

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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

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

1. Request Information (1 of 3)

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

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

Children with Serious Emotional Disorder

C. Type of Request: new

Requested Approval Period: (For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

3 years 5 years

New to replace waiver

Replacing Waiver Number:

Base Waiver Number:

Amendment Number

(if applicable):

Effective Date: (mm/dd/yy)

Draft ID: WV.021.00.00

D. Type of Waiver (select only one):

Regular Waiver

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

10/01/19

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (check each that applies):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

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

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

Mountain Health Trust Waiver was recently re-approved by the Division of Medical Field Operations East (Philadelphia).

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

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

§1915(b)(2) (central broker)

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

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

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

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

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

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

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The Children with Serious Emotional Disorder Waiver (CSEDW) is a Medicaid HCBS Waiver program authorized under §1915(c) of the Social Security Act. The CSEDW provides services that are additions to Medicaid State Plan coverage for CSED who are enrolled in the CSEDW program, from age 3 up to the youth’s 21st birthday. The CSEDW permits WV to provide an array of HCBS that enables children who would otherwise require institutionalization to remain in their homes and communities. In addition, it is anticipated that this waiver will reduce the number of children housed both in-state and out-of-state in Psychiatric Residential Treatment Facilities (PRTFs) and shorten the lengths of stay for children who require acute care in PRTFs.

WV defines the term "children with a serious emotional disorder" (CSED) as children with an SED who are age 3 to age 21 and 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 Diagnostic and Statistical Manual of Mental Disorders (DSM) (or International Classification of Disease (ICD) equivalent) that is current at the date of evaluation that results in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, and/or community activities.

The Bureau for Medical Services (BMS), within the WV Department of Health and Human Resources (DHHR), is the single state agency responsible for statewide administration of the Title XIX Medicaid Program. BMS operates the CSEDW in conjunction with the WV Mountain Health Trust, WV’s §1915(b) managed care program. As appropriate, Medicaid members receiving services under the CSEDW may receive any of the Medicaid State Plan services and waiver services identified in Appendix C of this §1915(c) HCBS Waiver application. Members enrolled in the CSEDW may not be enrolled simultaneously in another WV §1915(c) waiver.

WV Medicaid authority under the direction of the WV DHHR will contract with an administrative service organization and psychological testing firm to address program eligibility and enrollment. Medicaid managed care entities will be responsible for utilization management. The WV Medicaid Management Information System (WVMMS) contractor will be responsible for enrollment of providers who then must contract with the Managed Care Organizations (MCOs) to be providers for the CSEDW.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid

eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. **Appendix D** specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

Yes. This waiver provides participant direction opportunities. Appendix E is required.

No. This waiver does not provide participant direction opportunities. Appendix E is not required.

F. Participant Rights. **Appendix F** specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. **Appendix G** describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. **Appendix H** contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. **Appendix J** contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

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

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

Not Applicable

No

Yes

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

No

Yes

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

Geographic Limitation. A waiver of statewidelessness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

Limited Implementation of Participant-Direction. A waiver of statewidelessness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect

to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.

Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

--

5. Assurances

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

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery

processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

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

BMS met with relevant WV government agencies, as the State stakeholder group, to discuss the current system for CSED. BMS collaboratively identified ways each agency could assist in the Waiver development process and underwent brainstorming activities to identify priority services to support CSED. BMS directly engaged with high-level representatives from agencies across DHHR, including the Bureau for Children and Families (BCF) and the Bureau for Behavioral Health (BBH). The State stakeholder group has met multiple times to inform the development of the CSEDW.

BMS has also engaged numerous external stakeholders from different disciplines and regions of WV. Over the course of six stakeholder meetings, over 100 participants provided information, shared insights, and prioritized services to assist with Waiver development. External stakeholders attended public forums on November 27 – 30, 2018, in Beckley, Parkersburg, Morgantown, Martinsburg, and Charleston, and represented a wide variety of service agencies, providers, schools, and MCOs. BMS solicited feedback during these facilitated forums to identify priority services for the CSEDW. Notifications for these events were issued via BMS' email to listserv and Fall Provider Workshops.

During both State agency and external stakeholder meetings, common themes regarding CSED were raised. Stakeholders indicated concerns regarding workforce shortages, the number of children in out-of-state facilities due to limited in-state capacity, and lack of transportation. Feedback also included requests for training and ongoing support for families, as well as trauma-informed care training for parents/caregivers/legal representatives, mental health providers, teachers, and other school staff. Stakeholders did provide positive feedback regarding the WV Safe at Home wraparound program.

On November 8, 2018, BMS initiated a Project Kickoff Meeting inclusive of BMS and BCF staff, psychological assessors, and other State agency representatives. The BMS Commissioner noted the priority for the CSEDW design was to keep children in their homes, connect families with needed services, provide caregiver support, and reunify families. Stakeholders discussed defining eligibility criteria for Waiver participants, potentially including the Child and Adolescent Functional Assessment Scale (CAFAS) and/or the Child and Adolescent Needs and Strengths (CANS) tool, as well as other related considerations for CSEDW participants.

BMS engaged in a strategy meeting comprised of high-level representatives from BMS, BCF, BBH, and other State agencies on November 8, 2018. Stakeholders highlighted the existing BCF-administered Title IV-E Safe at Home wraparound program as an example of a successful initiative in WV. Participants did identify a need for broad-based trauma-informed care training to ensure school staff, parents, and other community members were equipped with CSED knowledge. The group also discussed performance data of existing providers and confirmed that BCF providers were independently evaluated every six months, resulting in 10 statewide lead coordinating agencies.

During the external stakeholder public forums held throughout WV in November 2018, BMS provided an overview presentation regarding the potential CSEDW and followed with a facilitated discussion with participants. Participants covered a broad range of topics, including the expansion of the number of evidence-based therapy-trained clinicians, the addition of trauma-informed care training, and current workforce challenges for psychiatric services throughout WV. Participants suggested that provider incentives may help with recruitment and retention and that DHHR should consider increasing reimbursement rates. Participants also raised multiple questions regarding the judiciary due to a large percentage of potential CSEDW participants having court involvement; participants suggested communication, education, and training for judges regarding trauma-informed best practices and local resources.

Public forum participants were asked to complete a brief survey, comprised of the following questions, to garner additional insight and feedback:

- What is working well in the current system?
- What are needed services that aren't available?
- What is not working well in the current system?
- If you could create a treatment system for members with SED, what would it look like?
- Below are a number of potential HCBS services that could be included under the future 1915(c) Waiver. Please select the five services you feel would be the most important in a future Waiver.

(Case Management, Child Therapeutic Foster Care, Counseling and Therapeutic Services, Crisis Intervention, Day Services, Environmental Modifications and Adaptive Aids, Family Support and Training, Financial Management and Community Transition, Person-Centered Support, Prevocational Services and Supported Employment, Respite, Specialized Transportation, Youth Peer Advocate/Youth Support and Training)

Per the public forums, stakeholder input identified six priority HCBS services for the CSEDW, including: Family Support and Training, Crisis Services, Counseling and Therapeutic Services, Respite Care, Case Management, and Therapeutic

Foster Care.

WV does not have any recognized tribal governments and thus no tribal consultation was required.

The CSEDW was placed out for 30-day public comment on April 23, 2019. The notice was placed in WV's largest newspaper, The Charleston Gazette Mail, appearing on April 23, 2019, as well as on the BMS and the Children with SED websites. A flyer was sent to the LBHCs, the multi-agency State stakeholder group and all participants from the public forums who requested notification. A log of the comments received and BMS' responses will be available on the BMS website for public review.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Nisbet

First Name:

Patricia

Title:

Office Director 3 HCBS and OBHS Units

Agency:

Bureau for Medical Services WVDHHR

Address:

350 Capitol Street, Room 251

Address 2:

City:

Charleston

State:

West Virginia

Zip:

25301

Phone:

(304) 356-4904

Ext:

TTY

Fax:

(304) 558-4398

E-mail:

Patricia.S.Nisbet@wv.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

West Virginia

Zip:

Phone:

Ext:

TTY

Fax:

E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State

Medicaid Director submits the application.

Last Name:

Beane

First Name:

Cynthia

Title:

Commissioner

Agency:

Bureau for Medical Services WVDHHR

Address:

350 Capitol Street, Room 251

Address 2:

City:

Charleston

State:

West Virginia

Zip:

25301

Phone:

(304) 558-1700

Ext:

TTY

Fax:

(304) 558-4398

E-mail:

Attachments

Cynthia.E.Beane@wv.gov

Attachment #1: Transition Plan

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

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

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

Reducing the unduplicated count of participants (Factor C).

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

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

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

Specify the transition plan for the waiver:

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

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

Bureau for Medical Services

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) *(select one)*:
Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

- Mountain Health Trust (WV MCOs): Medicaid member enrollment, execution of Medicaid CSEDW provider agreements, prior authorization and utilization management of CSEDW services, care coordination (differs from the CSEDW Case Management service), ensures the development, review, and execution of a CSEDW member’s Individual Service Plan (ISP), and quality assurance and quality improvement activities including Incident Management collection and reporting.
 - Medical Eligibility Contracted Agent (MECA): Conduct level-of-care evaluation and annual redetermination.
 - Administrative Services Organization (ASO): CSEDW enrollment, on-site waiver service provider reviews (clinical service review), collecting and aggregating ad hoc reports, and conducting annual level-of-care reevaluation.

