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Summary of Waiver Renewal updates and technical changes.

The purpose of this application is to renew WVs TBIW 5-year application. Below are listed the changes that can be found and the Appendix information.

1. Throughout the application the Department of Health and Human Resources (DHHR) has been changed to WV Department of Human Services (DoHS) to reflect the name change of the agency BMS falls under.
2. Throughout the application where it stated "on-site" review by the UMC, the "on-site" was dropped.
3. Throughout application, changed individual to member, and changed person to member that had been missed in previous addendums.
4. Added text to describe how systemic deficiencies are identified and mitigated across all applicable quality measures (Appendices A, B, C, D, G, and I, subsection b.i.).
5. Qualifications of individuals performing initial/annual assessment. Changed to "have CIBS certification or be under the supervision of someone with a CBIS Certification. (Appendix B-6(c)).
6. Removed the yellow DHS-2 form and process (Appendix B-6 f. (c)).
7. Performance Measure B-1 changed to "Percent of applicants who receive medical eligibility determination by the UMC withing timelines. Medical eligibility determination must be made within 45 calendar days of receipt of completed Initial MNER." (Appendix B).
8. Access to services information updated to reflect more recent census data for English speaking West Virginia residents (Appendix B-8).
9. Throughout Appendix C-1/C-3, changed Provider Agency to Case Management Agency.
10. Case Management Provider/Agency - removed: If the individual does possess a provisional or temporary license in social work, counseling, or nursing, they also would need to successfully complete the online case management certification training developed by BMS; added HCBS training/competency-based curriculum requirements (Appendix C-1/C-3).
11. Removed “The UMC will perform certification validation during on-site reviews” from Environmental Accessibility Adaptations Vehicle/Individual; Personal Emergency Response System (PERS)/Individual and Agency (Appendix C-1/C-3).
12. Removed Case Managers need to be familiar with local housing requirements, local housing authority requirements, or local ordinances on rental properties related to rental property requirements on pest control from Pest Eradication Services (Appendix C-1/C-3).
13. Changed direct care worker to personal attendant for Pre-transition Case Management Service Definition (Appendix C-1/C- 3).
14. Changed Employee credential verification period from 3 years to 5 years for Non-medical Transportation Individual and Agency (Appendix C-1/C-3).
15. Removed narrative in box C-1-c, per application instructions; added HCBS training competencies to Case Management service requirements (Appendix C-1 b and c).
16. Added process to ensure continuity of care for members whose service provider was added to the abuse registry (Appendix C-2-b).
17. Updated language to include HCBS settings description; means by which BMS ascertains all waiver settings meet federal HCB settings requirements; and marked assurances (Appendix C-5).
18. Added: for Personal attendants living in the home are not required to use EVV; removed from Verification of Provider Qualifications and move to relevant text box with billing info Other Standards text box; Personal Options/Individual and Agency (Appendix C-1/C-3).
19. Changed the frequency of Service Planning from every 6 months to every 12 months or if changes are necessary. (Appendix D-1).
20. Removed outdated language from service plan development safeguards: Any case manager working for a case management agency that will also be providing personal attendant services will need to sign a CM Conflict of Interest Assurance form. The completed and signed form must be placed in the member file at the CM Agency. Failure to have the form in the file when reviewed will result in sanctions. (Appendix D-1-b).
21. Removed “with back up planning” from service plan development process (Appendix D-1-e).
22. Removed monthly review of tax information from participant direction of services (Appendix E-1-j).
23. Updated the number of members who self-direct their services to 50 (Appendix E-1-n).
24. Removed ARPA funding language that no longer applies (Appendix I-2)
25. Removed of code T1016 UB, rates and explanation of its use. This was not approved by CMS in a previous addendum but missed being removed from the application (Appendix J-2 Ci and I-2-a). 26. Rate changes reflecting the recent amendment (Appendix J)
27. Updated the number of slots for all 5 Waiver years to 102 slots. (Appendix J-2-a).

