HELP4WV.

502.18 CSEDW HOME AND COMMUNITY-BASED SERVICES

The services under this waiver are limited to additional services not otherwise covered under the Medicaid State Plan, including Early Periodic Screening, Diagnosis, and Treatment (EPSDT), but consistent with waiver objectives of avoiding institutionalization.

The CSEDW providers must use nationally recognized evidence-based practice based on the high-fidelity wraparound model.

If staff assigned to the case will be out for a week, the provider is responsible for having coverage for questions that may arise from the youth/legal guardian/caretaker and not necessarily responsible for coverage of the CSEDW services for the week the staff is out. However, if the staff will be out for an extended period of two weeks or more, the agency is responsible for ensuring service provision continues during the extended period. Extended leave is often known in advance and arrangements should be made in advance so the youth/legal guardian/caretaker and team know who to call and who will be providing services during the leave.

Providers rendering services that require prior authorization must receive authorization before rendering all services. Prior authorization does not guarantee payment for services rendered. See Section 502.21 Prior Authorizations.

502.18.1 Wraparound Facilitation

Procedure Code: T1016HA-TF, moderate intensity
T1016HA-TG, high intensity

Service Unit: Monthly

Telehealth: Available with 02 place of service location. Telehealth justification must be provided within the service note. Telehealth may be utilized to deliver services for up to 50% of the total services the child/adolescent receives per calendar year of enrollment (one calendar year from the child/adolescent's anchor date. If telehealth is selected by the child/adolescent and family/legal guardian, a telehealth backup plan must be discussed and added to the Plan of Care, the telehealth backup plan must include alternative service connections available to the child/adolescent and family/legal guardian, for example switching to in-person face-to-face visits, emergency power supply or a mobile device that allows connection.

Service Limit: Up to 12 units per plan of care year; caseloads capped at 15 members per wraparound facilitator. The 15-caseload cap does not include members who are on hold.

Site of Service: This service may be provided in the child/adolescent's residence, a licensed CSEDW provider agency office, public community locations, or via telehealth as indicated above. Can also be provided at school if not during instructional hours or if not in combination with crisis response.

Staff Credentials: Wraparound facilitation services must be provided by an individual fully licensed (this does not include provisional or temporary license) in West Virginia as a social worker, professional counselor, or registered nurse, or may be an individual with a four-year degree (BA or BS) in a human service field with one year's post graduate experience in a related field. Staff must obtain certification in the online case management training developed by the BMS or may be an individual with a two-year degree (Associates) in a human services field with two years' post graduate work experience in this field and certification in an on-line case management training developed by the BMS. The wraparound facilitator must be fully certified in the CANS assessment, and re-certified annually. The wraparound facilitation agency must have a contract with the MCO. Wraparound facilitators are also required to receive initial training in conflict-free wraparound facilitation.

Facilitators must complete required training through the State of West Virginia Wraparound Training Center within one year of hire. The Wraparound Training series includes the following:

- Introduction to Wraparound Training; Three-Day
- Engagement in the Wraparound Process Training; One-Day
- Intermediate Wraparound Training; Two-Day

Documentation demonstrating that the wraparound agency has been certified as meeting National Wraparound Implementation Center (NWIC) standards for high-fidelity wraparound. Agencies must keep certifications on file for each wraparound facilitation after completion of the training through the West Virginia Wraparound Training Center.

Definition: The wraparound facilitation is responsible for engaging the child/adolescent and family/legal guardian in a partnership of shared decision-making regarding Plan of Care development and implementation throughout enrollment in the CSEDW. The wraparound facilitation ensures and coordinates a comprehensive set of supports, resources, and strategies for each child/adolescent and family/legal guardian (as applicable). They work closely with service providers to ensure that CSEDW services and clinical treatment modalities augment each other for optimal outcomes. The wraparound facilitation will lead the CFT through engagement and team preparation, initial plan development, plan implementation, and transition. This includes the development and implementation of a transition plan for adolescents who will reach the waiver's maximum age limit.

The wraparound facilitation will use a nationally recognized evidence-based therapeutic approach in developing the knowledge and skills necessary to understand and address the specific needs of the child/adolescent in relation to the serious emotional disorder and treatment. The nationally recognized evidence-based services may focus on elements such as developing and enhancing problem-solving skills, coping mechanisms, and strategies for symptom/behavior management.

The wraparound facilitation and the agency that employs them, cannot provide any other waiver or State Plan services for the child/adolescent, unless approved for an exception by the BMS program manager. Exceptions may be granted to meet the language or cultural needs of the child/adolescent and family/legal guardian. The wraparound facilitator must have documentation of authorization issued by the MCO on behalf of the BMS agency present in the child/adolescent adult's file.

The agency providing wraparound facilitation, must provide the freedom of choice for all waiver and State Plan services providers.

Documentation: A Medicaid-enrolled provider of wraparound facilitation services must maintain the following information/documentation:

- An individual permanent clinical record for each child/adolescent receiving wraparound facilitation services that includes the most up to date and current:
    - Name
    - Address
    - Telephone numbers
    - Wraparound facilitation provider
    - Parent/legal guardian name
    - Contact information
- Asses and plans for coordination of healthcare needs within the Plan of Care.
- The wraparound facilitation will assist adolescents who are planning to live independently in the community with securing a lease that provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law. The dwelling must include privacy in the unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit, ability of control his/her own schedule including access to food at any time, allow for visitors at any time, and be physically accessible. In addition, the wraparound facilitation will ensure the lease includes provisions to address bed bug infestations and other housing concerns that may impact health and stability, including a plan for relocation and seeking reimbursement from financially responsible party(ies).

- A clinical record that must include documentation specific to services/activities reimbursed as CSEDW wraparound facilitation. This includes a specific note for each individual service/activity provided and billed.
- A signed case note for each home visit, unless there is documentation from the MCO granting an exception for any home visit not completed. These requests are generally based on the request, due to special circumstances, like a visit with relatives out of state.

Each case note must include all components as identified in the Progress Note form including, but not limited to:

- Be dated and signed by the wraparound facilitation along with their credentials, e.g., Bachelor of Arts (BA), Bachelor of Social Work (BSW)
- Have relevance to a goal or objective in the Plan of Care
- Include the purpose and content of the activity as well as the outcome achieved
- Include a description of the type of contact provided (e.g., face-to-face, correspondence, telephone contacts)
- List the location where the activity occurred

502.18.1.1 Child/Adolescent Acuity Levels

Wraparound facilitation is a service provided at two levels, moderate and high acuity. Each child/adolescent will be assigned to an "acuity tier" defined by the below criteria. The acuity tier determines a per-member per-month (PMPM) rate for the service. The child/adolescent CAFAS/PECFAS score will be used to determine acuity and help inform the wraparound facilitator of appropriate contact care coordination activities.

Wraparound Facilitation Acuity Levels

CAFAS/PECFAS Score	Acuity	Contact Requirement	Face-to-Face Requirement
90-130	Moderate	Minimum of bi-weekly contact with the member/family	Minimum one monthly face-to-face meeting
140+	High	Weekly contact with the member/family	Minimum two monthly face-to-face meetings

The wraparound facilitator will meet in person with the child/adolescent and their family/legal guardian at their home or a location in the community and at a time selected by the child/adolescent and their family/legal guardian to:

- Confirm the child/adolescent's health and wellbeing and to monitor for abuse or neglect
- Verify safe service delivery
- Assess progress, training objectives, and unmet needs
- Discuss any incidents that have occurred in the past week
- Provide necessary support
- Review and update the crisis plan to ensure it covers all environments in which the child/adolescent functions
- Record strengths-based improvements demonstrated by the child/adolescent in the past week

All service activities provided must be reflective of members' acuity, their unique needs and included in the child/adolescent's Plan of Care. The wraparound facilitator must offer all age appropriate CSEDW services to the child/adolescent and/or family/legal guardian, the child/adolescent and/or family/legal guardian then may accept or deny the services offered.

Required activities performed by the wraparound facilitation by acuity level are provided below:

Moderate Intensity:

- Minimum of biweekly contact with the member/family
- Minimum one monthly face-to-face meeting with the member/family
- Monthly contact with the assigned Aetna care manager
- Monthly contact with therapist/psychologist/mental health counselor
- Monthly contact with education supports (IEP, guidance counselor, etc.)
- Monthly contact with all HCBS providers currently serving the member
- Biweekly contact with the inpatient or residential care manager as the member approaches discharge from residential care (*if appropriate*)
- Biweekly contact as the member approaches discharge or transition off the CSEDW program (*if appropriate*)
- Quarterly contact with other utilized community supports
- Quarterly contact with the Bureau for Social Services (BSS) case worker (*if appropriate*)
- Quarterly contact with a court related issue (*if appropriate*)
- Monthly Plan of Care and CFT review and updates with member/family
- CANS assessment per policy

High Intensity:

- Weekly contact with the member/family
- Minimum two monthly face-to-face meetings with the member/family
- Biweekly contact with the assigned Aetna Care manager
- Biweekly contact with therapist/psychologist/mental health counselor
- Biweekly contact with education supports (IEP, guidance counselor, etc.)
- Biweekly contact with all HCBS providers currently serving the member
- Biweekly contact with the inpatient or residential care manager as the member approaches discharge from residential care (if appropriate)
- Biweekly contact with care manager as the member approaches discharge or transition off the CSEDW program (if appropriate)
- Monthly contact with other utilized community supports
- Monthly contact with BSS case worker (if appropriate)
- Monthly contact with court-related issues (if appropriate)
- Monthly Plan of Care and CFT review and updates with member/family
- CANS assessment per policy

The assignment date is the date the child/adolescent is assigned to the wraparound facilitation services agency. The following activities are required by the wraparound facilitator for all regardless of the acuity level.