No. Contracted entities do not perform waiver operational and administrative functions on behalf of the

Medicaid agency and/or the operating agency (if applicable).

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The WVDHHR BMS is responsible for assessing the performance of contracted entities with delegated Waiver operations and administrative functions. The BMS CSEDW Program Manager will manage contracts with the Managed Care Organization (MCO), Administrative Service Organization (ASO), and Medical Eligibility Contracted Agent (MECA).

The WVDHHR has an ongoing contract with the MCOs. The MCOs will provide assistance and services as stated in the current contract; this includes claims processing and reporting to WV's Fiscal Agent. Note: The Fiscal Agent will not act as WV's claims processing vendor for this waiver; it will serve as a repository for MCO claims data. The WVDHHR will be responsible for updating the MCO contract to align with CSEDW. The MCO is also responsible for development and distribution of the CSEDW Program Member Handbook and a reference guide to individuals accepted onto the program to assist the individual making a decision regarding which providers they want to receive services from.

KEPRO will serve as the ASO for the CSEDW program. KEPRO's responsibilities will include tracking eligibility, tracking participant waiting list (as applicable), and verifying and tracking provider training through initial and annual provider reviews. KEPRO will also provide training and technical assistance to providers enrolled in the CSEDW program and will be responsible for completing the annual member revaluation. As a part of the program's quality assurance activities, the ASO will report on performance measures as identified in the approved application. Additionally, they will conduct health and safety follow-up with providers as necessary to ensure the continued health and safety of the individuals enrolled in the program. KEPRO will also facilitate the meetings of the quarterly Quality Improvement Advisory Council meetings with the Bureau for Medical Services.

Psychological Consultation & Assessment, Inc. will serve as the MECA for the CSEDW. As the MECA Psychological Consultation & Assessment, Inc. will provide criteria assistance, provide assistance with training of the Independent Provider Network (IPN), recruit psychologists for the IPN, develop standards and report to KEPRO, review assessment reports for eligibility, monitor and track application timelines, make eligibility determinations/redeterminations, attend eligibility hearings, provide continued training to the IPN, and will remain actively involved in the evaluation process.

Appendix A: Waiver Administration and Operation

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

BMS conducts monthly contractual oversight meetings with the MCOs, ASO, MECA, and WV DHHR's Office of Health Facility Licensure and Certification (OHFLAC). During these monthly meetings, performance for each contractor is reviewed and any issues/concerns are identified and addressed.

The quality management data collected through discovery methods are compiled using the Discovery and Remediation Report (DNR) template and reviewed at least monthly by BMS at its contract meetings. The DNR is also compiled and reviewed quarterly by the Quality Improvement Advisory (QIA) Council. A comprehensive report summarizing the findings of provider reviews is compiled at the end of each review cycle, reviewed and analyzed by Waiver staff and presented to the QIA Council for its review and analysis.

Reports:

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

1. ASO's monthly DNR report on delegated functions, ad hoc reports, and audits as requested.
2. Claims Processing Vendor (MCO) monthly DNR report on delegated functions and routine reports on claims data and ad hoc reports as requested.
3. MECA Vendor Monthly DNR Report on delegated functions and ad hoc reports as requested.
4. Reports from OHFLAC on licensure reviews, investigations and monthly DNR report on delegated functions.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:

A-ai-1: Percent of requests for prior authorizations that the MCOs responded to within established timelines. Numerator- Number and percent of requests for prior authorization responded to by the MCOs within established timelines. **Denominator-** Number of requests for prior authorization.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: 100%;">MCOs</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

Performance Measure:

A-ai-2: Percent of written grievances/complaints resolved by the MCO within established timelines. Numerator- Number and percent of written grievances/complaints resolved by the MCO within established timelines. Denominator- Number of written grievances/complaints submitted to the MCO.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

	Ongoing	Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

Performance Measure:

A-ai-3: Percent of member satisfaction surveys pertaining to MCO functions rated 80% or higher. Numerator- Number and percent of member satisfaction surveys pertaining to MCO functions rated 80% or higher. **Denominator-** Number of member satisfaction surveys submitted.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>MCOs</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

Performance Measure:

A-ai-4: Percent of on-site provider reviews conducted within established timelines.

Numerator- Number and percent of on-site provider reviews conducted within established timelines. **Denominator-** Number of on-site provider reviews conducted.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

A-ai-5: Percent of required monthly reports provided by the contracted entities to BMS by the due date. Numerator- The number and percent of required monthly reports provided to BMS by the due date. **Denominator-** The number of required monthly reports.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

No

Yes

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Disabled (Physical)			
		Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Intellectual Disability			
Mental Illness					
		Mental Illness	18	21	
		Serious Emotional Disturbance	3	17	

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

In order to be eligible to receive CSEDW program services, an applicant must meet the following eligibility criteria:

The applicant must be a WV resident, between the ages of 3 and 21, meet medical eligibility, and meet financial eligibility. Applicants must choose HCBS over those provided in an institution.

Medical eligibility criteria is defined as having 1) an overall Child and Adolescent Functional Assessment Scale (CAFAS) / Preschool and Early Childhood Functional Assessment Scale (PECFAS) score of “severe” (90 or higher) and 2) currently or at any time during the past year (12 months) having had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most current edition of the DSM. These disorders include any mental disorders listed in the DSM with the exception of "V" codes, substance use, and developmental disorders, which are excluded unless they co-occur with another diagnosable serious emotional disturbance (SED).

Additionally, this Waiver prioritizes children/youth with SED who are in Psychiatric Rehabilitation Treatment Facilities (PRTFs) or other residential treatment providers out-of-state, and those who are in such facilities in-state. Then, Medicaid-eligible Children with SED who are at risk of institutionalization are the target group.

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

Not applicable. There is no maximum age limit

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

Specify:

Youth that are enrolled in the CSEDW are likely to continue to have mental health needs that require planning on the part of the youth and family service planning team. The Waiver's purpose is to provide community-based services and supports to increase mental health functioning across life domain areas and decrease the need for psychiatric or other mental health institutional placement.

When youth are enrolled in the CSEDW, the Multi-Disciplinary Team (MDT) develops measurable outcomes that guide the member toward transition or graduation from enrolled Waiver status. As stated above, this does not always mean that the individual no longer needs any type of mental health services; rather that the individual typically needs less intensive services from intake to graduation.

As a youth approaches his/her 15th birthday, the child and family team focus on planning for this period of transition. There are many things to consider during this time. Some of the basic issues deal with housing, employment, vocational training or school status, emotional/behavioral health, physical health, and safety. During this time, it is common to focus on the life domain areas that will impact the youth's success as an adult. The team will focus on enhancing skills utilizing Medicaid State Plan and Waiver services, as well as by helping the youth and family identify and understand what services may be available post-Waiver. If the youth's disability impacts his/her ability to earn income, the team will work with the youth to apply for Supplemental Security Income (SSI) benefits at age 18. The team will also work with the youth to identify other entitlements that would assist the youth post-Waiver. This is also the time during which the team will explore what mental health needs the youth may have after his/her 21st birthday and start that transition process with adult services. Whenever possible, the adult services staff are encouraged to become part of the MDT to assure a smooth transition to adult services.

When youth are enrolled in the Waiver, transition planning starts at intake and continues until the youth successfully transitions. Transitions are very different for each individual, but the MDT assumes the responsibility for meeting the youth's needs post-Waiver.

The oversight process includes review of all plans, including transition plans. This process identifies individual and systems issues including those related to transition planning. Transition planning for youth enrolled in the Waiver is part of a plan of service and is individualized for each youth. Some older youth may receive services from adult mental health services or they may receive services from other systems (vocational, housing, etc.), and this is part of the transition planning that occurs. This planning will assist the youth/young adults in making a smooth transition to adult mental health or community-based services.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

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

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

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	<div>500</div>
Year 2	<div>1000</div>
Year 3	<div>2000</div>

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: (*select one*) :

The state does not limit the number of participants that it serves at any point in time during a waiver year.

The state limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
	500
Year 2	1000
Year 3	2000

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Purpose(s) the state reserves capacity for:

Purposes	
Prioritizing Youth in PRTF or Other Residential Treatment Facilities	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (*provide a title or short description to use for lookup*):

Prioritizing Youth in PRTF or Other Residential Treatment Facilities

Purpose (*describe*):

This Waiver prioritizes children/youth with SED who are in Psychiatric Treatment Facilities or other residential treatment facilities out-of-state, and those who are in such facilities in-state.

Describe how the amount of reserved capacity was determined:

WV is currently serving up to 100 children/youth at in-state PRTFs. Another 350 children/youth are being served in settings out-of-state; this figure is an average and subject to change based on demand. By combining these figures, it has been determined that 250 waiver slots will be reserved to best serve these two priority populations.