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Appendix A-5 Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities p. 6-17		
The WV Department of Health and Human Resources, Bureau for Medical Services (BMS) is responsible for assessing the performance of contracted entities with delegated Waiver operations and administrative functions.	BMS Change	Changed WV Department of Health and Human Resources to WV Department of Human Services (DoHS)
A-QIS-b-i: Description of method for addressing individual problems as they are discovered p. 28		
The operating agency and the UMC are required to submit several regular reports to the Bureau for Medical Services (BMS). BMS utilizes these reports to monitor delegated administrative functions. Any individual issues or concerns that are identified via these reports are addressed directly to individual contractors during monthly contract oversight meetings. Strategies to remedy specific identified issues are developed with the contractors and monitored through these meetings. Documentation is maintained with detailed contract meeting minutes.	CMS added systemic deficiencies	Added text in red font: The UMC is required to submit a number of regular reports to the Bureau for Medical Services (BMS). BMS utilizes these reports to monitor delegated administrative functions and identify potential systemic deficiencies. Any individual issues or concerns that are identified via these reports are addressed directly with individual contractors during monthly contract oversight meetings. Strategies to remedy specific identified systemic deficiencies and issues are developed with the contractors and monitored through these meetings. Documentation is maintained with detailed contract meeting minutes.
B-QIS-b-i: Description of method for addressing individual problems as they are discovered p. 52		
The UMC is required to submit several regular reports to the Bureau for Medical Services (BMS). BMS utilizes these reports to monitor delegated administrative functions. Any individual issues or concerns that are identified via these reports are addressed directly to individual contractors during monthly contract oversight meetings. Strategies to remedy specific identified issues are developed with the contractors and monitored through these meetings. Documentation is maintained with detailed contract meeting minutes.	CMS added systemic deficiencies	Added text in red font: The UMC is required to submit a number of regular reports to the Bureau for Medical Services (BMS), including (but not limited to) quality assurance and quality improvement activities, and level of care evaluation/reevaluation data. BMS utilizes these reports to monitor delegated administrative functions. Any individual issues, systemic deficiencies, or concerns that are identified via these reports are addressed directly with individual contractors during monthly contract oversight meetings. Strategies to remedy specific identified issues are developed with the contractors and monitored through these meetings. Documentation is maintained with detailed contract meeting minutes.
B8: Access to Services by Limited English Proficient Persons p. 54		
Per the Census 2010, 97.6% of West Virginian's speak only English. Due to this high percentage, the ADW program addresses any needs or requests for alternative material on an individual basis. All materials are currently available in alternate formats for individuals who cannot access standard print material. These formats include large print, audio and Braille. In addition, BMS and all contract staff are available to read printed materials upon request.	BMS Update	Updated census data to: Per the Census 2020, 97.5%

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C-1/C-3: Participant Services/Provider Specifications for Service p. 56-59		
Service Type: Statutory **Service: Case Management** **Agency/Certified Provider Agency** **Other Qualifications**: Case management services must be provided by an individual fully licensed (this does not include provisional or temporary license) in West Virginia as a social worker, counselor or registered nurse or may be an individual with a four-year degree (BA or BS) in an approved human service field and successful completion of the CM certification in the on-line case management training developed by BMS. If the individual does possess a provisional or temporary license in social work, counseling or nursing, they also would need to successfully complete the on-line case management certification training developed by BMS.	BMS Change (removed old language) CMS requirement for D1-a (qualifications specified in Appendix C-1/C-3): New Language Added to Technical Guide and HCBS Waiver Application including the importance of the role of the person-centered SP in HCBS provision, should include for these individuals (case managers) the training or competency requirements for the HCBS settings criteria and person-centered plan development.	Removed: If the individual does possess a provisional or temporary license in social work, counseling, or nursing, they also would need to successfully complete the online case management certification training developed by BMS. Added: All training must use a competency-based training curriculum defined as a training program which is designed to give staff the skills needed to perform certain tasks and/or activities. The curriculum should have goals, objectives, and an evaluation system to demonstrate competency in training areas. Competency is defined as passing a graded posttest at no less than 70% except for Person Centered Case Management Certification and HCBS Settings Compliance training which require 80%.
Personal Options/Individual **Other Standards:** Daily billing is required by Vendor. Certified Nursing Assistants (CNA)s who are able to provide documentation of current Certification, can be hired with their CNA credentials once they have completed First Aid and CPR training.	BMS Change	Added: Personal attendants living in the home are not required to use EVV. Removed from Verification of Provider Qualifications and move to relevant text box with billing info (Other Standard). Added LPN
Personal Attendant/Agency **Other Standards:** Daily billing is required by the PA agency. Personal Attendants will be subject to usage of the Electronic Visit Verification (EVV) and all of the requirements.	BMS Change	Daily billing is required by the PA agency. Personal Attendants will be subject to usage of Electronic Visit Verification (EVV) and all of the requirements. Added Personal Attendants living in the home are not required to use EVV.