Below are examples of specific tasks in each category that should be performed by a wraparound facilitator throughout enrollment in the CSEDW program. The tasks below are not all inclusive to the work that a wraparound facilitation may complete. The examples are intended to highlight more common tasks and serve as a reminder for the wraparound facilitator to include in their service delivery and billing for services once delivered.

Assessment, Social History, Progress Review, and Reassessment:

- Gather information to complete the Plan of Care (WV-BMS-CSED-14)
- Complete the CANS assessment prior to the master Plan of Care meeting, at any identified significant life event, and in preparation for Plan of Care reassessments
- Research funding sources, including non-Medicaid sources, for services needed prior to Plan of Care implementation
- Help identify strengths and needs as part of the Plan of Care development
- Manage and warehouse all information related to child/adolescent, family/legal guardian, or other CFT member issues, questions, and critical incidents and will work to help ensure all such items are addressed

Care Planning:

- Assemble the CFT, including the child/adolescent and their family/legal guardian
- Lead CFT meetings
- Verify Medicaid eligibility every month through the Gainwell system
- Help identify strengths and needs
- Be a resource for understanding and accessing CSEDW services and, when appropriate, suggest a service that may offer support to a need
- Assist with contact and follow up with service providers to support gaining access to CSEDW and other medical, social, and educational services
- Maintain communication among all team members
- Review progress on goals
- Update the Plan of Care Work with the MCO care manager to identify service providers, natural supports, and other community resources to meet needs and make necessary referrals
- Facilitate connection with identified resources and providers
- Be an advocate, which includes the process of helping to empower the child/adolescent and family/legal guardian to initiate and sustain interactions that support their overall wellness, interceding on their behalf when necessary to gain access to needed services and supports
- Consult with the team to make necessary adjustments and revisions to the Plan of Care

Referral and Linkage:

- Initiate and coordinate discharge and after-care planning; linkage and referral to services and supports as specified in the Plan of Care, including, but not limited to, identifying local resources and services for use during both enrollment and discharge planning; sharing information on relevant resources and service providers, including local family support programs, advisors, and advocates, and engages the child/adolescent and/or parent/legal guardian in making informed choices
- Initiate contact to complete service arrangements (e.g., arranging transportation).

- Assist with scheduling appointments for child/adolescent with other providers

Monitoring and Follow-Up with the CFT to:

- Determine if services are being provided in accordance with the Plan of Care, including time spent reviewing service provider files
- Determine whether the services in the Plan of Care are adequate to meet the needs
- Determine whether there are changes in the needs or status of the child/adolescent
- Make necessary adjustments in the Plan of Care and service arrangements with providers to address changes in needs
- Complete forms or reports to ensure the health and safety of the child/adolescent, including incident reports
- Ensure each case note includes all components as identified in the CSEDW Wraparound Facilitation form, including, but not limited to:
    - Be dated and signed by the wraparound facilitator along with their credentials, (e.g., BA or BSW)
    - Have relevance to a goal or objective in the Plan of Care Include the purpose and content of the activity as well as the outcome achieved
    - Include a description of the type of contact provided (e.g., face-to-face, correspondence, telephone contacts)
    - List the location the activity occurred
    - List the actual time spent providing each activity by itemizing the start and stop time
- Complete the signed case note for each home visit, unless there is documentation from the MCO granting an exception for any home visit not completed. Exceptions are generally based on a request by the child/adolescent or family/legal guardian, due to special circumstances, such as a visit with relatives out of state.

502.18.1.2 Six-Month Progress Review

To conduct periodic reassessment of the child/adolescent's needs, the ASO will conduct a CAFAS/ PECFAS every six months for children/adolescents who have met less than 50% of their goals to determine the child/adolescent's acuity level. The acuity level for the CSEDW informs the Level of Care the child/adolescent will receive while enrolled in waiver services.

For CAFAS/PECFAS scores of 140 or more, the child/adolescent will receive a higher Level of Care. For CAFAS/PECFAS scores between 90 and 130, the child/adolescent will be determined to receive a moderate Level of Care. If the CAFAS/PECFAS is below 90 at the six-month progress review the child will remain at the moderate Level of Care through their transition/discharge period.

The six-month reassessment timeline includes:

- The ASO has 72 hours to schedule an independent evaluation (IEN).
- The ASO has 30 calendar days to make contact, with three contact attempts.
- The ASO has 48 hours after assessment completion to send all information to the MCO care manager and supervisor (Plan of Care assessments, CANS).
- The medical director from the MCO will review as needed.

- The medical director from the MCO will participate in clinical staffing calls as determined necessary.

Children/adolescents who are reassessed at moderate Level of Care or below during the six-month reassessment should begin transition planning. The ASO has 14 calendar days to submit Fair Hearing forms.

502.18.2 Independent Living/Skills Building

Procedure Code: H2033-HA

Service Unit: 15 minutes

Telehealth: Available with a 02 place of service location. Telehealth justification must be provided within the service note. Telehealth may be utilized to deliver services for up to 25% of the total services received per year of enrollment (one calendar year from the anchor date). If telehealth is selected by the child/adolescent and family/legal guardian, a telehealth backup plan must be discussed and added to the Plan of Care, the telehealth backup plan must include alternative service connections available to the child/adolescent and family/legal guardian, for example switching to in person face to face visits, emergency power supply or a mobile device that allows connection.

Service Limit: Up to 160 units per calendar week in combination with job development and supported employment. Recipients must be 15 to 20 years of age to access this service.

Site of Service: This service may be provided only in public community locations.

Staff Credentials: Bachelor's or Associate degree in human services and a minimum of one year of documented experience working with children/adolescents with behavioral health challenges *or* high school diploma or General Educational Development Test (GED) and a minimum of two years of documented experience working with the same population. The independent living/skills building staff are indirectly supervised by the therapist. Indirect supervision is defined as supervision provided by a licensed individual who monitors but is not required to be present in the setting when services are rendered.

Documentation: An approved authorization for services dated prior to the initiation of services must be included in the adolescent's record, and the service must be included in the Plan of Care. A service note must be included for each instance or day of service that describes the service activity provided (within guidelines of the CSEDW manual, name of the service provider, date of the service, start and stop time of the service, the service code and signature and credential of the provider in ink or in an electronic documentation system with a time and date stamp).

Independent living/skills building will be subject to usage of the EVV utilization and all corresponding requirements.

Definition: Independent living/skills building (CMS defined: day habilitation) services focus on empowering the adolescent to attain or maintain their maximum potential and shall be coordinated with

any needed therapies in the individual's Plan of Care, such as physical, occupational, or speech therapy. Provision of regularly scheduled activities in a non-residential setting, separate from the adolescent's home or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice. Services are furnished consistently with the child/adolescent's Plan of Care. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day). Independent living/skills building services will facilitate the adolescent's achievement of their goals of community inclusion and remaining in/returning to their home.

Therapeutic mentorship offers structured, one-to-one, strength-based support services between a therapeutic mentorship and an adolescent for the purpose of addressing daily living, social, and communication needs. The mentor collaborates with the therapist to explore an adolescent's interests and abilities and creates activities that build various life skills and result in linkages to community activities. These services will include coaching, supporting, and training the adolescent in age-appropriate behaviors, interpersonal communication, conflict resolution and problem-solving, and are provided in community settings (such as libraries, stores, parks, city pools, etc.). Independent living/skills building can be related to activities of daily living, such as personal hygiene, household chores, volunteering, household management, money management/budgeting, and socialization, if these skills are affected by the adolescent's serious emotional disorder. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy, and informed choice necessary to successfully function in the community.

The independent living/skills building provider will use a nationally recognized evidence-based therapeutic approach to assist the child/adolescent in developing the knowledge and skills necessary to understand and address their specific needs as related to their serious emotional disorder and treatment. The nationally recognized evidence-based therapy sessions may focus on, but not be limited to, elements such as developing and enhancing the family/legal guardian's problem-solving skills, coping mechanisms, and strategies for the child/adolescent's symptom/behavior management. Services provided in this category will be in response to a specific goal(s) in the adolescent's Plan of Care provided under the direction of the therapist and will not duplicate any other services provided to the adolescent.

502.18.3 Job Development

Procedure Code: T2021-HA

Service Unit: 15 minutes

Telehealth: Not available

Service Limit: Up to 160 units per calendar week in combination with independent living/skills building and supported employment. Recipients must be 15 to 20 years of age to access this service.

Site of Service: This service may only be provided in community locations.

Staff Credentials: High school diploma or GED, indirectly supervised by an in-home support staff person. Indirect supervision is defined as supervision provided by a licensed individual who monitors but is not required to be present in the setting when services are rendered.

Documentation: An approved authorization for services dated prior to the initiation of services must be included in the young adult's record, and the service must be included in the Plan of Care. A service note must be included for each instance or day of service that describes the service activity provided (within guidelines of the CSEDW manual, name of the service provider, date of the service, start and stop time of the service, the service code and signature and credential of the provider in ink or in an electronic documentation system with a time and date stamp).