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

Waiver Year	Capacity Reserved
Year 1	250
Year 2	250
Year 3	250

Appendix B: Participant Access and Eligibility

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

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

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

Waiver capacity is allocated to local/regional non-state entities.

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

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

When the capacity for people served by the CSEDW program is reached, applicants for CSEDW services are placed on a Managed Enrollment List (MEL). Applicants for entry into the program will be processed on a first-come-first-serve basis based upon the date/time of the determination of medical eligibility and will come onto the program as capacity becomes available.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

§1634 State

SSI Criteria State

209(b) State

2. Miller Trust State.

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

No

Yes

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

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

Low income families with children as provided in §1931 of the Act

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

Optional state supplement recipients

Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

100% of the Federal poverty level (FPL)

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

Specify percentage:

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

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

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

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

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

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

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

Specify:

Parents and other caretaker relatives (42 CFR 435.110) Children under age 19 (42 CFR 435.118) Pregnant Women (42 CFR 435.116) Adult Group (42 CFR 435.119) Former WV Foster Care Children (42 CFR 435.150) Adoption Assistance, Foster Care, or Guardianship Care under IV-E (42 CFR 435.145) Subsidized Legal Guardianship (42 CFR 435.222) Non IV-E Adoption Assistance (42 CFR 435.227)

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

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

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

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

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The state requires (select one):

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Per contract with the MECA, licensed psychologists specifically trained to evaluate applicants with SED will conduct all initial assessments to determine medical eligibility for this waiver. BMS will make the final determination as to whether or not a member is enrolled in the waiver.

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

An independent psychological evaluation (IPE) will be utilized by the MECA to determine initial eligibility for applicants seeking participation in the CSEDW. Psychometric instruments, to include the CAFAS/PECFAS and the Behavior Assessment System for Children-Third Edition (BASC-3), will be utilized and eligibility criteria will be identified within BMS' CSEDW policy. Other specific instruments may be required based on the needs and age of the applicant. All members will be administered a CAFAS/PECFAS at enrollment and at annual redetermination; if the member has had a CAFAS/PECFAS completed within 90 days of application, then it can be used as the initial assessment for CSEDW. The CANS instrument will also be administered at any identified "significant life event" (as determined by the MDT) that may alter the member's existing level-of-care status, as well as in preparation for the annual ISP development, the member's six (6) month MDT meeting and during the annual redetermination. BMS will make the final determination as to whether or not a member is enrolled in the waiver.

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

The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.

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

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

An IPE will be completed to determine initial eligibility for CSEDW level of care. Psychometric instruments, to include the CAFAS/PECFAS, the BASC-3, and other instruments based on the needs and age of the applicant, will be identified within BMS' CSEDW policy and administered by trained representatives of the IPN ensuring reliable, valid, and fully comparable results. BMS will make the final determination as to whether or not a member is enrolled in the waiver.

Currently, the institutional level-of-care evaluation consists of an interview with a trained, licensed psychologist. This evaluation process may vary as judicial influence regularly determines a child's/youth's placement in this level of care.

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

The ASO contacts the applicant and provides a list of statewide independent psychologists associated with MECA's Independent Psychologist Network (IPN) and their contact information. The applicant contacts the independent psychologist of their choice and schedules the IPE. The independent psychologist will inform the ASO of the scheduled date, time and location of the appointment. The independent psychologist completes the IPE, which includes background information, mental status examination, measure of intelligence, measure of emotional functioning, and achievement when appropriate. The independent psychologist submits the IPE along with all scores electronically to the ASO. The ASO then submits the IPE and scores electronically to the MECA for CSEDW medical eligibility determination. The MECA electronically notifies the ASO of determination of medical eligibility. The ASO notifies the applicant and the MCO (as applicable). If the applicant is found to not meet medical eligibility, the ASO also provides the applicant with Medicaid Fair Hearing information, which includes the right to request a second medical evaluation by a different member of the IPN. BMS will make the final determination as to whether or not a member is enrolled in the waiver.

For annual reevaluation, the ASO submits diagnoses and annual functional assessments within 45 days prior to the anchor "annual date" to the MECA. The MECA reviews the diagnoses and annual assessments and determines eligibility. Every person must have a re-determination of medical eligibility completed at least annually. Additionally, if at the member's six (6) month ISP review the MDT determines he/she has not benefited from waiver enrollment (i.e. no progress has been made on the member's treatment goals and objects), then the MDT will refer the member to the IPN to re-determine level-of-care placement. The anchor date of the person's annual re-determination is the first day of the month after the initial medical eligibility was established by the MECA. If the reevaluation results in waiver eligibility the final decision will be made by BMS.

The ASO employs assessors to conduct re-evaluations for program members. Qualifications include a bachelor's degree in a human service field and at least one-year experience with the target population. Staff go through a rigorous training protocol, which includes trainer-led instruction, shadowing experienced staff, and periodic evaluation of their work.

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

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

Every 12 months or in the case of a significant life event of the member. Additionally, if at the member's six (6) month ISP review, the MDT determines he/she has not benefited from waiver enrollment (i.e. no progress has been made on the member's treatment goals and objectives), then the MDT will refer the member to the IPN to re-determine level-of-care placement.

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

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.

Specify the qualifications:

Reevaluations will be conducted by the ASO with minimal qualifications of a bachelor's degree and training to administer the instrument identified by BMS policy.

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

Working with the case manager, the ASO schedules the annual assessment. The ASO is responsible for ensuring that annual redetermination functional assessments are completed within 45 days prior to the anchor "annual date." BMS will make the final determination as to whether or not a member continues to be enrolled in the waiver.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the state assures that written and/or

electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All initial assessments and reevaluations of medical eligibility determinations are maintained for a minimum of five years by the MECA and the ASO.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

- a. *Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

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

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

Performance Measure:

B-aia-1: Percent of applicants who received Level of Care determinations prior to receipt of CSEDW services. Numerator- Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving CSEDW services. Denominator- Total number of enrolled CSEDW participants.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div></div>
Other Specify: <div>MECA</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

B-aib-1: Percent of enrolled CSEDW participants that were reevaluated within 1 year of their previous LOC review. Numerator- Number and percent of enrolled CSEDW participants that were reevaluated within 1 year of their previous LOC review. Denominator- Total number of enrolled CSEDW participants requiring a LOC reevaluation within the calendar month.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">ASO</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- c. *Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

Performance Measures

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

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

Performance Measure:

B-aic-1: Percent of secondary reviews of LOC determinations that are consistent with the current LOC determination. Numerator- Number and percent of secondary review LOC decisions that were consistent with the current LOC determinations. Denominator- Number of secondary reviews completed.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:

B-aic-2: Percent of waiver participants whose CSEDW eligibility determination utilized WV's approved screening instrument and process. Numerator- The number and percent of CSEDW eligibility determinations made when the instrument and process were applied as determined by WV. **Denominator-** Number of waiver participants who had an eligibility determination.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

No

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

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

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

As part of the CSEDW Application process, applicants and/or parent/caregiver/legal representative (as applicable) are provided informational materials from the ASO that detail services available to eligible individuals through the CSEDW. The member and/or their parent/caregiver/legal representative (as applicable) are provided with the Freedom of Choice Form via mail or email in order to indicate their selection between HCBS and institutional services. An additional form will also be transmitted that allows the applicant to choose from a designated psychologist to perform the medical eligibility assessment. Applicants are required to return this form to the ASO within 10 business days.

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

The ASO maintains Freedom of Choice Forms electronically for a minimum of five years.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

BMS utilizes the latest census data, data from school systems and community organizations, and data from state and local governments to inform the proportion of Limited English Proficiency (LEP) persons within WV and the WV Medicaid program. In 2014, data from the Department of Justice Civil Rights Division indicated that 0.4% of WV residents were LEP persons. As of 2017, 97.5% of West Virginians spoke English as their primary language, with 2.5% of persons over five years of age speaking a language other than English in their household.

To accommodate individuals with LEP, BMS and all MCOs address needs for alternative language requests on an ad hoc basis. Requests for printed materials in alternative languages are fulfilled within five business days, per CFR 438.10(c)-(d) at no charge to the enrollee. All materials are currently available in alternative formats for individuals who cannot access standard print material, including large print, audio, and braille. MCOs notify enrollees that oral interpretation services are available for any language, that written information is available in prevalent languages, and how to access those services. Written materials include taglines in the prevalent non-English languages and large print (in a font size no smaller than 18 point) explaining the availability of written translation or oral interpretation and the toll-free and Teletypewriter (TTY)/Telecommunication Device for the Deaf (TDY) telephone number of the MCOs. MCOs make their written materials available in the prevalent non-English languages in their service areas.