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C-1/C-3 Participant Services/Service Specification p. 64-70		
Environmental Accessibility Adaptations – Home/Individual **Service Definition:** EAA-Home must be documented in the SP. Additionally, these adaptations enable the member who receives services to function with greater independence in the home. This service is used only after all other available funding sources have been exhausted. If approved, the Provider Agency is responsible for verifying the adaptation(s) to the home is completed as specified in the plan. **Applicable Limits:** …. the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services.	BMS Change	Removed: This service is used only after all other available funding sources have been exhausted. Changed: "Changed Provider Agency" to "Case Management Agency" "Changed participant-directed" to "self-directed"
Environmental Accessibility Adaptations – Vehicle/Agency **Service Definition:** If approved, the Provider agency is responsible for ensuring the adaptation to the vehicle is completed as specified prior to receiving payment and/or paying contracted vendor(s). **Applicable Limits:** Car seats unless specifically adapted/modified for the person.	BMS Change	Changed "Provider agency" to "Case Management agency" Changed "person" to "member"
Environmental Accessibility Adaptations – Vehicle/Individual **Personal Options** **Other Standard:** Individuals or legal representatives (if applicable) who self-direct their services are responsible for ensuring that the provider of EAA meets the qualifications/standards with assistance from the F/EA or their Case Manager. The UMC will perform certification validation during on-site reviews.	BMS Change	Changed "Individuals" to "Members" Removed: The UMC will perform certification validation during on-site reviews.
C-1/C-3 Participant Services/Provider Specification for Service p. 72		
Other Services: Personal Emergency Response System (PERS)/Individual The Personal Options vendor is responsible for ensuring all of the PERS requirements are met. The UMC performs reviews of the program during on-site reviews.	BMS Change	Removed: The UMC will perform certification validation during on-site reviews.
Other Services: Personal Emergency Response System (PERS)/Agency The Personal Options vendor is responsible for ensuring all of the PERS requirements are met. The UMC performs reviews of the program during on-site reviews.	BMS Change	Removed: The UMC will perform certification validation during on-site reviews.

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C-1/C-3 Participant Services/Service Specification p. 74		
Other Services: Pest Eradication Services Case Managers must also determine if landlords are required to provide this service to make the rental property habitable. This can be done by reviewing the lease to determine the landlord's responsibility. Case Managers need to be familiar with local housing requirements, local housing authority requirements, or local ordinances on rental properties related to rental property requirements on pest control. Case Managers will contact landlords to convey the importance of maintaining and treating adjourning properties once the member's property is treated for pests. This is to ensure that pests do not return to the member's residence.	BMS Change	Removed: Case Managers need to be familiar with local housing requirements, local housing authority requirements, or local ordinances on rental properties related to rental property requirements on pest control.
C-1/C-3 Participant Services/Service Specification p. 80		
Other Service: Pre-transition Case Management **Service Definitions (scope):** Coordinate with the Personal Attendant Agency to ensure that direct-care services are in place the first day the resident returns home;	BMS Change	Changed "direct care" to "personal attendant"
C-1/C-3 Participant Services/Provider Specification for Service p. 81		
Other Services: Pre-transition Case Management/Agency Agency is verified by the Utilization Management Contractor. Agency staff is verified by the Utilization Management Contractor. The Utilization Management Contractor will perform certification validation during on-site reviews.	BMS Change	Removed "on-site."
C-1/C-3 Participant Services/Service Specification p. 83-84		
Other Services: Non-medical Transportation/Agency and Individual **Verification of Provider Qualification (Frequency):** The employee's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks which are checked every 3 years and the OIG which is checked monthly.	BMS Change	Changed "3 years" to "5 years."