Definition: Job development (CMS defined: prevocational services) provides learning and work experiences, including volunteer work and personal skills, where the adolescent can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period that does not exceed one year and have specific outcomes to be achieved, as determined by the adolescent and their CFT through an ongoing Plan of Care process. Young adults receiving job development must have employment-related goals in their Plan of Care; the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which an adolescent is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by adolescents without a serious emotional disorder, is the successful outcome of job development. Job development should enable each child/adolescent to attain the highest level of work in the most integrated setting and with the job matched to the child/adolescent's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills that lead to competitive and integrated employment including, but not limited to, ability to communicate effectively with supervisors, coworkers, and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem-solving skills and strategies; and general workplace safety and mobility training. Participation in job development is not a required prerequisite for supported employment services provided under the waiver. Adolescents, particularly those transitioning from school to adult activities, are likely to choose to go directly into supported employment. Supported employment for adolescents with behavioral health conditions emphasizes rapid job placement in lieu of job development. Documentation is maintained in the file of each child/adolescent receiving this service that a referral has been made to a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401 et seq.). Adolescents may utilize the CSEDW non-medical transportation service for travel to and from the adolescent's home and their supported employment or job development sites. Services provided in this category will be in response to a specific goal(s) in the adolescents' Plan of Care and will not duplicate any other services provided.

502.18.4 Supported Employment, Individual

Procedure Code: T2019-HA

Service Unit: 15 minutes

Telehealth: Not available

Service Limit: Up to 160 units per calendar week in combination with independent living/skills building and job development. Recipients must be 18 to 20 years of age to access this service.

Site of Service: This service may only be provided in public community locations.

Staff Credentials: High school diploma or GED, indirectly supervised by in-home support staff person. Indirect supervision is defined as supervision provided by a licensed individual who monitors but is not required to be present in the setting when services are rendered.

Documentation: An approved authorization for services dated prior to the initiation of services must be included in the adolescent's record, and the service must be included in the Plan of Care. A service note must be included for each instance or day of service that describes the service activity provided (within guidelines of the CSEDW manual, name of the service provider, date of the service, start and stop time of the service, the service code and signature and credential of the provider in ink or in an electronic documentation system).

Definition: Supported employment - individual support services are the ongoing supports to young adults who, because of their serious emotional disorder, need intensive ongoing support to obtain and maintain an individual job. The job may be in competitive or customized employment, or self-employment. It should be in an integrated work setting in the general workforce at or above West Virginia's minimum wage, or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. This service may also include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services:

- Vocational/job-related discovery or assessment
- Employment planning
- Job placement,
- Job development
- Negotiation with prospective employers
- Job analysis, training, and systematic instruction
- Job coaching
- benefits and work incentives
- Planning and management
- Transportation
- Asset development
- Career advancement services
- Other workplace support services, including services not specifically related to job skill training that enable the adult with serious emotional disorder to be successful in integrating into the job setting such as personal care activities

Documentation is maintained in the file of each young adult receiving this service that a referral has been made to a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with

Disabilities Education Act (IDEA) (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment
- Payments that are passed through to users of supported employment services

The young adult may use the CSEDW non-medical transportation service for travel to and from their home and their supported employment or job development sites. Services provided in this category will be in response to a specific goal(s) in the Plan of Care and will not duplicate any other services provided.

502.18.5 Extended Professional Services: Specialized Therapy

Procedure Code: G0176-HA

Service Unit: $1.00

Telehealth: Not available

Service Limit: Up to $1,000.00 per Plan of Care year in combination with assistive equipment

Site of Service: This service may be provided in the child/adolescent's home, a licensed CSEDW provider agency office, and/or public community locations.

Staff Credentials: Staff providing this service must have documented experience with specialized therapies such as music, art, or play therapy recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work.

Definition: Specialized therapy refers to activity therapy, such as music, dance, art, or play therapies not for recreation, related to the care and treatment that arise because of a serious emotional disorder. The service is intended to assist in acquiring the knowledge and skills necessary to understand and address these treatment needs, e.g., developing and enhancing problem-solving skills, coping mechanisms, strategies for the child/adolescent's symptom/behavior management. Specialized therapies are professional services that should promote full membership in the community and/or increase safety in the home environment and local public community and/or assist the individual in self-directing their services. The specialized therapy provider will use a nationally recognized evidence-based therapeutic approach to assist the child/adolescent and/or family/legal guardian in developing the knowledge and skills necessary to understand and address specific needs. Specialized therapy services must be directed and provided by professionals who are trained, qualified, and/or certified to provide activity therapies. Providers of specialized therapy cannot treat their own family members. Services provided in this category will be in response to a specific goal(s) in the Plan of Care and will not duplicate any other services provided to the child/adolescent and based on medical necessity.

Documentation: An approved authorization for services dated prior to the initiation of services must be included in the child/adolescent's record, and the service must be included in the Plan of Care. A service note must be included for each instance or day of service that describes the service activity provided,

name of the service provider, date of the service, start and stop time of the service, the service code and signature and credential of the provider in ink or in an electronic documentation system.

Documentation must show progress or lack of progress toward the achievement of goals and objectives that are the focus of the sessions.

The services must be specified in the Plan of Care. The plan may be incorporated into the initial or master Plan of Care or, after referencing the service on the Plan of Care, be a separate plan created by the professional clinician. The plan must be signed by the clinicians responsible for implementing the service.

The plan must identify the specific, sequential steps necessary toward identified skill acquisition identified in the goal and be related to previously assessed deficits of the child/adolescent (e.g., hand over hand, instruction, demonstration, practice, independent implementation, and mastery). The steps identified must establish a means for measuring the achievement of objectives within the specified time frame. The plan must establish a realistic time frame for skill acquisition. If objectives have not been achieved within a realistic time frame established by the Plan of Care, it must be discontinued or revised.

502.18.6 Assistive Equipment

Procedure Code: T2035-HA

Service Unit: $1.00

Telehealth: Not available

Service Limit: Up to $1,000.00 per plan of care year in combination with specialized therapy

Site of Service: N/A

Definition: Assistive equipment refers to an item or piece of equipment that is used to address the needs that arise because of a serious emotional disorder. The equipment should increase, maintain, or improve functional capabilities of the child/adolescent, assist them to remain in the home and/or community and avoid an out-of-home placement.

Services provided in this category will be in response to a specific goal(s) in the Plan of Care and will not duplicate any other services provided and will be based on medical necessity. Efforts to obtain assistive equipment from resources available in the community and sustainability after discharge considerations should be made before adding to the Plan of Care.

Documentation: For this service to be reimbursed, it must be prior authorized by the MCO and included in the Plan of Care as a service connected to the needs and goals and within the guidelines identified in Section 502.17.4 POC Development of this policy. Documentation for equipment covered under this service must be specified in the Plan of Care. The plan may be incorporated into the initial or master Plan of Care or, after referencing the service on the Plan of Care, be a separate document created by the professional clinician. The plan must be signed by the clinicians responsible for implementing the service. These services must be purchased from an established business or otherwise qualified entity or individual and must be documented by a dated and itemized receipt or other documentation.

502.18.7 Community Transition

Procedure Code: T2038-HA

Service Unit: $1.00

Telehealth: Not available

Service Limit: Up to $3,000 for a one-time transition period; a transition period can last up to six months. Recipients must be 18 to 20 years of age to access this service.

Site of Service: N/A

Definition: Community transitions services are non-recurring set-up expenses for young adults who are transitioning from an institutional living arrangement to a living arrangement in a private residence where the young adult is responsible for their own living expenses. Allowable expenses are those necessary to establish a basic household that do not constitute room and board and may include:

- Security deposits that are required to obtain a lease on an apartment or home
- Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens
- Setup fees or deposits for utility or service access, including telephone, electricity, heating, and water
- Services necessary for the individual's health and safety, such as one-time cleaning prior to occupancy
- Necessary home accessibility adaptations
- Activities to assist with purchasing or obtaining needed transition supports, including services necessary for the member's health and safety such as pest eradication and one-time cleaning prior to occupancy

Community transition services are furnished only to the extent that they are reasonable and necessary, as determined through the POC development process, clearly identified in the Plan of Care see Section 502.17.4 Plan of Care Development), and the adult is unable to meet such expense or when the services cannot be obtained from other sources.

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/mortgage expenses
- Home improvements or repairs that are considered regular maintenance or upkeep
- Recreational or illegal drugs
- Alcohol
- Medications or prescriptions
- Credit card or medical bills (even if they are past due)
- Payments to someone to serve as a representative
- Gifts for staff, family/legal guardians, 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 expenses, 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, haircuts, etc.)
- Assistive technology
- Discretionary cash
- Groceries
- Household appliances
- Items intended for purely diversional/recreational purposes

Any service or support that does not address an identified need in the Plan of Care, decreases the need for other Medicaid services, increases safety in the home, or improves and maintains opportunities for full membership in the community is excluded.

Services provided in this category will be in response to a specific goal(s) in the Plan of Care and will not duplicate any other services provided and will be based on medical necessity.

All community transition services must be approved by the MCO prior to being purchased/provided. The funding request process is as follows:

- The funding request is completed by the wraparound facilitation to request an item determined necessary by the CFT, is not an excluded item/is an approvable item (listed above) and is incorporated in the Plan of Care.
- The wraparound facilitation will ensure the items listed do not exceed $3,000.00.
- Email the estimate and request form/invoice to the MCO. If a retailer for the item has been identified, a screenshot or image for each item to be purchased can be included in the email.
- If the request is approved, the wraparound facilitation agency will invoice the MCO, which will pay the wraparound facilitation agency. The wraparound facilitation agency will then purchase items required from the vendor directly for the items to be sent to the adult.
- At no time will the young adult be reimbursed directly for community transition items.
- All funding requests and supporting documentation are saved in the file.

If there is a question about whether an item can be approved, the wraparound facilitation can contact the MCO in advance of the request.

502.18.8 Family Therapy

Procedure Code: H0004-HO-HA

Service Unit: 15 minutes

Telehealth: Available with 02 service location, and telehealth justification must be provided within the service note. Telehealth is an allowable service modality for family therapy. Telehealth may be utilized to deliver services for up to 50% of the total services the child/adolescent receives per year of enrollment (one calendar year from the child/adolescent's anchor date).