BMS also makes available information regarding the waiver on the DHHR and BMS websites for electronic access and utilization. BMS and all MCOs provide oral interpretation services for all languages via a language interpretation line for verbal review of applicable Waiver materials, and BMS and all contract staff are available to read printed materials to enrollees upon request.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Case Management		
Statutory Service	In-Home Family Support		
Statutory Service	Independent Living/Skills Building		
Statutory Service	Job Development		
Statutory Service	Respite Care, In-Home		
Statutory Service	Supported Employment, Individual		

Service Type	Service		
Other Service	Assistive Equipment		
Other Service	Community Transition		
Other Service	In-Home Family Therapy		
Other Service	Mobile Response		
Other Service	Non-Medical Transportation		
Other Service	Peer Parent Support		
Other Service	Respite Care, Out-of-Home		
Other Service	Specialized Therapy		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

01 Case Management

Sub-Category 1:

01010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

The Case Manager is responsible for engaging the member and family in a partnership of shared decision-making regarding the ISP development and implementation throughout their enrollment in the CSEDW. The Case Manager ensures and coordinates a comprehensive set of supports, resources and strategies for each member and family. S/he works closely with service providers to assure that CSEDW services and clinical treatment modalities augment each other for optimal outcomes for members and parents/caregivers/legal representatives.

The Case manager will lead the MDT through engagement and team preparation, initial plan development, plan implementation, and transition, and provide intensive case management. This includes the development and implementation of a transition plan for participants who will reach the Waiver's maximum age limit.

The Case Manager:

- Engages the member and parent/caregiver/legal representative throughout CSEDW enrollment;
- Assembles the MDT, including the member and his/her parent/caregiver/legal representative;
- Helps to identify strengths and needs of the member and parent/caregiver/legal representative as a precursor to ISP development;
- Leads ISP meetings;
- Develops and updates ISP in partnership with the member and parent/caregiver/legal representative that is reflective of the member's and parent/caregiver/legal representative's priorities, individualized, strengths-based, related to all life domains, coordinated with any psychiatric treatment received through other providers, focused on developmental tasks, resiliency and wellness, inclusive of safety issues, targeted to address assessment indicators (e.g., CANS), and oriented towards discharge readiness;
- Administers the CANS to the member at any identified 'significant life event(s),' in preparation for the annual ISP development, as well as for the member's six (6) month MDT meeting;
- Works with the MCO Care Manager to identify service providers, natural supports, and other community resources to meet member and parent/caregiver/legal representative needs and make necessary referrals to include behavioral health, health, and dental care providers;
- Facilitates connections with identified resources and providers; advocacy which includes the process of helping to empower members and parents/caregivers/legal representatives to initiate and sustain interactions that support their overall wellness, interceding on their behalf when necessary to gain access to needed services and supports.
- Documents and maintains all documentation regarding the ISP and all revisions to the ISP;
- Monitors the implementation of ISP, making sure the member and parent/caregiver/legal representative are receiving the services identified in ISP; on-going assessment and documentation of the member and parent/caregiver/legal representative's strengths and needs, progress towards achieving goals, and efficacy of delivered services;
- Maintains communication among all team members;
- Consults with the family and other team members to make sure the services the member and parents/caregivers/legal representatives are receiving continue to meet their needs, and assembles the team to make necessary adjustments and revisions;
- Initiates and coordinates discharge and after-care planning; linkage and referral to services and supports as specified in the ISP; this encompasses identifying local resources and services for use during both enrollment and discharge planning, sharing information with the member and parent/caregiver/legal representative on relevant resources and service providers, including local family support programs, advisors and advocates; engaging the member and parent/caregiver/legal representative in making informed choices.
- Meets in person monthly with the member and his/her parent/caregiver/legal representative in the member's home to verify services are delivered in a safe environment, in accordance with the ISP, and appropriately documented and that the person receiving services continues to meet financial eligibility. The purpose of these visits is to determine progress of the person receiving services and resources, assess achievement of training objectives, to identifying unmet needs and provide for the appropriate support as necessary;
- Acts as the primary CSEDW contact for the member, parent/caregiver/legal representative, or other MDT members;
- Manages and warehouses all information related to member, parent/caregiver/legal representative, or other MDT member issues, questions, critical incidents, etc. and will work to ensure all such items are addressed
- Facilitates the development and implementation of an individualized transition plan for members who will reach the Waiver's maximum age limit

The case manager, and the agency that employs them, cannot provide any other Waiver or State plan services for the member. The agency providing case management must provide freedom of choice for all other Waiver and State plan services providers.

Services provided in this category will be in response to a specific goal/s in the member's ISP and will not duplicate any other services provided to the member. 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.

Services provided in this category will be in response to a specific goal/s in the member's ISP and will not duplicate any other services provided to the member. 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.

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

Unit = 15 minutes; up to 874 units per service plan year; caseloads capped at 20 members per case manager.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center
Individual	Conflict Free Case Manager

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications

License (*specify*):

Licensed Behavioral Health Center (LBHC).

Certificate (*specify*):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.

Other Standard (*specify*):

Must have a minimum of a bachelor's degree in social work, psychology, sociology or other human services field plus two (2) years post college, work experience servicing this population. Must be certified to complete the CANS assessment. Must have a contract with the MCO(s).

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

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the OHFLAC.

Agency staff is verified by the Licensed Behavioral Health Provider every other year and the ASO annually.

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

Frequency of Verification:

Agency behavioral health license is verified biennially.

Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are updated every three (3) years and the OIG, which is checked monthly.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Individual

Provider Type:

Conflict Free Case Manager

Provider Qualifications

License (specify):

Certificate (specify):

Must be an approved CSEDW provider and enrolled as a WV Medicaid provider.

Agency is certified by the ASO.

Other Standard (specify):

Must have a minimum of a bachelor's degree in social work, psychology, sociology or other human services field plus two (2) years post college, work experience servicing this population. Must be certified to complete the CANS assessment. Must have a contract with the MCO(s).

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

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications

Entity Responsible for Verification:

ASO verifies initially and annually via on-site review.

Frequency of Verification:

Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are updated every three (3) years and the OIG, which is checked monthly.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Psychosocial Rehabilitation

Alternate Service Title (if any):

In-Home Family Support

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10090 other mental health and behavioral services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

☐

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

☐

In-Home Family Support services allow the member and family to practice and implement the coping strategies introduced by the in-home therapist. The family support worker works with the member and family on the practical application of the skills and interventions that will allow the member and family to function more effectively. The family support worker assists the family therapist by helping the parent/child communicate their concerns; providing feedback to the therapist about observable family dynamics; helping the family and youth implement changes discussed in family therapy and/or parenting classes; providing education to the parent/caregiver/legal representative regarding their child's mental illness; coaching, supporting, and encouraging new parenting techniques; helping parents/caregivers/legal representatives learn new parenting skills specific to meet the needs of their child; participating in family activities and supports parents/caregivers/legal representatives in applying specific and on-the-spot parenting methods in order to change family dynamics.

Services provided in this category will be in response to a specific goal/s in the member's ISP and will not duplicate any other services provided to the member. 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.

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

Unit = 15 minutes; Up to 2 hours per day (8 units per day), approximately 14 hours per week (56 units/week).

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: In-Home Family Support

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.

Other Standard (*specify*):

Must have a minimum of a bachelor's degree in social work, psychology, sociology or other human services field plus one (1) year of experience working with this population. Must have a contract with the MCO(s).

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

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the OHFLAC.
Agency staff is verified by the Licensed Behavioral Health Provider every other year and the ASO annually.
The ASO will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.
Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are updated every three (3) years and the OIG, which is checked monthly.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Independent Living/Skills Building

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04020 day habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Independent Living/Skills Building (CMS defined: Day habilitation) services focus on enabling the member to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the individual's person-centered service plan, such as physical, occupational, or speech therapy.

Provision of regularly scheduled activities in a non-residential setting, separate from the member's private residence 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 consistent with the member's person-centered service plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Independent Living/Skills Building services will also utilize a Therapeutic Mentoring (TM) model to facilitate the member's achievement of his/her goals of community inclusion and remaining in/returning to his/her home. TM offers structured, one-to-one, strength-based support services between a therapeutic mentor and a youth for the purpose of addressing daily living, social, and communication needs. The mentor works with a clinical therapist to explore a youth's interests and abilities and creates activities that build various life skills and result in linkages to community activities. Utilizing this model services will include: coaching, supporting, and training the youth 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 Waiver member's SED.

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 home and community.

Services provided in this category will be in response to a specific goal/s in the member's ISP provided under the direction of the in-home therapist and will not duplicate any other services provided to the member. 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.

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

Unit = 15 minutes; Up to 40 hours per week (160 units/week), approximately 160 hours/month (640 units/month) in combination with Job Development and Supported Employment.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Independent Living/Skills Building

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.

Other Standard (*specify*):

Bachelor's or Associates degree in a human service field and a minimum of one (1) year of experience working with children/adolescents OR High school diploma or GED and a minimum of two (2) years of experience working with this age group. Must have a contract with the MCO(s).

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

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Agency behavioral health license is verified biennially.
Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are verified every three (3) years and the OIG, which is checked monthly.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

Job Development

HCBS Taxonomy:

Category 1:

03 Supported Employment

Sub-Category 1:

03010 job development

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Job Development (CMS defined: Prevocational Services) provides learning and work experiences, including volunteer work and personal care activities, where the individual 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 of time that does not exceed one (1) year and have specific outcomes to be achieved, as determined by the member and his/her MDT through an ongoing ISP process; ISP to be reviewed not less than annually or more frequently as requested by the member. Members receiving Job Development must have employment-related goals in their person-centered service plan; the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which a member 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 members without disabilities is considered to be the successful outcome of Job Development.