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C-1-b: Provision of Case Management Services to Waiver Participants and C-1-c: Delivery of Case Management Services p. 84		
a. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*): ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants. ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants. *Check each that applies:* ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*	CMS New Language that includes an additional case management checkbox option: As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management) -N/A	Removed narrative in C-1-c, per instructions on the waiver services selected. Added to C-2 for case management services requirements: All training must use a competency-based training curriculum defined as a training program which is designed to give staff the skills needed to perform certain tasks and/or activities. The curriculum should have goals, objectives, and an evaluation system to demonstrate competency in training areas. Competency is defined as passing a graded posttest at no less than 70% except for Person Centered Case Management Certification and HCBS Settings Compliance training which requires 80%.
C-2-b: Abuse Registry Screening p. 86		
Check Box: Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.	CMS New language regarding narrative included with indication of whether the state requires waiver service provider abuse registry screening, including: [Specify] the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry.	Added to specifications in text box: The SP includes waiver services, non-waiver services, informal support, and emergency backup planning so that continuity of care is maintained. If a crisis occurs which results in a critical incident being substantiated, then a prevention plan will be created by the member and their Case Manager to support the crisis plan and outline strategies that will work to ensure similar incidents do not occur in the future and that continuity of care is maintained for the member.
C-QIS-b-i: Describe the state's method for addressing individual problems as they are discovered p. 103-109		
All data surrounding this sub-assurance will be collected through the UMC Quality and Utilization Review process.	CMS systemic deficiencies addition	Modified language to include: All data surrounding this sub-assurance will be collected through the UMC Quality and Utilization Review process. Performance measures that fall below the 86% threshold are reviewed and examined to identify trends potentially indicating the presence of systemic deficiencies.
C-5-1: Home and Community-based Settings: Description of the settings in which 1915(c) HCBS are received p. 105-107		

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Text box: Description of the settings in which 1915(c) HCBS are received None – new section	CMS Added Section Description of the settings in which 1915(c) HCBS are received. (Specify and describe the types of settings in which waiver services are received.) Description of the means by which the state Medicaid agency ascertains that all settings in which HCBS are received meet federal HCB settings requirements, at the time of this submission and in the future as part of ongoing monitoring. (Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)	Added: Member-controlled settings are defined as a home or apartment, owned or leased by an HCBS member or by one of their family members. The member's case manager must assess the setting annually to determine that the member continues to reside in a setting with the characteristics of a member-controlled setting and that the setting continues to meet the standards described below: • The setting is integrated in and supports full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. • The setting is selected by the member from among setting options including non-disability specific settings. • The setting ensures a member's rights of privacy, dignity, and respect, and freedom from coercion and restraint. • The setting optimizes, but does not regiment, member initiative, autonomy, and independence in making life choices including but not limited to daily activities, physical environment, and with whom to interact. The setting facilitates the members' choice regarding services and support and who provides them. If the setting does not meet the standards listed above, then remediation will occur. The case manager will assist the members to remediate the identified issue(s), including, as a last resort, transitioning to a setting that does meet requirements. A member that chooses not to comply with the home and community-based settings requirements may risk losing their services. The member-controlled setting assessment may be found under the Resource section of the West Virginia Statewide Transition Plan webpage Provider-controlled settings are settings where a member resides with a paid unrelated caregiver or with an agency provider who provides HCBS services most of the day. All provider-controlled settings and members who receive services in these settings will be evaluated at least annually by the BMS or its designee (the utilization management contractor) annually to determine that the setting continues to exhibit the characteristics of a provider-controlled setting and that the setting meets the standards as described below: • The setting was selected by the member from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the member's needs, preferences, and, for residential settings, resources available for room and board. • The member participates in unscheduled and scheduled community activities in the same manner as individuals not receiving Medicaid HCBS services.