Service Limit: Up to eight units per day, approximately 14 hours per week (56 units/week).

Site of Service: This service may be provided in the child/adolescent's home or community setting where privacy can be established or via telehealth as indicated above.

Staff Credentials: Staff qualified for this service are as follows: Licensed psychologist, supervised psychologist, licensed professional counselor, licensed graduate social worker, licensed independent clinical social worker, licensed certified social worker, board-certified behavioral analyst, advanced alcohol and drug counselor, and master addictions counselor. Effective December 1, 2021, master's-level non licensed but license-eligible clinicians may provide CSEDW services while receiving clinical supervision as is required for LBHCs. Staff providing this service must have documented experience in trauma-informed care and using generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work.

Definition: Family therapy consists of counseling and training services for the child/adolescent and family/legal guardian provided by a mental health professional listed within Section 502.3.3 CSEDW Service Providers – Staff Qualifications of this chapter. This service includes trauma-informed individual and family therapy. It should assist the child/adolescent and family/legal guardian to acquire the knowledge and skills necessary to understand and address the specific needs in relation to their serious emotional disorder and treatment, such as developing and enhancing the family's problem-solving skills, coping mechanisms, and strategies for the child/adolescent's symptom/behavior management.

The family therapist indirectly supervises the in-home family support, independent living, and respite care positions. The family therapy provider will use a nationally recognized evidence-based therapeutic approach to assist the child/young adult and their family/legal guardian in developing the knowledge and skills necessary to understand and address specific needs in relation to the serious emotional disorder and treatment. The evidence-based therapy sessions may focus on, but not be limited to, elements such as developing and enhancing the family's problem-solving skills, coping mechanisms, and strategies for the symptom/behavior.

Therapy should be established with a CSEDW therapy provider when available. If the child/adolescent already has an established therapist prior to obtaining CSEDW eligibility through the Medicaid State Plan, the child/adolescent's care team will work with the care manager to complete a coordination of care agreement. The form will indicate the agency chosen to provide all the other CSEDW services and the family/legal guardian wants to pursue this option, and that family therapy will not be billed for under the CSEDW program. The outside therapist is still a crucial part of the CFT and will be integral in the meetings. Documentation needs to occur when the outside therapist is invited to participate but chooses not to participate in the CFT meetings.

Services provided in this category will be in response to a specific goal(s) in the child/adolescent's Plan of Care and will not duplicate any other services provided.

502.18.9 In-Home Family Support

Procedure Code: H0004-HA

Service Unit: 15 minutes

Telehealth: Available with 02 service location and telehealth justification must be provided within the service note.

Telehealth is an allowable service modality for in-home family support. Telehealth may be utilized to deliver services for up to 50% of the total services the child/adolescent receives per year of enrollment (one calendar year from the child/adolescent's anchor date).

Service Limit: Up to eight units per day

Site of Service: This service may be provided in the child/adolescent's home or community setting where privacy can be established or via telehealth as indicated above.

Staff Credentials: Bachelor's degree in human services with one year of documented experience working with this population.

Definition: In-home family support services allow the child/adolescent and family/legal guardian to practice and implement the coping strategies introduced by the therapist. The family support worker works with the child/adolescent and family/legal guardian on the practical application of the skills and interventions that will allow the family to function more effectively. The family support worker assists the therapist by helping the child/adolescent and/or family/legal guardian communicate their concerns; providing feedback to the therapist about observable family dynamics; helping the family/legal guardian and/or child/adolescent implement changes discussed in therapy and/or parenting classes; providing education to the family/legal guardian regarding their child/adolescent's serious emotional disorder; coaching, supporting, and encouraging new parenting techniques; helping family/legal guardians learn new parenting skills specific to meet the needs of their child/adolescent; participating in family activities and supports family/legal guardians in applying specific and on-the-spot parenting methods in order to change family dynamics. Additionally, the in-home family support staff person supervises the job development and supported employment position(s).

Services provided in this category will be in response to a specific goal(s) in the child/adolescent's Plan of Care and will not duplicate any other services provided. The worker supervises the peer parent support worker and will be supervised by the family therapist.

502.18.10 Peer Parent Support

Procedure Code: H0038-HA

Service Unit: 15 minutes

Telehealth: Available with 02 service location and telehealth justification must be provided within the service note. Telehealth is an allowable service modality for peer parent support. Telehealth may be

utilized to deliver services for up to 50% of the total services the child/adolescent receives per year of enrollment (one calendar year from the child/adolescent's anchor date).

Service Limit: Up to eight units per week

Site of Service: This service may be provided in the residence, a licensed CSEDW provider agency office, and/or public community locations.

Staff Credentials: High school diploma or GED and lived experience as an individual or family member/legal guardian of a child/adolescents with serious emotional disorder.

Definition: Peer parent support services are designed to offer support to the family/legal guardian. The service is geared toward promoting empowerment, enhancing community living skills, and developing natural supports. This service connects the family/legal guardian with an individual who is raising or has raised a child/adolescent with serious emotional disorder and is personally familiar with the associated challenges. Peer parent support providers explain community services, programs, and strategies they have used to achieve goals. It fosters connections and relationships, which builds the resilience of the child/adolescent and their family. This service is aimed at providing support and advice based on the lived experience of a family member or self-advocate. Peer parent support providers cannot mentor their own family members. Peer parent support services encourage the child/adolescent and their family/legal guardian to share their successful strategies and experiences in navigating a broad range of community resources beyond those offered through CSEDW with other children/adolescents in the waiver and their families. Service includes facilitation of parent or family member "matches" and follow-up support to ensure the matched relationship meets peer expectations. Peer parent support providers will not supplant, replace, or duplicate activities required to be provided by the wraparound facilitator, family therapy, or in-home family support.

Services provided in this category will be in response to a specific goal(s) in the Plan of Care and will not duplicate any other services provided. The worker will be supervised by the in-home family support worker.

Documentation: Documentation report must be maintained in the medical record and contain the following:

- Name
- Date, location, and start/stop time of service/meeting
- Activity note (describing each activity):
    - Self-Help: Cultivating the ability to make informed, independent choices. Helping develop a network of contacts for information and support based on experience of peer parent support. Assisting with developing social skills, repairing, rebuilding, or establishing prevention networks.
    - System Advocacy: Assisting the child/adolescent and/or their family/legal guardian to talk about what it means to struggle with behavioral health issues (including substance use) and including other co-occurring health or habilitation needs to an audience or group. Assisting the child/adolescent with communicating about an issue related to maintaining their mental health.

  - Individual Advocacy: Discussing concerns about medication at the child/adolescent's request. Assisting with developing independence in self-referral techniques, accessing appropriate care, and understanding clear communication and coordination with any health care provider.
  - Treatment Planning: Helping the child/adolescent and/or family/legal guardian make appointments for all medical treatment when requested. Guiding the child/adolescent toward a proactive role in health care, jointly assessing services, and building support network.
  - Crisis Support: Assisting the child/adolescent with the development of a personal crisis plan. Helping with stress management and developing positive strategies for dealing with potential stressors and crisis situations.
  - Crisis Prevention: Giving feedback to the child/adolescent on early signs of crisis and how to request help to prevent a crisis. Assisting the child/adolescent in learning how to use the crisis plan. Educating on crisis prevention and identifying triggers as well as developing a crisis plan and prevention skills. Learning new ways to cope with behavioral health issues, participating in skills building for such things as time management, and connecting with prosocial activities.
  - Housing: For adolescents who are working toward living independently, assisting the adolescent with learning how to maintain stable housing through bill paying and organizing their belongings. Assisting the adolescent in locating improved housing situations. Teaching the adolescent to identify and prepare healthy foods according to cultural and personal preferences of the adolescent and their medical needs.
  - Education/Employment: Assisting the child/adolescent in gaining information about going back to school or job training. Facilitating the process of asking an employer for reasonable accommodation for psychiatric disability (mental health day, flex time, etc.).
- Type of Service:
  - Emotional: Demonstrating empathy, caring, or concern to bolster a child/adolescent's self-esteem and confidence
  - Informational: Sharing knowledge and information and/or providing life or vocational skills training
  - Instrumental: Providing concrete assistance to help others accomplish tasks
- Signature of the peer support staff providing the service and agency where the provider is employed, in ink or in an electronic documentation system.

NOTE: More than one activity can be utilized at any one service/meeting.

If there is a master Plan of Care, the intervention should be reflective of a goal and/or objective on the plan. The activity note must include the reason for the service, symptoms and functioning of the child/adolescent, and the response to the intervention and/or treatment.

Peer-parent support services may not be provided during the same time/at the same place as any other direct support Medicaid service. A fundamental feature of peer parent support is that the services are provided in the natural environment as much as possible.

502.18.11 Respite Care

Documentation for in-home and out-of-home respite must be completed on the Progress Note form (WV-BMS-CSED-07) to include the items listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues, the staff person should complete the accompanying Progress Note form (WV-BMS-CSED-07) to detail the issue.

The Progress Note form (WV-BMS-CSED-07) must include all the following information:

- Name
- Provider name and signature of the person providing respite services in ink or in an electronic documentation system
- Date of service; start and stop times; total time spent
- Service code, including modifier, to indicate ratio of staff to children/adolescents who receive services
- Indication (Y/N) of whether training was provided
- Record of transportation, including beginning location (from) and end location (to), and total number of miles for the trip.