Job Development should enable each member to attain the highest level of work in the most integrated setting and with the job matched to the member'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, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training.

Participation in Job Development is not a required pre-requisite for supported employment services provided under the waiver. Many members, particularly those transitioning from school to adult activities, are likely to choose to go directly into supported employment. Similarly, the evidence-based Individual Placement and Support (IPS) model of supported employment for members with behavioral health conditions emphasizes rapid job placement in lieu of Job Development.

Documentation is maintained in the file of each member receiving this service that a referral has been made to a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Members may utilize the CSEDW Non-Medical Transportation service for travel to and from the member's residence and his/her supported employment or job development sites. Services provided in this category will be in response to a specific goal/s in the member's ISP and will not duplicate any other services provided to the member. 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.

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

Unit = 15 minutes; up to 40 hours per week (160 units/week), approximately 160 hours/month (640 units/month) in combination with Independent Living/Skills Building and Supported Employment.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Job Development

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications

License (*specify*):

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

Licensure and Certification (OHFLAC).

Certificate (*specify*):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.

Other Standard (*specify*):

Supervised by bachelor's-level In-Home Support staff person. Must have a High School diploma or GED. Must have a contract with the MCO(s).

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

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the OHFLAC.

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

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

Frequency of Verification:

Agency behavioral health license is verified biennially.

Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are updated every three (3) years and the OIG, which is checked monthly.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Care, In-Home

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Respite Care services provide temporary relief to the member's regular caregiver and include all the necessary care that the usual caregiver would provide during that period. In-Home Respite must be provided in the member's home that may include biological homes, kinship homes, and adoptive homes. Member's 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.

Respite may be provided in the local public community if delivery begins and ends in the member's home. Service can be used to support the member in engaging in age-appropriate community activities, such as shopping, volunteering, attending concerts, etc.

Services provided in this category will be in response to a specific goal/s in the member's ISP and will not duplicate any other services provided to the member. 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 member is asleep.

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

Unit = 15 minutes; Up to 24 days per year in combination with Out-of-Home Respite Care.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite Care, In-Home

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.

Other Standard (*specify*):

Must have a High School diploma or GED. Must have a contract with the MCO(s).

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

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the OHFLAC.

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

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

Frequency of Verification:

Agency behavioral health license is verified biennially.

Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are updated every three (3) years and the OIG, which is checked monthly.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment, Individual

HCBS Taxonomy:

Category 1:

03 Supported Employment

Sub-Category 1:

03021 ongoing supported employment, individual

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Supported Employment - Individual Employment Support services are the ongoing supports to adult members who, because of their disabilities need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above WV's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by members 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.

Supported employment - individual employment supports 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, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits and work-incentives planning and management, transportation, asset development and career advancement services. Other workplace support services including services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting such as personal care activities.

Documentation is maintained in the file of each member receiving this service that a referral has been made to a program funded under section 110 of the Rehabilitation Act of 1973 or the 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:

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

Members may utilize the CSEDW Non-Medical Transportation service for travel to and from the member's residence and his/her supported employment or job development sites. Services provided in this category will be in response to a specific goal/s in the member's ISP and will not duplicate any other services provided to the member. 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.

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

Unit = 15 minutes; up to 40 hours per week (160 units/week), approximately 160 hours/month (640 units/month) in combination with Independent Living/Skills Building and Job Development.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Supported Employment, Individual

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center

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

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

Certificate (*specify*):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.

Other Standard (*specify*):

Supervised by bachelor's-level In-Home Support staff person. Must have a High School diploma or GED. Must have a contract with the MCO(s).

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

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

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

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

Frequency of Verification:

Agency behavioral health license is verified biennially.
Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are updated every three (3) years and the OIG, which is checked monthly.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not

specified in statute.

Service Title:

Assistive Equipment

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:

14 Equipment, Technology, and Modifications

Sub-Category 2:

14032 supplies

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Assistive Equipment refers to an item or piece of equipment that is used to address the Waiver member's needs that arise as a result of his/her SED. The equipment should increase, maintain, or improve functional capabilities of the member, assist him/her 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 member's ISP and will not duplicate any other services provided to the member and based on medical necessity. 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.

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

Unit is \$1. Up to \$500 per service plan year in combination with Specialized Therapy.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center, CSEDW Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assistive Equipment

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center, CSEDW Provider

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

The MCO is responsible for ensuring that providers of Assistive Equipment meet qualification standards prior to processing invoices. The MCO is responsible to review for prior authorization to assure items/services are indicated on the ISP as a need. The ASO will perform certification validation during on-site reviews.

Frequency of Verification:

The ASO will monitor compliance during annual on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Transition

HCBS Taxonomy:

Category 1:

Sub-Category 1:

16 Community Transition Services

16010 community transition services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Community Transitions Services are non-recurring set-up expenses for adult individuals who are transitioning from an institutional living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- (a) security deposits that are required to obtain a lease on an apartment or home;
- (b) 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;
- (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;
- (e) moving expenses;
- (f) necessary home accessibility adaptations; and,
- (g) activities to assess need, arrange for and procure need resources.

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Services provided in this category will be in response to a specific goal/s in the member's ISP and will not duplicate any other services provided to the member and based on medical necessity. 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.

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

Unit = \$1; Up to \$3,000 for a one time transition. A transition period can last up to six (6) months.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center, CSEDW Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Transition

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center, CSEDW Provider

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

The MCO is responsible for ensuring that providers of Community Transition meet qualification standards prior to processing invoices. The ASO is responsible to review for prior authorization to assure items/services are indicated on the ISP as a need. The ASO will perform certification validation during on-site reviews.

Frequency of Verification:

The ASO will monitor compliance during on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

In-Home Family Therapy

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10090 other mental health and behavioral services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

In-Home Family Therapy consists of counseling and training services for the member and family provided by a licensed mental health professional (with a master's degree or a licensed individual under supervision). This service includes trauma-informed individual and family therapy in the family home and should assist the family to acquire the knowledge and skills necessary to understand and address the specific needs of the member in relation to his/her SED and treatment, such as developing and enhancing the family's problem-solving skills, coping mechanisms, and strategies for the member's symptom/behavior management.

In -Home Family Therapy providers will implement and oversee all Mobile Response activities; including primary point of contact for the service, on-call coverage, staff training and credentialing, referral, and data reporting. Written policy and procedures, as defined by BMS, specific to Mobile Response must be developed and maintained by any agency providing the service. Additionally, the In-Home Family Therapist supervises the In-Home Family Support worker.

Services provided in this category will be in response to a specific goal/s in the member's ISP and will not duplicate any other services provided to the member. 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.

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

Unit = 50 minutes; up to two units per day

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: In-Home Family Therapy

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.

Other Standard (*specify*):

Must be performed by a minimum of a master's level therapist who is licensed or under supervision, including Board Certified Behavior Analyst (BCBA), who is experienced in trauma-informed care and is using generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work. Must have a contract with the MCO(s).

Staff qualified for this service are as follows: Doctor of Medicine (MD); Doctor of Osteopathic Medicine (DO); Advanced Practice Registered Nurse (APRN); Licensed Psychologist (LP); Supervised Psychologist (SP); Licensed Professional Counselor (LPC); Licensed Independent Social Worker (LICSW); Licensed Clinical Social Worker (LCSW); Licensed Social Worker (LSW); Advanced Alcohol and Drug Counselor (AADC) and an Addictions Counselor (ADC).

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

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Agency behavioral health license is verified biennially.
Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are updated every three (3) years and the OIG, which is checked monthly.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Mobile Response

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10030 crisis intervention

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Mobile Response services are 24-hour services designed to respond immediately to issues that threaten the stability of the member's placement and his/her ability to function in the community. This service is intended to be of very short duration and primarily to engage/link to other services and resources, e.g., intensive in-home supports and services. This service may only be delivered in an individual, one-to-one session. The service includes: de-escalation, issue resolution support, and the development of a stabilization plan for any additional services that are needed to resolve the immediate situation.

The Case Manager will remain the primary contact for CSEDW, however the agency providing the In-Home Family Therapy will implement and oversee all Mobile Response activities; including primary point of contact for the service, on-call coverage, staff training and credentialing, referral, and data reporting. Written policy and procedures, as defined by BMS, specific to Mobile Response must be developed and maintained by any agency providing the service. The Case Management agency will be notified of any Mobile Response activities.

Services provided in this category will be in response to a specific goal/s in the member's ISP and will not duplicate any other services provided to the member. 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.

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

Unit = 15 minutes; up to 14 hours per week

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Mobile Response

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.

Other Standard (*specify*):

Must have a minimum of a bachelor's degree in social work, psychology, sociology or other human services field plus one (1) year of experience working with this population. Must have a contract with the MCO(s).

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

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the OHFLAC.

Agency staff is verified by the Licensed Behavioral Health Provider every other year and the ASO annually.

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

Frequency of Verification:

Agency behavioral health license is verified biennially.

Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are verified every three (3) years and the OIG, which is checked monthly.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

Category 1:

15 Non-Medical Transportation

Sub-Category 1:

15010 non-medical transportation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

Service offered in order to enable waiver members to be transported to and from local, public community locations for services specified in the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the state plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Foster parents/homes are excluded from this service under the Waiver, as the Title IV-E payment to foster care families should include transportation.

Services provided in this category will be in response to a specific goal/s in the member's ISP and will not duplicate any other services provided to the member. 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.

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

Unit = 1 mile; up to 800 miles per month.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.

Other Standard (*specify*):

Must have a current and valid drivers license. The vehicle must also be insured and have a current WV Motor Vehicle Inspection. Must have a contract with the MCO(s).

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

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Agency behavioral health license is verified biennially.
Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are verified every three (3) years and the OIG, which is checked monthly.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Peer Parent Support

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09020 caregiver counseling and/or training

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

Peer Parent Support services are designed to offer support to the parent/caregiver/legal representative of the member with SED. The services are geared toward promoting parent/caregiver/legal representative empowerment, enhancing community living skills, and developing natural supports. This service connects the parent/caregiver/legal representative with a parent(s) who is raising or have raised a child with mental health issues and are personally familiar with the associated challenges.

Peer Parent Support providers are mentors who have shared experiences as the member, family, or both member and family and who provide support and guidance to the member and his or her family members. Peer Parent Support providers explain community services, programs and strategies they have used to achieve the waiver member's goals. It fosters connections and relationships which builds the resilience of the member and his or her family. This service, limited in nature, is aimed at providing support and advice based on lived experience of a family member or self-advocate. Peer Parent Support providers cannot mentor their own family members.

Peer Parent Support services encourage members and their family members to share their successful strategies and experiences in navigating a broad range of community resources beyond those offered through the waiver with other waiver members and their families. Includes facilitation of parent or family member "matches" and follow-up support to assure the matched relationship meets peer expectations. Peer Parent Support providers will not supplant, replace, or duplicate activities that are required to be provided by the Case Manager.

Services provided in this category will be in response to a specific goal/s in the member's ISP and will not duplicate any other services provided to the member. 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.

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

Unit = 15 minutes; Up to 2 hours/week (8 units/week), approximately 8 hours/month (32 units/month).

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Peer Parent Support

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.

Other Standard (*specify*):

Must have a contract with the MCO(s).

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

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the OHFLAC.

Agency staff is verified by the Licensed Behavioral Health Provider every other year and the ASO annually.

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

Frequency of Verification:

Agency behavioral health license is verified biennially.

Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are verified every three (3) years and the OIG, which is checked monthly.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Respite Care, Out-of-Home

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09011 respite, out-of-home

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Respite Care services provide temporary relief to the member's regular caregiver and include all the necessary care that the usual caregiver would provide during that period. Out-of-Home Respite must be provided by a certified therapeutic foster parent(s) in a certified therapeutic foster care home. Foster parents/homes are excluded from receiving this service under the Waiver, as the Title IV-E payment to foster care families should include respite. Please note waiver services may be furnished to children 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. Waiver funds are not available to pay for room and board and supervision of children who are under the state's custody, regardless of whether the child is eligible for funding under Title IV-E of the Act. The costs are associated with maintenance and supervision of these children are considered a state obligation.

Respite may be provided in the local public community if delivery begins and ends in the member's certified therapeutic foster care home. Service can be used to support the member in engaging in age-appropriate community activities, such as shopping, volunteering, attending concerts, etc.

Services provided in this category will be in response to a specific goal/s in the member's ISP and will not duplicate any other services provided to the member. 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 member is asleep.

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

Unit = 15 minutes; Up to 24 days per year in combination with In-Home Respite Care.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Respite Care, Out-of-Home

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.
Must have a current Therapeutic Foster Care Home Certification.

Other Standard (*specify*):

Must have a High School Diploma or GED. Must have a contract with the MCO(s).

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

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the OHFLAC.
Agency staff is verified by the Licensed Behavioral Health Provider every other year and the ASO annually.
The ASO will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.
Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are updated every three (3) years and the OIG, which is checked monthly.
Renewal for Therapeutic Foster Care Home is completed every three (3) years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Therapy

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17990 other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Specialized Therapy refers to activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of a member's needs that arise as a result of his/her SED. The service is intended to assist the member 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 member's symptom/behavior management.

Specialized Therapy 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 is self-directing his or her services. 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. A member receiving the service does not have the funds to purchase it directly or the service is not available through another source; cannot be accessed as a means of reimbursement for services that have already been obtained and not been pre-approved by the MCO.

Services provided in this category will be in response to a specific goal/s in the member's ISP and will not duplicate any other services provided to the member and based on medical necessity. 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.

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

Unit is \$1. Up to \$500 per service plan year in combination with Assistive Equipment.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center, CSEDW Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Therapy

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center, CSEDW Provider

Provider Qualifications

License (*specify*):

Business license, professional license/certification and/or relevant skills in the specialized area.

Certificate (*specify*):

Other Standard (*specify*):

Must be over the age of 18 and have a contract with the MCO(s).

Verification of Provider Qualifications

Entity Responsible for Verification:

The MCO is responsible for ensuring that providers of Specialized Therapy meet qualification standards prior to processing invoices. The MCO is responsible to review for prior authorization to assure items/services are indicated on the ISP as a need. The ASO will perform certification validation during on-site reviews.

Frequency of Verification:

The ASO will monitor compliance during on-site reviews annually.

Appendix C: Participant Services

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

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

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

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

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

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

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

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

Appendix C: Participant Services

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

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

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

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

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

WV was one of 25 states awarded grant funds from the Centers for Medicare and Medicaid Services (CMS) to create a comprehensive background check program for employees who have direct access to patients. Title VI, Subtitle B, Part III, Subtitle C, Section 6201 of the Patient Protection and Affordable Care Act of 2010 (PL 111-148) established the framework for a nationwide program for states to conduct background checks, review the results and provide employers with a fitness determination for potential employees. The program's purpose is to protect members from neglect, abuse, and financial exploitation.

Per WV Code §16-49-1 et. seq, covered providers licensed by the WV DHHR to perform services that include any direct access services are required to conduct employee background checks. These providers include:

- Nursing homes
- Skilled nursing facilities
- Home health agencies
- Hospice care
- Long-term care hospitals
- Long-term residential care
- Personal care services
- Adult daycare services
- Intermediate care facilities
- Substance Use Disorder Waiver providers
- Other facilities and providers required to participate by DHHR

Policy:

WV Clearance for Access: Registry & Employment Screening (WV CARES) is administered by the DHHR in consultation with the WV State Police Criminal Investigation Bureau (CIB), CMS, the Department of Justice (DOJ), and the Federal Bureau of Investigation (FBI).

The web-based system provides an efficient and effective means for an employer to prescreen an applicant prior to paying the cost of fingerprints. Through fingerprinting, this program provides a comprehensive criminal history records search of national and state criminal history records that was not available under the previous reliance on name-based records searches.

In addition to the initial fingerprint-based criminal history background check, WV CARES is able to monitor applicants and employees through RapBack for potential changes in criminal history and employment status. RapBack allows applicants/employees to move between providers covered by WV CARES without waiting for additional fingerprints.

A facility must receive documentation that fingerprints have been taken before hiring an individual. An applicant may be provisionally employed for up to 60 days while the WV CARES fitness determination is pending. Provisional employees must be directly supervised by an employee who has cleared both the criminal background and the required registry checks, completed at the time of their hire.

The WV State Police contracts with a private agency to securely capture and transmit fingerprints to be processed through the WV State Police and the FBI.

Any covered provider that knowingly hires or retains a person who has been convicted of a disqualifying offense will be in violation of WV Code §16-49-3 and WV Code of State Rules (CSR) §69-10-2.10.

Pre-Screening:

All direct access personnel will be prescreened for negative findings by way of an internet search of registries and licensure databases through WV CARES application process.

Direct access personnel includes individuals who have direct access by virtue of ownership, employment, engagement, or agreement with a covered provider or covered contractor. Direct access personnel do not include volunteers or students performing irregular or supervised functions, or contractors performing repairs, deliveries, installations, or similar services for the covered provider.

Any applicant with a negative finding on any required registry or licensure database is not eligible to be employed.

Fingerprinting Requirements:

If the applicant does not have a negative finding in the prescreening process, and the entity or independent health contractor, if applicable, is considering the applicant for employment, the applicant must submit to fingerprinting for a state and federal criminal history record check. An applicant may be employed as a provisional employee once fingerprints have been collected and documentation submitted to the provider. Provisional hire is not to exceed 60 days subject to the provisions of this policy.

Applicants considered for hire must be notified by the hiring entity that their fingerprints will be retained by the CIB and the FBI to allow for updates of criminal history record information according to applicable standards, rules, regulations, or laws.

Note: WV CARES may request a name-based search when two federal or two state rejections have been received. Once the name-based search results are received they will enter a fitness determination.

Employment Fitness Determination:

After an applicant's fingerprints have been compared with the state and federal criminal history record information, the WV State Police shall notify WV CARES of the results to make an employment fitness determination.