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Continued: C-5-1: Home and Community-based Settings: Description of the settings in which 1915(c) HCBS are received None – new section	CMS Added Section	• Members have opportunities to seek employment and work in competitively integrated settings and engage in community life. • The members have their own bedroom or share a room with a roommate of choice. • The member chooses and controls a schedule that meets their wishes in accordance with a person-centered plan. • The members control their personal resources. • The members choose when and what to eat and may have access to food at any time. • The members choose with whom to eat or to eat alone. • Member choices are incorporated into the services and supports received. • The members choose from whom they receive services and support. • The member has access to make private telephone calls/text/email at the member's preference and convenience. • Members are free from coercion and restraint. • The member, or a person chosen by the individual, has an active role in the development and updating of the member's person-centered plan. • The setting does not isolate members from individuals not receiving Medicaid HCBS in the broader community. • State laws, regulations, licensing requirements, facility protocols or practices do not limit members' choices. • The setting is an environment that supports members' comfort, independence, and preferences. • The member has unrestricted access in the setting. • The physical environment meets the needs of those members who require support. • Members have full access to the community. • The members' right to dignity and privacy is respected. • Members who need assistance to dress are dressed in their own clothes appropriate to the time of day and individual preferences. • Staff communicate with members in a dignified manner. • The member can have visitors of their choosing at any time. • The members' unit has an entrance door that can be locked by the member, with only appropriate staff having keys to doors. Any provider-controlled setting that does not meet these standards will be referred to the BMS or its designee for assistance with remediation to attempt to attain compliance. If the setting cannot be remediated to meet all these standards, then the setting will be removed from the approved provider listing and the member(s) will be required to transition to an approved setting. If a transition is refused, the member will be discharged from the program. The provider-controlled setting assessment may be found under the Resource tab of the West Virginia Statewide Transition webpage.

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C-5-2: HCBS Setting: Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring p. 107-108		

Text box: Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring.
 	
None – new section
	CMS Added Section	Added:
		All waiver agencies will be contacted annually to verify the settings owned, leased, or operated by the provider agency. It is the responsibility of the agency to notify the BMS within 15 days of any change in status, i.e., sites are added or removed. When a new setting is added, the BMS or its designee must review the site and ascertain it complies before any HCBS services may be billed.
		
		If a setting is unable or unwilling to become compliant with remediation, as determined by on-site review of the setting, then the state will initiate the process for resolution.
		
		Some settings may be presumptively non-HCBS settings that are isolated as described below:
		• Settings that are in a building that is also a public or privately-operated facility that provides inpatient institutional support treatment.
		• Settings that are in a building on the grounds of, or immediately adjacent to, a public institution; or
		• Any other settings that have the effect of isolating members receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS, include:
		  ○ Where members have limited opportunities for interaction in and with the broader community, including individuals not receiving Medicaid HCBS
		  ○ Where the setting restricts member choice to receive services or to engage in activities outside of the setting
		  ○ Where the setting is physically located separate and apart from the broader community and does not facilitate member opportunity to access the broader community and participate in community services, consistent with the member's person-centered service plan
		These settings will be subject to a heightened scrutiny process. In such cases, the setting would be submitted to the CMS for a heightened scrutiny review. Evidence compiled by the State will accompany this submission. This evidence will include review documents, stakeholder interviews and comments and other evidence as necessary.

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C-5-3: Home and Community-based Settings, Continued p. 108-109		
N/A – new section	CMS Check boxes that ensure that each setting will meet HCBS requirements. An indication of whether provider-owned/controlled settings are used.	The following assurances have been checked: -The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. -The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered SP and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. (see Appendix D-1-d-ii) -Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint. -Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact. -Facilitates individual choice regarding services and supports and who provides them. -Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital, or any other locations that have qualities of an institutional setting.
D-1-b: Participant-Centered Planning and Service Delivery Service Plan Development p. 110		
Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant. Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan: See language in waiver.	CMS New language included instructing states to include a narrative that explains how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan, if the state selects that entities and or induvial that have responsibility for service plan development may provide other direct waiver services to the participant.	The existing waiver language appears to include requirements