502.18.11.1 Respite Care, In-Home

Procedure Code: T1005-HA

Service Unit: 15 minutes

Telehealth: Not available

Service Limit: Up to 24 calendar days per year in combination with out-of-home respite care. Children/adolescents residing in a foster care, facility, or independent living setting do not qualify for the service. Foster parents/homes are excluded from this service under the waiver, as the Title IV-E payment to foster care families should include respite. Waiver funds are not available to pay for room, board and supervision of children/adolescents who are in the State's custody, regardless of whether the child/ adolescent is eligible for funding under Title IV-E of the Social Security Act. The costs associated with maintenance and supervision are considered a state obligation and not reimbursable via the waiver.

Site of Service: Must be provided in the child/adolescent's home that may include biological homes, kinship homes, and adoptive homes. Respite may be provided in a community setting if delivery begins and ends in the child/adolescent's home.

Staff Credentials: High school diploma or GED and must be indirectly supervised by the family therapist.

Documentation: An approved authorization for services dated prior to the initiation of services must be included in the record and the service must be included in the Plan of Care. A service note must be included for each instance or day of service that describes the service activity provided (within guidelines of the CSEDW manual, name of the service provider, date of the service, start and stop time of the service, the service code and signature and credential of the provider in ink or in an electronic documentation system).

In-home respite will be subject to usage of the EVV utilization and all corresponding requirements.

Definition: Respite care services provide temporary relief to the child/adolescent's family/legal guardian and include all the necessary care that the usual caregiver would provide during that period. Service can be used to support the child/adolescent in engaging in age-appropriate community activities, such as shopping, volunteering, and attending concerts.

Services provided in this category will be in response to a specific goal(s) in the child/adolescent's Plan of Care and will not duplicate any other services provided to the child/adolescent. The worker will be supervised by the therapist. The services under the waiver are limited to additional services not otherwise covered under the Medicaid State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Service cannot be provided while the child/adolescent is asleep.

502.18.11.2 Respite Care, Out-Of-Home

Procedure Code: T1005-HA-HE

Service Unit: 15 minutes

Telehealth: Not available

Service Limit: Up to 24 calendar days per year in combination with in-home respite care. Children/adolescents residing in a foster care, facility, or independent living setting do not qualify for the service. Foster parents/homes are excluded from this service under the waiver, as the Title IV-E payment to foster care families should include respite. Waiver funds are not available to pay for room, board and supervision of children/adolescents who are in the State's custody, regardless of whether the child/adolescent is eligible for funding under Title IV-E of the Social Security Act. The costs associated with maintenance and supervision of these children/adolescents are considered a state obligation and not reimbursable via the waiver.

Site of Service: Provided in the local public community.

Staff Credentials: High school diploma or GED and must be supervised by the family therapist.

Documentation: An approved authorization for services dated prior to the initiation of services must be included in the record, and the service must be included in the Plan of Care. A service note must be included for each instance or day of service that describes the service activity provided (within guidelines of the CSEDW manual, name of the service provider, date of the service, start and stop time of the service, the service code and signature and credential of the provider in ink or in an electronic documentation system).

Definition: Respite care services provide temporary relief to the child/adolescent's family/legal guardian and include all the necessary care that the usual caregiver would provide during that period. Please note waiver services may be furnished to children/adolescents in foster care living arrangements but only to the extent that waiver services supplement maintenance and supervision services furnished in such living arrangements and waiver services are necessary to meet the identified needs of the children/adolescents. Service can be used to support the child/adolescent in engaging in age-appropriate community activities, such as shopping, volunteering, and attending concerts.

Services provided in this category will be in response to a specific goal(s) in the Plan of Care and will not duplicate any other services provided.

502.18.12 Transportation

Transportation services are only to be utilized for services covered under the CSEDW in this chapter.

Procedure Code: A0160-HA

Service Unit: 1 mile

Telehealth: Not available

Service Limit: Up to 800 miles per month. Children/adolescents placed in foster care are eligible for non-emergency medical transportation (NEMT) services. Foster families cannot be reimbursed for providing transportation, as this would be considered a duplication of Title IV-E reimbursed services.

Staff Credentials: Any person who provides transportation services via personal or agency vehicle(s) must be 18 years of age or older and abide by local, state, and federal laws regarding operation and maintenance of current licensing, insurance, registration, and inspections according to the West Virginia Department of Motor Vehicles.

Definition: Service offered to enable children/adolescents to be transported to and from local, public community locations for services specified in the plan of care. This service is offered in addition to NEMT, detailed *in* *Chapter 524, Transportation*, and required under 42 CFR §431.53 and transportation services under the Medicaid State Plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Services provided in this category will be in response to a specific goal(s) in the Plan of Care and will not duplicate any other services provided to the child/adolescent.

Documentation: Documentation must be completed on the Progress Note form (WV-BMS-CSED-07) to include the items listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues, the staff person should complete the accompanying Progress Note form (WV-BMS-CSED-07) to detail the issue. The Progress Note form (WV-BMS-CSED-07) must include all the following items:

- Child/adolescent name
- Provider name and signature of the staff person providing transportation services in ink or in an electronic documentation system
- Date of service; start and stop times; and total time spent
- Service code, including modifier, to indicate ratio of staff to children/adolescents who receive services
- Indication (Y/N) of whether training was provided
- Transportation log section including the beginning location (from) and end location (to) and total number of miles for the trip
- Copy of current, valid driver's license, registration, and proof of vehicle insurance for staff providing transportation
- Current valid proof of vehicle inspection in the state where the vehicle is registered

This service may be billed concurrently with day services, respite care services, or peer parent support. The number of miles per service must be included in the child/adolescent's Plan of Care.

Children/adolescents enrolled in CSEDW may access NEMT for non-CSEDW services such as routine medical appointment through the Medicaid State. For more information, see *Chapter 524, Transportation*.

502.19 SERVICE LIMITATIONS AND SERVICE EXCLUSIONS

Services governing the provision of all West Virginia Medicaid services apply pursuant to *Chapter 300 Provider Participation Requirements*, of the Provider Manual and 502.17.4 Plan of Care Development, of this chapter. Reimbursement for services is made pursuant to *Chapter 600 Reimbursement Methodologies*. The following limitations also apply to the requirements for payment of services that are appropriate and necessary for CSEDW services described in this chapter. CSEDW services are made available with the following limitations:

- All CSEDW regulations and policies must be followed in the provision of the services. This includes the requirement that all CSEDW providers be licensed in the State of West Virginia, enrolled in the West Virginia Medicaid program, and contracted with the MCO.
- The services provided must conform with the stated goals and objectives in the Plan of Care.
- Regular cancellation should be discussed during the CFT meetings. The CFT should plan to discuss barriers preventing attendance at appointments and potential solutions to maintain future appointments. In the event of a one-time cancellation, staff services should not be canceled. However, if three or more cancellations occur within a three-month rolling period, these services should be placed on hold until the therapist is able to complete sessions with the child/adolescent and family/legal guardian.
- Individual service and limitations described in this manual must be followed.
- The CSEDW services may be provided within 30 miles of the West Virginia border to children/adolescents residing in a West Virginia County bordering another state.
- In addition to the non-covered services listed in *Chapter 100, General Information*, of the West Virginia Medicaid Provider Manual, the BMS will not pay for the following services:
    - The CSEDW program must not substitute for entitled programs funded under other federal public laws such as Special Education under P.L. 99 – 457 or 101 – 476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973
    - Public school services, including children/adolescents who are home-schooled, receive home-bound instruction, and children/young adults who are eligible for public school services but are not enrolled
    - Service payments may not be made for room and board or the cost of facility maintenance and upkeep
    - Birth-to-Three services paid for by Title C of the Individuals with Disabilities Education Act (IDEA) for children/young adults enrolled in the CSEDW program
    - CSEDW services may not be provided concurrently
    - Telephone consultations between providers, except for wraparound facilitators gathering updates for the purposes of case planning
    - Meeting with the child/adolescent and/or family/legal guardian for the sole purpose of reviewing evaluation and/or results
    - Missed appointments, including but not limited to, canceled appointments and appointments not kept

  - Services not meeting the waiver definition of medical necessity
  - Services that duplicate other services, e.g., CSEDW family therapy services cannot be provided at the same time as intensive individual therapy and group therapy provided under the Medicaid State Plan
  - A copy of medical report when the agency paid for the original service
  - Experimental services or drugs
  - Any activity provided for leisure or recreation
  - Services rendered outside the scope of a provider's license
- Reimbursement for CSEDW services cannot be made for services provided outside a valid Plan of Care. To be considered valid, the Plan of Care must be current (dated within the past year and reviewed monthly by the CFT), signed by all required CFT members, and include all services provided. The following are considered reasons for the invalid Plan of Care:
  - Services provided when eligibility has not been established
  - Services provided when there is no Plan of Care
  - Services provided without supporting documentation
  - Services provided by unqualified staff
  - Services are provided before prior authorization or outside of authorized dates
  - Services provided outside the scope of a defined service

502.20 TELEHEALTH MODALITIES AND SERVICE PROVISION

Telehealth is not available for certain services included in CSEDW, including job development, supported employment, specialized therapy, assistive equipment, community transition, respite, and transportation. Family therapy, family support, peer parent support, and wraparound facilitation may use telehealth for up to 50% of the total services the child/adolescent receives per year of enrollment (one calendar year from the anchor date). For independent living/skills building telehealth may be used for up to 25% of the total services the child/adolescent receives per year of enrollment (one calendar year from the anchor date). West Virginia Medicaid encourages providers that have the capability to render services through telehealth to allow children/adolescents and their family/legal guardians with additional options to access services. The child/adolescent and/or family/legal guardians will determine the service modality that best meets their current needs. If the child/adolescent and/or family/legal guardian decides to utilize telehealth, providers will need to document that the service was rendered under that modality. The child/adolescent and/or family/legal guardian has the right to change their service delivery modality at any time, and those changes will need to be followed immediately by the agency. When filing a claim, the provider will bill the service code and add "02" as the place of service. Each service in this manual is identified as "Available" or "Not Available" for telehealth. Some services codes give additional instruction and/or restriction for telehealth as appropriate. Services provided through telehealth must align with requirements in *Chapter 519.17 Practitioner Services, Telehealth Services*.