If the review of the criminal history record information reveals the applicant does not have a disqualifying offense, the applicant will receive a fitness determination of "eligible" and may be employed.

If the review of the criminal history record information reveals a conviction of a disqualifying offense, the applicant will receive a fitness determination of "not eligible" and may not be employed, unless a variance has been requested or granted.

Negative findings that would disqualify an applicant in the WV CARES Rule:

1. State or federal health and social services program-related crimes;
2. Patient abuse or neglect;
3. Health care fraud;
4. Felony drug crimes;
5. Crimes against care-dependent or vulnerable individuals;
6. Felony crimes against the person;
7. Felony crimes against property;
8. Sexual Offenses;
9. Crimes against chastity, morality and decency;
10. Crimes against public justice;
11. Felony driving offenses;
12. Felony crimes against the peace; and
13. Falsification of the self-disclosure and consent form.

The hiring entity will receive written notice of the employment fitness determination. Although fitness determination is provided, no criminal history record information will be disseminated to the applicant or hiring entity.

A copy of the applicant's fitness determination must be maintained in the applicant's personnel file.

Responsibility of the Covered Provider or Contractor:

The covered provider or covered contractor is required to review monthly registry rechecks for any disqualifying offenses. The covered provider and covered contractor are to retain documentation in relation to background checks for all direct access personnel.

Monthly Registry Rechecks:

The WV CARES system will provide monthly rechecks of all current employees against the required registries. The covered provider or covered contractor will receive notification of any potential negative findings. The covered provider or covered contractor is required to research each finding to determine if the potential match is a negative finding for the employee. The covered provider or covered contractor must maintain documentation establishing no

negative findings for current employees.

NOTE: This includes the Office of Inspector General List of Excluded Individuals and Entities (OIG LEIE) check.

Record Retention:

Documents related to the background checks for all direct access personnel must be maintained by the covered provider or covered contractor for the duration of their employment. These documents include:

1. Documents establishing that an applicant has no negative findings on registries and licensure databases.
2. The employee's eligible employment fitness determination;
3. Any variance granted by the Secretary or designee, if applicable; and
4. For provisional employees, the covered provider or covered contractor shall maintain documentation that establishes that the individual meets the qualifications for provisional employment.

Failure of a covered provider or covered contractor to ensure proper completion of the background check process for each individual employed as a direct access personnel may result in the imposition of civil money penalties of \$2,500 per occurrence. Engaging individuals knowing that they are ineligible to work may subject the employer to civil money penalties of \$2,500 per occurrence. Each civil money penalty will be levied by the Secretary or his designee.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Per WV Code Chapter 15, Article 13, WV Police are responsible for maintaining WV's abuse and neglect registry. The WV CARES system utilized by BMS is linked with this registry. The following outlines the WV CARES system and procedures:

WV was one of 25 states awarded grant funds from the Centers for Medicare and Medicaid Services (CMS) to create a comprehensive background check program for employees who have direct access to patients. Title VI, Subtitle B, Part III, Subtitle C, Section 6201 of the Patient Protection and Affordable Care Act of 2010 (PL 111-148) established the framework for a nationwide program for states to conduct background checks, review the results and provide employers with a fitness determination for potential employees. The program's purpose is to protect members from neglect, abuse, and financial exploitation.

Per WV Code §16-49-1 et. seq, covered providers licensed by the WV DHHR to perform services that include any direct access services are required to conduct employee background checks. These providers include:

- Nursing homes
- Skilled nursing facilities
- Home health agencies
- Hospice care
- Long-term care hospitals
- Long-term residential care
- Personal care services
- Adult daycare services
- Intermediate care facilities
- Substance Use Disorder Waiver providers
- Other facilities and providers required to participate by DHHR

Policy:

WV Clearance for Access: Registry & Employment Screening (WV CARES) is administered by the DHHR in consultation with the WV State Police Criminal Investigation Bureau (CIB), CMS, the Department of Justice (DOJ), and the Federal Bureau of Investigation (FBI).

The web-based system provides an efficient and effective means for an employer to prescreen an applicant prior to paying the cost of fingerprints. Through fingerprinting, this program provides a comprehensive criminal history records search of national and state criminal history records that was not available under the previous reliance on name-based records searches.

In addition to the initial fingerprint based criminal history background check, WV CARES is able to monitor applicants and employees through RapBack for potential changes in criminal history and employment status. RapBack allows applicants/employees to move between providers covered by WV CARES without waiting for additional fingerprints.

A facility must receive documentation that fingerprints have been taken before hiring an individual. An applicant may be provisionally employed for up to 60 days while the WV CARES fitness determination is pending. Provisional employees must be directly supervised by an employee who has cleared both the criminal background and the required registry checks, completed at the time of their hire.

The WV State Police contracts with a private agency to securely capture and transmit fingerprints to be processed through the WV State Police and the FBI.

Any covered provider that knowingly hires or retains a person who has been convicted of a disqualifying offense will be in violation of WV Code §16-49-3 and WV CSR§69-10-2.10.

Pre-Screening:

All direct access personnel will be prescreened for negative findings by way of an internet search of registries and licensure databases through WV CARES application process.

Direct access personnel include individuals who have direct access by virtue of ownership, employment, engagement, or agreement with a covered provider or covered contractor. Direct access personnel do not include

volunteers or students performing irregular or supervised functions, or contractors performing repairs, deliveries, installations, or similar services for the covered provider.

Any applicant with a negative finding on any required registry or licensure database is not eligible to be employed.

Fingerprinting Requirements:

If the applicant does not have a negative finding in the prescreening process, and the entity or independent health contractor, if applicable, is considering the applicant for employment, the applicant must submit to fingerprinting for a state and federal criminal history record check. An applicant may be employed as a provisional employee once fingerprints have been collected and documentation submitted to the provider. Provisional hire is not to exceed 60 days subject to the provisions of this policy.

Applicants considered for hire must be notified by the hiring entity that their fingerprints will be retained by the CIB and the FBI to allow for updates of criminal history record information according to applicable standards, rules, regulations, or laws.

Note: WV CARES may request a name-based search when two federal or two state rejections have been received. Once the name-based search results are received, they will enter a fitness determination.

Employment Fitness Determination:

After an applicant's fingerprints have been compared with the state and federal criminal history record information, the WV State Police shall notify WV CARES of the results to make an employment fitness determination.

If the review of the criminal history record information reveals the applicant does not have a disqualifying offense, the applicant will receive a fitness determination of "eligible" and may be employed.

If the review of the criminal history record information reveals a conviction of a disqualifying offense, the applicant will receive a fitness determination of "not eligible" and may not be employed, unless a variance has been requested or granted. A variance may be granted if mitigating circumstances surrounding the disqualifying offense are provided, and it is determined that the individual will not pose a danger or threat to residents or their property.

Mitigating circumstances may include: 1. The passage of time; 2. Extenuating circumstances such as the applicant's age at the time of conviction, substance abuse, or mental health issues; 3. A demonstration of rehabilitation such as character references, employment history, education, and training; and 4. The relevancy of the particular disqualifying information.

Negative findings that would disqualify an applicant in the WV CARES Rule:

1. State or federal health and social services program-related crimes;
2. Patient abuse or neglect;
3. Health care fraud;
4. Felony drug crimes;
5. Crimes against care-dependent or vulnerable individuals;
6. Felony crimes against the person;
7. Felony crimes against property;
8. Sexual Offenses;
9. Crimes against chastity, morality and decency;
10. Crimes against public justice;
11. Felony driving offenses;
12. Felony crimes against the peace; and
13. Falsification of the self-disclosure and consent form.

The hiring entity will receive written notice of the employment fitness determination. Although fitness determination is provided, no criminal history record information will be disseminated to the applicant or hiring entity.

A copy of the applicant's fitness determination must be maintained in the applicant's personnel file.

Responsibility of the Covered Provider or Contractor:

The covered provider or covered contractor is required to review monthly registry rechecks for any disqualifying offenses. The covered provider and covered contractor are to retain documentation in relation to background checks for all direct access personnel.

Monthly Registry Rechecks:

The WV CARES system will provide monthly rechecks of all current employees against the required registries. The covered provider or covered contractor will receive notification of any potential negative findings. The covered provider or covered contractor is required to research each finding to determine if the potential match is a negative finding for the employee. The covered provider or covered contractor must maintain documentation establishing no negative findings for current employees.

NOTE: This includes the Office of Inspector General List of Excluded Individuals and Entities (OIG LEIE) check.

Record Retention:

Documents related to the background checks for all direct access personnel must be maintained by the covered provider or covered contractor for the duration of their employment. These documents include:

1. Documents establishing that an applicant has no negative findings on registries and licensure databases.
2. The employee's eligible employment fitness determination;
3. Any variance granted by the Secretary or designee, if applicable; and
4. For provisional employees, the covered provider or covered contractor shall maintain documentation that establishes that the individual meets the qualifications for provisional employment.

Failure of a covered provider or covered contractor to ensure proper completion of the background check process for each individual employed as a direct access personnel may result in the imposition of civil money penalties of \$2,500 per occurrence. Engaging individuals knowing that they are ineligible to work may subject the employer to civil money penalties of \$2,500 per occurrence. Each civil money penalty will be levied by the Secretary or his designee.