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D-1-b: Service Plan Development Safeguards p. 110-112		
D-1-b (2 of 8) Text Box: (2) Any case manager working for a case management agency that will also be providing personal attendant services will need to sign a CM Conflict of Interest Assurance form. A(.) The completed and signed form must be placed in the member file at the CM Agency. Failure to have the form in the file when reviewed will result in sanctions.	BMS Change	Removed language from list (2) Any case manager working for a case management agency that will also be providing personal attendant services will need to sign a CM Conflict of Interest Assurance form. A(.) The completed and signed form must be placed in the member file at the CM Agency. Failure to have the form in the file when reviewed will result in sanctions.
D-1-d-1: Participant-Centered Planning and Service Delivery. 113-114		
Service Plan Development Process (4 of 8) Text Box: (g.) Case Managers are required to conduct a monthly contact and minimally quarterly F2F home visit with members to monitor PCSP implementation, identify when member's needs change and revise the PCSP to address changing needs. Additionally, PCSP's must be reviewed at least every six months and revised at that point as necessary. An annual PCSP meeting to develop a new plan is required. Case managers are expected to schedule these meetings at times and locations convenient to the member.	BMS Change	Removed language: Additionally, PCSP's must be reviewed at least every six months and revised at that point as necessary
D-1-e: Participant-Centered Planning and Service Delivery p. 115		
Service Plan Development Process: Risk Assessment and Mitigation (5 of 8) Text Box: The UMC completes the HCBS Consumer Assessment of Health Care Providers and Systems (CAHPS) annually. When the survey exposes a deficiency with back-up planning, the UMC reaches out to the Case Management or Personal Attendant provider for additional interview and follow-up.	BMS Change	Removed language: with back-up planning

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D-1-g: Participant-Centered Planning and Service Delivery		
Service Plan Development Process: Service Plan Development **Process for Making Service Plan Subject to Approval of the Medicaid Agency (7 of 8) Text Box:** 100% of initial and annual Service Plans are submitted to and reviewed by the UMC to request prior authorization of TBI services. The UMC conducts annual on-site provider reviews for 100% of providers and 100% of program member files. The UMC conducts on-site reviews via an approved review tool that evaluates all components of documentation, member health and safety and member experience.	BMS Change	Removed language: All mentions of “on-site” removed throughout text box
D-1-h: Service Plan Review and Update p. 116		
Every six months or more frequently when necessary	CMS added new language to the application include the phrase, if “other schedule”/when the individual's circumstances or needs change significantly, or at the request of the individual pertaining to a service plan reviews and updates. BMS Change	Changed cadence of review to **Every twelve months or more frequently when necessary**
D-2-a: Service Plan Implementation and Monitoring p. 117-118		
Service Plan Implementation and Monitoring Text Box	BMS Change	Removed language: All mentions of “on-site” removed throughout text box
D-QIS-b-i: Methods for Remediation/Fixing Individual Problems p. 132-133		
All information related to this assurance is collected by the UMC through the review of member's charts. Individual issues/concerns related to this assurance identified during the chart review process are addressed immediately by the UMC with providers during an exit interview. Providers are then required to submit a Plan of Correction with evidence of completion addressing identified issues. All Plans of Correction must be approved by the UMC and BMS. Services provided that are not documented on the SP or are provided by unqualified staff are disallowed and payment is recouped from the Provider agency.	CMS systemic deficiencies addition	Added text: All information related to this assurance is collected by the UMC through the review of member's charts. Individual issues/concerns and potential systemic deficiencies related to this assurance identified during the chart review process are addressed immediately by the UMC with providers during an exit interview. Performance measures that fall below the 86% threshold are reviewed and examined to identify trends potentially indicating the presence of systemic deficiencies. Providers are then required to submit a Plan of Correction with evidence of completion addressing identified issues. All Plans of Correction must be approved by the UMC and BMS. Services provided that are not documented on the SP or are provided by unqualified staff are disallowed and payment is recouped from the Provider agency.