Privacy is paramount in any health care and telemedicine interaction. The use of video conferencing, video monitoring, or any type of surveillance is not permitted at any time in any bedroom or bathroom. If at any time video monitoring, video conferencing, or any type of surveillance is discovered, the session must stop immediately, and a previously discussed backup plan must be followed.

The services below are approved for telehealth options with percentage allowable. The child/adolescent and/or their family/legal guardian may utilize telehealth in alignment with the frequency and duration

outlined in the Plan of Care; if telehealth is selected by the child/adolescent and family/legal guardian, a telehealth backup plan must be discussed and added to the Plan of Care. The telehealth backup plan must include alternative service connections available; for example, switching to an in-person face-to-face visit, emergency power supply, or mobile device that allows connection.

Delivery of services through telehealth will be conducted in compliance with HIPAA. Telehealth services must meet the current HIPAA and 42 CFR Part 2 regulations of compliance and is accepted by the West Virginia HIPAA Compliance Officer.
Types of allowable telehealth include:

- **Live video**: Also referred to as "real time;" a two-way, face-to-face interaction between the child/adolescent and provider using audiovisual communications technology.
- **E-visits**: Non-face-to-face communications through an online secure messaging application.
- **Audio-only visits**: Use of telephone or visits without video.
- **Case-based teleconferencing**: Method of providing holistic, coordinated, and integrated services across providers – usually interdisciplinary – with one or multiple internal and external providers and, if possible and appropriate, the child/adolescents and/or their family/legal guardian.

Providers that offer telehealth as an optional service modality must use applications with privacy protections for telehealth while using video communication products that are HIPAA compliant. Providers should notify children/adolescents and/or family/legal guardians if the telehealth applications are third party and could potentially introduce privacy risks. To help ensure child/adolescent protection and HIPAA compliance, users of telehealth applications should enable all available encryption and privacy modes when in use.

Telehealth will not be authorized as a duplicate service. Providers will be trained in exclusions of the services, and they will be provided in writing. Providers must follow program billing procedures, ensuring providers will not duplicate services and billing. The MCO will monitor service provision through the Plan of Care and claims reviews. The originating site must bill with the appropriate telehealth originating site code, and distant site providers must bill the appropriate Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT)/(HCPCS) code with the appropriate place of service code.

The MCO care manager and the wraparound facilitator are responsible for coordination and monitoring of telehealth use to help ensure that it is person-centered and conducted in accordance with state and federal guidance.

Services and Thresholds Available for Telehealth as an Allowable Service Modality

Service	Telehealth Allowance	Service Code
In-Home Family Support	50%	H0004-HA
Independent Living/Skills Building	25%	H2033-HA
Wraparound Facilitation	50%	T1016-HATF T1016-HATG
Peer Parent Support	50%	H0038-HA
Family Therapy	50%	H0004-HOHA

502.21 PRIOR AUTHORIZATIONS

Prior authorization requirements governing the provision of all West Virginia Medicaid services apply pursuant to *Chapter 300, Provider Participation Requirements*, of the BMS Provider Manual.
Please be advised that the following services do not require prior authorization in our system per policy:

- T1016-HA, Wrap Facilitation
- H0004-HOHA, Family Therapy
- H0004-HA, In-Home Support
- A1060-HA, Non-Medical Transportation
- H0038-HA, Peer Parent Support

As a reminder, providers can utilize the ProPat system to determine what services are covered, not covered, or if they require prior authorization.

502.22 BILLING PROCEDURES

Claims from providers must be submitted on the designated form or electronically transmitted to the fiscal agent and must comply with the following:

- Must include all information required to process the claim for payment
- The amount billed must represent the provider's usual and customary charge for the services delivered
- Claims must be accurately completed with the required information
- By signing the Provider Enrollment Agreement, providers help certify that all information listed on claims for reimbursement from Medicaid is true, accurate, and complete. Therefore, claims may be endorsed with computer-generated, manual, or stamped signatures
- Claim must be filed on a timely basis, i.e., filed within 365 calendar days from the date of service, and a separate claim must be completed for each individual child/adolescent

CSEDW providers that deliver Medicaid home and community-based services must submit their claims within 365 calendar days (or 1 full calendar year) of the date the services were delivered. If a claim isn't filed within this time limit, BMS will not reimburse the CSEDW provider. No Medicaid-reimbursed CSEDW services may be provided until the child/adolescent has been activated with the MCO.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms*, apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

Abuse: The infliction or threat to inflict bodily injury on or the imprisonment of any child/young adult or incapacitated adult.

Abuse and Neglect: As defined in and West Virginia Code §9-6-1 and West Virginia code §49-1-201.

Administrative Service Organization (ASO): Acts as an agent of the BMS and screens potential waiver applicants during the initial eligibility determination process and facilitates both initial evaluations and annual redeterminations of medical eligibility. The ASO is responsible for:

Agency Staff: Staff or contracted extended professional staff employed by a CSEDW provider to provide services to children/young adults in the CSEDW program through the traditional option.

Anchor Date: The annual date assigned by the ASO by which the child/young adult's medical eligibility must be recertified and is determined by the anniversary date that is the first day of the month following the date when initial medical eligibility was established by the MECA.

Assignment Date: The date the child/adolescent is assigned to the wraparound facilitation services agency by the MCO. The wraparound facilitation services agency will initiate services within 72 hours of assignment from the MCO.

Behavior Assessment System for Children (BASC): A standardized assessment used to evaluate the behavior and self-perceptions of children and young adults ages two through 25 years.

Case: The record of one child/adolescent in CSEDW.

Child and Adolescent Functional Assessment Scale (CAFAS): A standardized instrument that assesses the degree of impairment in youth with emotional, behavioral, psychiatric, or substance use problems. It provides an objective, comprehensive assessment of a youth's needs as they change over time.

Child and Adolescent Needs and Strengths (CANS): A functional assessment tool developed to support decision-making, including treatment planning, facilitating quality improvement initiatives, and monitoring the outcomes of services.

Child and Family Team (CFT): The child/adolescent and/or parent/legal guardian, the child/adolescent 's wraparound facilitator, representatives of each professional discipline, provider and/or program providing services to that child/adolescent (inter- and intra-agency), and MCO care coordinator (if requested), and others who possess the knowledge, skill, and expertise necessary to accurately identify the comprehensive array of services required to meet the individual's needs and design appropriate services and specialized programs responsive to those needs. It is a goal in developing the CFT to have greater than 50% participation from natural supports and community resources identified by the child/young adult and/or family/legal guardian. The Plan of Care meetings are guided by the child/adolescent's needs, wishes, desires, and goals.

Certificate of Need: A process often associated with cost containment measures. Additionally, the Legislative findings in the Certificate of Need Law declare the need for health services to be provided in an orderly, economical manner that discourages unnecessary duplication. The Certificate of Need is to be submitted to the Health Care Authority. West Virginia issues a Certificate of Need to indicate a health service's compliance with West Virginia Code §16-2D-1 et seq.

Children with a Serious Emotional Disorder (CSED): Children/young adults who are three years of age and up to 20 years of age who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM (or ICD equivalent) that is current at the date of evaluation that results in functional impairment that substantially interferes with or limits the child/young adult's role or functioning in family, school, and/or community activities.

Community Behavioral Health Clinic (CBHC): A healthcare provider setting offering behavioral health services licensed under West Virginia Code §64-11.

Corrective Action Plan (CAP): The report that providers must submit to the ASO with a plan to address any concerns stemming from a provider quality review. It includes where standards were not sufficiently met, based upon on-site and desk documentation, staff interviews, telephone satisfaction surveys with children/adolescents who receive services and/or their parent/legal guardian, and day service visits to validate certification documentation and address the CMS quality assurance standards.

Critical Incidents: Critical incidents are serious in nature and pose immediate risk to health, safety, and welfare to the individual receiving services or others.

Direct-Care Staff: The individuals who provide the day-to-day care to personal care members. Sometimes referred to as homemakers or personal assistants.

Discharge: release from a child/adolescent from the CSEDW program when the child/adolescent meets goals and is ready to step down to less intensive services or more intensive services, has aged out of services, has lost medical eligibility, or has not maintained compliance with the program.

Days: Calendar days unless otherwise specified.

Duration: As it relates to the plan of care, the duration is the length of time a service will be provided. Example: six months, three months, one month.

Diagnostic and Statistical Manual of Mental Disorders (DSM): A comprehensive classification of officially recognized psychiatric disorders, published by the American Psychiatric Association, for use by mental health professionals to help ensure uniformity of diagnosis.

Eligibility: The criteria that allows a child/young adult to qualify for the CSEDW program participation.

Enrollment: The process of a child/adolescent becoming a member in the CSEDW program.

Fiscal Agent: The contracted vendor responsible for claims processing and provider relations/enrollment.

Freedom of Choice Form: A form signed by the child/young adult and/or family/legal guardian where an individual expresses their choice for of HCBS or an Institutionalization placement. A Freedom of Choice form may also be used for the individuals to express their choice of providers HCBS Providers.

Frequency: As it relates to plan of care, the frequency refers to how often a service is provided.

Example: Monday through Friday, daily, etc.