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E-1-j.: Participant Direction of Services Overview p. 142-143		
Information and Assistance in Support of Participant Direction Services Overview (9 of 13) Text Box: d) Bureau for Medical Services (BMS) oversight of the Personal Options vendor includes: -Monthly contract meetings -Monthly review of program activity reports -Monthly review of tax information -Quarterly review of complaints and grievances report -Results of the annual Customer Satisfaction Surveys	BMS Change	Removed language: Monthly review of tax information
E-1-m: Participant Direction of Services Overview p. 145-146		
Overview (12 of 13) Involuntary Termination of Participant Direction Text Box: The Case Manager and Personal Options vendor must develop a report to the UMC outlining the reasons the Personal Options vendor is requesting termination the member from Personal Options.	BMS Change	Removed “Case Manager” and modified language to read: Modified last paragraph to read: When there is the possibility of involuntary transfer from Personal Options, the member is informed of the reasons, potential actions that need to be initiated to remain on the program and the timeline for demonstration of the actions. Reasons for an Involuntary Transfer to the Traditional Service Model are non-compliance with program requirements, inability to hire employees in an expected time period and/or maintain an employee, demonstrated in ability to supervise their employee(s), demonstrated in ability to complete and keep track of employee paperwork, and the program representative left, and the member has no replacement.
F-1: Participant Rights Opportunity to Request a Fair Hearing p. 151		
Procedures for Offering Opportunity to Request a Fair Hearing text box: The Member Handbook is provided to and reviewed with applicants and members during eligibility assessments (annual for members) by the UMC.	BMS Change	Removed “applicants and”
G-1-c: Response to Critical Events or Incidents p. 154		
Participant Training and Education Text Box: Information that defines abuse, neglect and exploitation and how to notify the appropriate authorities is provided by the UMC to the applicant and/or legal representative (if applicable) at their initial medical eligibility assessment as well as to the member and/or their legal representative (if applicable) at their annual medical eligibility re-evaluation.	BMS Change	Changed applicant to member

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Traumatic Brain Injury Waiver Renewal Worksheet		
Current Waiver Language	**CMS Waiver App or Tech Requirements**	**Revised or New Drafted Language**
G-1-d: Response to Critical Events or Incidents p. 154-155		
Responsibility for Review of and Response to Critical Events or Incidents Text Box: Providers will be required to review their incident data and identify and address systemic issues and concerns quarterly per policy. The UMC will monitor compliance with this policy during annual on-site provider reviews.	BMS Change	Removed “on-site”
G-2-a: Safeguards Concerning Restraints and Restrictive Interventions p. 155-156		
Use of Restraints	BMS Change	Added to list of critical incidents not resulting from abuse/neglect/exploitation. These incidents may include, but are not limited to: m. Death of a member
G-2-b: Safeguards Concerning Restraints and Restrictive Interventions p. 157-159		
Use of Restrictive Interventions (2 of 3) Text Box: APS/CPS is required to investigate these allegations. Providers also have a responsibility per policy to investigate and to report the incident in the WV Incident Management System (WVIMS) until such time it becomes available, they must report to the UMC.	BMS Change	Removed: “until such time it becomes available, they must report to the UMC.” Changed “MAY” to read “may” (removed emphasis) Added to list of critical incidents not resulting from abuse/neglect/exploitation. These incidents may include, but are not limited to: “m. Death of a member”
G-2-c: Safeguards Concerning Restraints and Restrictive Interventions p. 159-160		
Use of Seclusion (3 of 3) Text Box: Providers are mandatory reporters and as such are required to report any incidents of the use of restraints and restrictive interventions directly to Adult Protective Services (APS)or Child Protective Services (CPS). APS or CPS is required to investigate these allegations. Providers also have a responsibility per policy to investigate and to report the incident directly to the UMC or the WV Incident Management System (WVIMS) when available).	BMS Change	Removed “when available”
G QI -a-i-a Sub-assurance Performance Measure p. 164		
Performance Measure: Percent of agency staff files reviewed with WV State Police, Criminal Identification Bureau (NCIB) checks		Changed “NCIB” to “CIB”