Formal plan of care meeting: A CFT meeting where all services and supports are present for the meeting to provide support to the child/young adult and/or their family/legal guardian and an update on the progress with the goals in the Plan of Care.

Foster Child: The West Virginia DoHS defines a foster child as a child or young adult receiving 24-hour substitute care while placed away from his or her parents or guardians and for whom the State agency has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, childcare institutions, and pre-adoptive homes.

GED: General Educational Development Test or General Equivalency Diploma that is used for educational testing services designed to provide a high school equivalency credential.

Goals: Statement of outcome with specific tasks and objectives to achieve those outcomes. Goals are set to help ensure that effective services are being provided to the child/adolescent.

Graduation: Successful discharge from the CSEDW program due to a need for a lower Level of Care determined by the child/adolescent's goals, assessments, or ability to manage their care independently, or the child/adolescent aging out of the program.

Home and Community-Based Services (HCBS): Services delivered in a person's home, work, or other community setting that helps individuals to remain in the community setting rather than being admitted to an institution.

Home or Residence: The child/adolescent's place of residence. Home does not include a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the intellectually disabled.

Human Services Degree: A master's or bachelor's degree granted by an accredited college or university in one of the following human services fields:

- Psychology
- Criminal Justice
- Nursing
- Sociology
- Counseling/Therapy
- Teacher Education
- Behavioral Health
- Social Work
- Other degrees approved by the program manager

Incident: Any unusual event occurring to a child/adolescent that needs to be recorded and investigated for risk management or quality improvement purposes.

Incident Management System (IMS): A program used by the MCO to track and report on critical and non-critical incidents.

Independent Evaluator: A West Virginia licensed provider who is a West Virginia Medicaid Provider who performs comprehensive evaluations independent of CSEDW providers and who is a person of the Independent Evaluator Network (IEN) trained by the Medical Eligibility Contracted Agent (MECA). Independent evaluators qualified to assess medical eligibility for the CSEDW include psychologists, supervised psychologists, licensed independent clinical social workers, and licensed professional counselors. They must be licensed to practice independently and must follow the internal regulations of their accrediting body, licensing board, and/or certification board.

Independent Evaluation: An evaluation completed by a licensed provider of the IEN, which includes background information, behavioral observations, documentation that addresses the six major life areas, developmental history, mental status examination, diagnosis, and prognosis.

Independent Evaluator Network (IEN): West Virginia licensed providers who are enrolled West Virginia Medicaid providers and have completed the required IEN Training provided by MECA training and agreed to complete the IE as defined.

Indirect Supervision: Supervision provided by a licensed individual who monitors but is not required to be present in the setting when services are rendered.

Informal Support/Informal's: Family/legal guardians, friends, neighbors, or anyone who provides a service to a child/adolescent but is not reimbursed.

Legal Guardian: The parent of a minor child or young adult, a court-appointed legal guardian for an adult or child, or anyone with the legal standing to make decisions for the child/adolescent.

Level of Care: The minimum amount of assistance an individual must require in order to receive services in an institutional setting under the State Plan. For the CSEDW, applicants must require a PRTF Level of Care and specifically have either resided in a PRTF within the past six months, or through medical evaluation, it is determined that there is a reasonable indication that the applicant is in imminent danger of being placed in a PRTF within the last six months.

Licensed Behavioral Health Clinic (LBHC): A healthcare provider offering behavioral health services licensed under West Virginia Code §64-11.

Licensed Professional Counselor: An individual who has obtained full licensure as defined by the West Virginia Board of Examiners in Counseling and by West Virginia Code §30-31-8.

Licensed Psychologist: A psychologist who has completed the requirements for licensure that have been established by the West Virginia Board of Examiners of Psychologists and is in current good standing with the board.

Licensed Independent Clinical Social Worker: An individual who has obtained Level D status as defined by the West Virginia Board of Social Work and by West Virginia Code §30-30-9.

Managed Enrollment List: A waiting list for waiver applicants determined eligible when no waiver slot is available. Waitlisted waiver enrollees are offered a waiver slot once a slot becomes available in the chronological order in which they were determined eligible.

Medical Eligibility Decision: The decision by the BMS or its agent that the health care status and treatment requirements, as prescribed by a medical practitioner, substantiate the Level of Care and criteria for the Waiver Program.

Managed Care Organization (MCO): As defined in 42 CFR §438.2, an entity that has a comprehensive risk contract with the Medicaid agency and is (1) a federally qualified Health Maintenance Organization (HMO) or (2) makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity.

Medical Eligibility Contracted Agent (MECA): The contracted entity that acts as an agent of the BMS and evaluates potential waiver applicants during the initial eligibility determination process and annual redeterminations of medical eligibility.

Member (aka person, user, client, beneficiary, recipient, or enrollee): An individual who is eligible to receive or is receiving benefits from Medicaid, or an individual who is enrolled in a managed care plan.

Child/adolescent's Family Residence: A residence where the child/adolescent has a 911 address and lives with at least one biological, adoptive, natural, or other family member and/or a certified specialized family care provider.

National Wraparound Implementation Center (NWIC) Model: Wraparound provides a comprehensive, holistic, youth- and family-driven way of responding when children or youth experience serious mental health or behavioral challenges. A wraparound facilitator puts the child/young adult and family/legal guardian at the center. The wraparound team can include the family's friends and people from the wider community, as well as providers of services and supports. With the help of the team, the family and young person take the lead in deciding vision and goals, developing a plan, monitoring how well it is working, and changing it as needed.

Non-Critical Incidents: Incidents that do not require an urgent response but may require clinical follow-up or further investigation.

Office of Health Facility Licensure and Certification (OHFLAC): The state agency that inspects and licenses CSEDW providers to help ensure the health and safety of a child/adolescent in CSEDW. Licensed entities include, but are not limited to, behavioral health providers, CSEDW providers, facility-based day programs, group homes, supported employment facilities, and wraparound facilitation agencies.

Person Centered Planning: is a way to assist people needing HCBS services and supports to construct and describe what they want and need to bring purpose and meaning to their life.

Plan of Care: A document developed with assistance as needed or desired from a representative or other persons of the individual's choosing. The process is designed to find the strengths, abilities, preferences, needs, and desired outcomes of the individual. The process may include other persons, freely chosen by the individual, who are able to serve as important contributors to the process. The person-centered planning process enables and helps the individual to find and access a personalized mix of paid and non-paid services and supports that help them to achieve personally defined outcomes in the community.

Pre-Hearing Conference: A meeting requested by the applicant or child/adolescent and/or legal guardian to review the information submitted for the medical eligibility determination and the basis for the denial/ termination. A Medicaid Fair Hearing pre-hearing conference may be requested any time prior to a Medicaid Fair Hearing.

Preschool and Early Childhood Functional Assessment Scale (PECFAS): Standardized assessment tool that assesses a preschool-aged child's day-to-day functioning across critical life domains and determines whether a child's functioning improves over time.

Prior Authorization: Prior approval necessary for specified services to be delivered for an eligible child/adolescent by a specified provider before services can be performed, billed, and payment made. It is a utilization review method used to control certain services that are limited in amount, duration, or scope.

Public Community Location: Any community setting open to the public, such as libraries, banks, stores, and post offices.

Respite Care: Short-term or intermittent care and supervision to provide an interval of rest or relief to family or caregivers.

Safe Environment: A place where people feel secure; where they are not at risk of being subject to harm, abuse, neglect, or exploitation; and where they have the freedom to make choices without fear of recourse.

Significant Life Event: Any time there is an event or change in the child/adolescent's life that requires a meeting of the CFT. The occurrence may require that a service needs to be decreased, increased, or changed. A significant life event constitutes a change in the child/adolescent's needs such as behavioral, mental, or physical health, service/service units, support, setting, or a crisis.

Slot: An allotted reservation for an eligible child/young adult to participate in the CSEDW program.

Supervised Psychologist: An individual who is an unlicensed psychologist with a documented completed degree in psychology at the level of a Master of Arts (MA), Master of Science (MS), Doctor of Philosophy (PhD), Doctor of Psychology (PsyD) or a Doctor in Education (EdD). and has met the requirements of, and is formally enrolled in, the West Virginia Board of Examiners of Psychologists Supervision program.

Telehealth: For purposes of Medicaid, telemedicine seeks to improve a patient's health by permitting two-way, real-time interactive communication between the patient and the physician or practitioner at the

distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio, and video equipment.

Transfer: Changing needed services from one CSEDW provider to another, agreed upon by the child/young adult and/or family/legal guardian and the receiving provider.

Waitlist: The list of individuals waiting for CSEDW services due to service availability.

Wraparound Facilitation Agency: A privately operated for-profit or nonprofit organization/agency licensed to do business in West Virginia, having a provider agreement with the BMS, and enrolled as a provider of wraparound facilitation services.

Wraparound Facilitator: A person who assists in planning, coordinating, monitoring, and evaluating medical services for a child/adolescent with emphasis on quality of care, continuity of services, and cost-effectiveness; also referred to as a caseworker.

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
New Chapter	Chapter 502, Children with Serious Emotional Disorder Waiver (CSEDW)	February 1, 2020
Entire Chapter	Updated language throughout to include wraparound facilitation replacing case management, changing Person-Centered Plan to Plan of Care, changing Person-Centered Planning Team to Child and Family Team Updated rates and limits to align with proposed waiver amendment effective 7/1/2021 502.3.3 Added language to include the Cures Act requirement that BMS will implement an Electronic Visit Verification (EVV) system to verify in-home visits by in-home respite workers, independent living service providers, and wraparound facilitators by April 1, 2021 Updated Program Description to include 10 principles of the wraparound process. 502.1 BMS Contractual Relationships—Clarified responsibilities of contractors under the waiver 502.3.2 Enrollment Requirements: CSEDW Medical Eligibility Evaluators—Language updated, added to Staff Qualifications section to clarify training and experience requirements for medical eligibility evaluation network	July 1, 2021

REPLACE	TITLE	EFFECTIVE DATE
	502.3.3 Enrollment Requirements—Language added to clarify CSEDW waiver provider requirements. Language added to clarify that training documentation may be on another form or in a tracking system if the documentation includes all elements on the CSED-06 form. 502.7 Provider Reviews—Added process for ASO to obtain a sample and data for quality reviews. 502.9 Added to Other Administrative Requirements section to require providers to monitor utilization in alignment with expected service usage based on POCs and electronic records. Added clarification that CSEDW cannot bill for administrative tasks. 502.10 Telehealth Services—Added clarification on billing 502.12 Added to Incident Reporting Requirements section to include documentation requirements and clarify definitions and requirements 502.13.2 Quality Improvement Advisory Council—Added responsibilities of the MCO and ASO 502.14.1 Streamlined eligibility process and made the process more chronological 502.14.2 Added new section for Right to Appeal, separating it from 502.14.1, made clarifications consistent with the approved waiver 502.14.2.1 Level of Care Instruments—Separated this section from Functionality and Diagnosis section 502.14.2.2 Diagnosis—Separated this section from Functionality 502.14.2.3 Functionality—Changed BASC score threshold for medical eligibility from 70 to 60 502.14.2.4 PRTF Level of Care—Separated this section from Functionality and provided more detail	

REPLACE	TITLE	EFFECTIVE DATE
	502.14.3 Slot Allocation Referral and Selection Process—Clarified the waitlist process 502.15 Clarified billing for wraparound facilitation services and other CSEDW services. Clarified eligibility process at redetermination. 502.16.2 Added language regarding continued eligibility for services 502.18 Updated POC Requirements section to include initial case plan completion within seven days of waiver enrollment, remove physicians as participants in the POC meeting, and clarify plan requirements 502.18.1 Child and Family Service Team—Added language regarding composition of the team to align with NWI requirements 502.18.2 Updated Plan of Care Development section to clarify plan components, attendee, and documentation requirements 502.18.2.1 Added to Seven-Day CFT Meeting to include initial case plan completion within seven days of waiver enrollment and clarify plan, prior authorization, attendee, and documentation requirements 502.18.2.2 30-Day CFT Meeting and 90-Day Review CFT Meetings—Added “90-Day Review” to section title; removed language allowing for less frequency than every 90 days for POC. Updated plan, prior authorization, attendee, and documentation requirements. Added language regarding continuing eligibility based upon progress with the Plan of Care and suspension of waiver services. 502.18.2.3 Updated Transfer/Discharge CFT Meeting section to clarify plan components, attendee, and documentation requirements 502.18.2.4 Updated significant life event CFT Meeting section to provide guidance on when meetings should be held; added attendee and documentation requirements 502.19 Added responsibilities and documentation requirements to wraparound facilitation section.	

REPLACE	TITLE	EFFECTIVE DATE
	502.19.1 Member Choice of Single Wraparound Facilitation Provider—Added special provisions to clarify situations and requirements when a provider offers both wraparound facilitation and other CSEDW services to the same member. 502.20.1 Wraparound Facilitation—Clarified requirements and added EVV requirements 502.21 Updated Crisis Services: Mobile response to add documentation and remove review within 72 hours of crisis requirements 502.22.1 Added Independent Living/Skills Building—Added documentation and authorization requirements and EVV requirements 502.22.2 Job Development—Added documentation and authorization requirements. 502.22.3 Supported Employment, Individual—Added documentation and authorization requirements 502.23 Extended Professional Services: Specialized Therapy—Added documentation and authorization requirements 502.24 Other Services—Added summary of requirements for services that have a limit counted in dollars per plan of care year 502.24.1 Assistive Equipment—Added documentation and authorization requirements: updated limit amount 502.24.2 Community Transition—Added allowable items, documentation, and authorization requirements; removed pest eradication as an allowable service 502.25.3 Peer Parent Support—Removed requirement that Peer Parent be certified 502.26.1 Respite Care, In-Home—Added documentation and authorization requirements 502.26.2 Respite Care, Out-Of-Home—Added documentation and authorization requirements	

REPLACE	TITLE	EFFECTIVE DATE
	502.27 Added provider requirements to Non-Medical Transportation section, clarified that foster parents cannot be reimbursed as providers of non-emergency medical transportation 502.28 Clarified billing requirements for telephone consultation and preparation of reports. Added additional definitions to the Glossary based on changes in names of services and to add further clarity Technical corrections and edits were also made to the document for clarity. Added Appendix A: Initial plan of care template Added Appendix B: Master plan of care template	
Entire Chapter	Changed language to child/adolescent from member. Added telehealth guidance for services permanently approved. CFT meetings were changed to occur every 30 days. CANS with 30 days of assignment date. Removal of mobile crisis; now State Plan Amendment (SPA) service 1/1/24. Legal representative to family/legal guardian. Maximum age corrected to young adult up to 21st birthday. Added discharge process section. Added clarifying language to SLE. Added wraparound facilitation acuity details. 502.2 – changed to Medical Necessity, language changes. 502.3 – changed to Provider Enrollment and Participation Requirements, language changes.	October 1, 2024

REPLACE	TITLE	EFFECTIVE DATE
	502.3.1 – changed to Comprehensive Behavioral Health Centers (CBHCs) and Licensed Behavioral Health Centers (LBHCs). 502.3.2 – changed to CSEDW Medical Eligibility Evaluator Staff Qualifications. 502.3.3 – CSEDW Service Providers – Staff Qualifications, language changes. 502.4 – changed to Criminal Background Checks. 502.5 – changed to Electronic Visit Verification (EVV), language changes. 502.6 – changed to Incident Reporting Requirements, headers added. 502.7 – changed to Clinical Supervision. 502.8 – changed to Methods of Verifying Medicaid Requirements. 502.9 – changed to Training and Technical Assistance. 502.10 – changed to Confidentiality. 502.10.1 – changed to Health Insurance Portability and Accountability Act (HIPAA) Regulations. 502.10.2 – changed to Quality Improvement advisory Council. 502.11 – changed to Quality Improvement Systems (QIS), language changes. 502.11.1 – changed to Centers for Medicare and Medicaid Services Quality Assurance. 502.11.2 – changed to Documentation and Record Retention Requirements. 502.12 – changed to Providers Review, language changes. 502.12.1 – changed to Self-Audit.	

REPLACE	TITLE	EFFECTIVE DATE
	502.13 – changed to Other Administrative Requirements. 502.14 – changed to CSEDW Applicant Eligibility. 502.14.1 – changed to Medical Eligibility. 502.14.2 – changed to Diagnosis. 502.14.3 – changed to Functional Impairment. 502.14.4 – changed to PRTF Level of Care. 502.14.5 – changed to Level of Care Instruments. 502.14.6 – changed to Eligibility Determination Process. 502.14.7 – changed to Right to Appeal. 502.15 – changed to Enrollment. 502.15.1 – changed to Slot Allocation. 502.15.2 – changed to Choice of Single Wraparound Facilitation Provider. 502.15.3 – changed to Member Rights. 502.15.4 – changed to Participation Responsibilities. 502.15.5 – changed to Grievances and Complaints. 502.16 – changed to Annual Redetermination of Waiver Eligibility Process. 502.16.1 – changed to Medical Redetermination Eligibility Appeals. 502.17 – changed to Person-centered Plan of Care, language changes. 502.17.1 – changed to Child and Family Team (CFT) 502.17.2 – changed to Child and Adolescent Needs and Strengths (CANS), language changes.	

REPLACE	TITLE	EFFECTIVE DATE
	502.17.3 – changed to Plan of Care Requirements, language changes. 502.17.4 – changed to Plan of Care Development, language changes. 502.17.5 – changed to Seven-Day CFT Meeting, language changes. 502.17.6 – changed to 30-Day CFT Meeting. 502.17.7 – changed to Transfer Process. 502.17.8 – changed to Discharge Process. 502.18 – changed to CSEDW Home and Community Based Services, language added. 502.18.1 – changed to Wraparound Facilitation, language changes. 502.18.1.1 – changed to Child/Adolescent Acuity Levels added. 502.18.1.2 – changed to Six-Month Progress Review. 502.18.1.2 – changed to Six-Month Progress Review. 502.18.2 – changed to Independent Living/Skills Building, changed language about staff credentials and definition. 502.18.3 – changed to Job Development, changed language about definitions. 502.18.4 – changed to Supported Employment, Individual, changed language about staff credentials and definition. 502.18.5 – changed to Extended Professional Services: Specialized Therapy, changed language for staff qualifications and definition. 502.18.6 – changed to Assistive Equipment 502.18.7 – changed to Community Transition.	

REPLACE	TITLE	EFFECTIVE DATE
	502.18.8 – changed to Family Therapy, changed language for staff credentials and definition. 502.18.9 – changed to In-Home Therapy, added language for definition. 502.18.10 – changed to Peer Parent Support, added, and changed language for definition. 502.18.11 – changed to Respite Care, added language about evidence-based therapeutic approach. 502.18.11.1 – changed to Respite Care, In-Home. 502.18.11.2 – changed to Respite Care, Out-of-Home. 502.18.12 – changed to Transportation. 502.19 – changed to Service Limitations and Service Exclusions, added, and changed language about regular cancellations. 502.20 – changed to Telehealth Modalities and Service Provision. 502.21 – changed to Prior Authorizations, language added about specific services. 502.22 – changed to Billing Procedures.	