Traumatic Brain Injury Waiver Renewal Worksheet		
Current Waiver Language	**CMS Waiver App or Tech Requirements**	**Revised or New Drafted Language**
G QI-b-i: Methods for Remediation/Fixing Individual Problems 178-179		
All information related to this assurance is collected and monitored by the UMC. The UMC will collect and monitor this assurance using the WVIMS. The UMC will collect and monitor this assurance using results of Provider reviews, BMS Fiscal Agency data, and mortality reviews.	CMS systemic deficiencies addition	Added language: All information related to this assurance is collected and monitored by the UMC. The UMC will collect and monitor this assurance using the WVIMS. The UMC will collect and monitor this assurance using results of Provider reviews, BMS Fiscal Agency data, and mortality reviews. Additionally, TBIW Providers must have policies and procedures to thoroughly review, investigate, and track all incidents involving the risk or potential risk to the health and safety of the members they serve. Providers are responsible for taking appropriate action on both an individual and systemic basis.
H-1-b: Quality Improvement Strategy Systems Improvement p. 182-184		
System Design Changes text box: A percentage of Providers are reviewed yearly to validate certification documentation. Targeted on-site provider reviews may be conducted based on Incident Management Reports and complaint data.	BMS Changes	Changed “A percentage” to “100%” Removed “on-site” Added “100% of personnel files with members reviewed” statement
I-1: Financial Accountability Financial Integrity and Accountability p. 186		
If the TBI Waiver provider disagrees with the final disallowance report, the TBI Waiver provider may request a document/desk review within 30 days of receipt of the final report pursuant to the procedures in the Common Chapter 800, General Administration of the West Virginia Medicaid Provider Manual. The TBI Waiver provider must still complete the written repayment arrangement within 30 days of receipt of the Final Disallowance Report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document review must be in writing, signed and set forth in detail the items in contention.	BMS Change	Updated language to read: If the TBI Waiver provider disagrees with the final disallowance and they responded within thirty (30) days of receipt of the draft report with written comments and supportive documentation to justify their billing to the review committee, they may request a document/desk review (DDR) within thirty (30) days of receipt of the determination. The request must be in writing with the basis for the appeal and the documentation to support the request for this level one appeal. Second level appeals without supportive documentation or are beyond 30 days of the date of the final demand letter/Final Report will not be considered. If a provider seeks a DDR, they must still complete the written repayment arrangement within 30 days of receipt of the letter. A request for a DDR does not impact the repayment process. If the overpayment determination is reversed by the DDR decision, BMS will refund any previous payments made by the provider.

Traumatic Brain Injury Waiver Renewal Worksheet		
Current Waiver Language	**CMS Waiver App or Tech Requirements**	**Revised or New Drafted Language**
I-2-a: Rates, Billing and Claims p. 194		
Rate Determination Methods Removed outdated language: In 2021 ARPA funds were dedicated to temporarily increase the rate for traditional Personal Attendant services by 50%. This increase was not determined using the rate-setting methodology. The increase was in response to COVID-related workforce shortages and provider agencies were required to attest that at least 85% of the increase would be passed through to direct-care workers.		Removed language that no longer applies
I-QIS-b-i: Methods for Remediation/Fixing Individual Problems p. 193		
All information relating to this assurance is collected through the review and analysis of claims data provided by the claims processing entity. Evidence collected via claims data is reviewed and analyzed by BMS and the claims processing entity in order to identify any system issues.	CMS systemic deficiencies addition BMS Change	All information relating to this assurance is collected through the review and analysis of claims data provided by the claims processing entity. Evidence collected via claims data is reviewed and analyzed by BMS and the claims processing entity in order to identify any systemic issues. If provider documentation does not support services billed, providers must submit a Plan of Correction to UMC and BMS for approval. Providers are required to reimburse BMS for services billed without supporting documentation. Updated percentage of provider compliance reviews from 50% to 100%,
Appendix J p. 205		
Service Code T1016 UB	BMS Change	Removed of code T1016 UB, rates and explanation of its use. This was not approved by CMS in a previous addendum but missed being removed from the application (Appendix J-2 Ci and I-2-a). 26. Rate changes reflecting the recent amendment (Appendix J) Updated the number of slots for all 5 Waiver years to 102 slots. (Appendix J-2-a)