Appendix C: Participant Services

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

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.

Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of

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

Self-directed

Agency-operated

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

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

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

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

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

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

To become a CSEDW Agency, an agency must apply for a Certificate of Need (CON) through an expedited Summary Review process and be approved by the WV Health Care Authority. Then, the agency must obtain a Behavioral Health License through OHFLAC. Licensure of a new agency involves an initial onsite OHFLAC review followed by a six month comprehensive on-site review (as necessary) to ensure all certification standards are substantially met.

Medicaid Enrollment:

The Affordable Care Act (ACA) and related regulations at 42 CFR 455, imposed new requirements on SMAs, and Children's Health Insurance Programs (CHIP) to enhance their provider enrollment and screening practices. The SMA and providers must comply with these federal regulations and the Centers for Medicare and Medicaid Services (CMS) Medicaid Provider Enrollment Compendium (MPEC). In addition, Medicaid-enrolled providers must comply with all additional requirements established by WV and the WV BMS. Providers may enroll as inpatient or outpatient facilities, agencies, pharmacies, suppliers, individual practitioners, or groups. All group practices must comply with WV law applicable to group and corporate practice. All rendering practitioners (i.e. providers who are providing services and directly bill WV Medicaid) and ordering, referring, and prescribing (ORP) practitioners or other professional practitioners (i.e. providers who are providing services, writing prescriptions and/or referring members, but are not permitted to directly bill WV Medicaid) must be enrolled as participating providers to be eligible for reimbursement of services. Not all applicable requirements are specified in 42 CFR 455.

The BMS fiscal agent's (FA) Provider Enrollment Unit is responsible for screening and enrolling providers into the WV Medicaid Program. Some provider types also require BMS' approval for enrollment.

Enrolled providers, in accordance with their license and scope of practice, may be eligible to participate and receive reimbursement for services provided to Medicaid members when they:

- Meet all applicable licensing as required by WV in which services will be performed and maintain a valid copy on file with the BMS FA
- Have a valid signed provider enrollment application/agreement on file with the BMS FA
- Meet and remain in compliance with BMS' provider enrollment requirements;
- Meet all Federal Requirements pertaining to provider screening and enrollment

The required screening measures vary according to the provider's categorical risk level of "limited," "moderate" or "high" in accordance with 42 CFR 455 and 42 CFR 424.518. All screening includes mandatory disclosures related to ownership and controlling interests and information about disclosing entities, fiscal agents, or managed care entities. Screening for providers in the moderate and high-risk categories includes site visits. Screening for high risk also includes fingerprint-based background checks. All providers are screened against state and federal databases to assure no provider is enrolled who is not deemed eligible based on federal and state criteria. A provider will not be enrolled, re-enrolled, re-activated, or revalidated until all screening activities applicable to that provider are completed.

Section 1902(a)(27) of the Social Security Act provides general authority for the Department of Health and Human Services (DHHS) Secretary to require provider agreements under WV Medicaid Plans with every person or institution providing services under the State plan. Under these agreements, the Secretary may require information regarding any payments claimed by such person or institution for providing services under the State plan. In addition, Section 2107(e) of the Act, provides that certain Title XIX and Title XI provisions apply to States under Title XXI, including 1902(a)(4)(C) of the Act, related to conflict of interest standards, and 1902(a)(77) and (kk) related to screening, oversight, and reporting requirements.

Renewals of license and/or certification must be current, and the documentation must be submitted to the BMS FA's Provider Enrollment Unit for inclusion in the provider record. A provider's participation in the WV Medicaid Program may be terminated if the BMS FA does not receive a copy of the provider's license/certification.

As a part of the federally required revalidation process, providers must verify their enrollment information and update the required disclosures at predetermined intervals. If a provider has been screened by Medicare or another State's Medicaid or CHIP program within the previous five years, information pertaining to federal requirements from that screening may be accepted by WV Medicaid. Additional state requirements may apply. Off cycle revalidations may be carried out by WV Medicaid, when warranted by situations such as random checks indicating health care fraud, complaints, national initiatives, etc.

WV will comply with the national system for reporting criminal and civil convictions, sanctions, negative licensure

actions, and other adverse actions.

Managed Care Enrollment:

MCOs that participate in WV Medicaid Managed Care must enroll as a provider and are responsible for contracting and credentialing their participating providers. MCOs establish standards for providers that participate in their networks. MCO standards must meet or exceed those for traditional Medicaid fee-for-service providers. If a provider wants to become a participating provider with a WV Medicaid MCO, he/she must contact the MCO directly. Please refer to Chapter 527 Mountain Health Trust (Managed Care) of the BMS Provider Manual for additional information.

Under Section 5005(b)(2) of the 21st Century Cures Act, by January 1, 2018, WV Medicaid must require that a provider in a managed care network is enrolled with WV Medicaid consistent with section 1902(kk) of this Title. Enrollment of the managed care provider must include provision of the provider's identifying information, including the name, specialty, date of birth, Social Security Number, National Provider Identifier (NPI) Number, Federal Tax ID Number, and WV license or certification number of the provider. Each provider must execute a provider agreement with WV Medicaid and all applicable screening must be performed.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

C-aia-1: Percent of approved CSEDW provider applications that initially meet licensure and/or certification standards. Numerator- Number and percent of approved CSEDW provider applications that initially meet licensure requirements and other waiver certification standards prior to furnishing waiver services.

Denominator- Number of CSEDW provider applications.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

collection/generation (check each that applies):	(check each that applies):	
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div></div>
Other Specify: <div>OHFLAC and ASO.</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

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

Performance Measure:

C-aia-2: Percent of CSEDW providers who continue to meet licensure and/or certification standards. Numerator- Number and percent of CSEDW providers who continue to meet licensure and/or certification standards. **Denominator-** Total Number of active CSEDW providers.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">ASO</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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

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

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

Performance Measure:

C-aib-1: Percent of licensed providers who delivered CSEDW services. Numerator- Number and percent of providers who delivered CSEDW services. Denominator- All licensed CSEDW providers.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

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

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

Performance Measure:

C-aic-1: Percent of CSEDW agency staff that meet all training requirements.

Numerator- Number and percent of CSEDW agency staff that meet all training requirements. **Denominator-** Total number of CSEDW agency staff fields reviewed.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

ii. **Remediation Data Aggregation**

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

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

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

Other Type of Limit. The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individualized Service Plan (ISP)

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Each member will be enrolled with an MCO and provided a member handbook. In the member handbook, the member's rights and responsibilities are identified. Before the member receives a CSEDW slot, the MCO provides the member and parent/caregiver/legal representative with the list of all approved-CSEDW providers in the county where the member resides. The member may choose to receive select services from the same agency or multiple agencies; as a safeguard, case management services cannot be provided by the same agency providing any other CSEDW or Medicaid State plan service. CSEDW providers will be categorized by type of services offered (i.e. case management) and members may choose their individual providers for each category. Members may change CSEDW providers at any time with the transfer becoming effective the first day of the month following the request. The member and their parent/caregiver/legal representative will complete a Freedom of Choice form, choosing their case management agency.

A Case Manager with the chosen case management agency will contact the member and parent/caregiver/legal representative to begin engagement in the ISP development process prior to the seven (7) day meeting taking place. During this contact, the Case Manager assures the delivery of the CSEDW enrollment information describing the waiver services, free choice of providers, and how to report abuse and neglect. A mutually agreed upon date will be set for the initial MDT meeting within seven (7) days of the CSEDW intake; the Case Manager will also schedule and administer the CANS instrument for use in development of the annual ISP. The ISP shall be developed within seven (7) days and completed within thirty (30) days of intake. The Case Manager is responsible for scheduling and coordinating MDT meetings, monitoring the implementation of the ISP, and for initiating MDT meetings as the needs of the member dictate. MDT meetings must be scheduled at times and places that facilitate the inclusion of the member and parent/caregiver/legal representative of the member. It is important to remember that, although coordination of the ISP process is the responsibility of the Case Manager, development of the ISP is the responsibility of the MDT. Participation of the MDT is expected to ensure the process is person-centered. WV utilizes the strengths model, which views the member and parent/caregiver/legal representative of the member as the expert on the strengths and needs of the member. These strengths and needs are then used to guide ISP development in combination with the information gathered during the intake. The MDT captures the strengths, needs, preferences, and desired outcomes of the member and decides frequency and duration of services and supports.

During the initial MDT meeting, the Case Manager in conjunction with the MDT informs the member and the parents/caregivers/legal representatives of the member of the available resources that may be included in the ISP. CSEDW services will emphasize the importance of combining natural supports from the community with professionals to create an ISP that supports the successful treatment of the member and the parents/caregivers/legal representatives of the member. The MDT consists of the member and/or parent/caregiver/legal representative of the member, the member's Case Manager, representatives of each professional discipline, provider and/or program providing services to that member (inter- and intra-agency), and MCO care coordinator (if requested). The Case Manager is ultimately responsible for facilitating the development of and subsequent updates to the ISP document; the member's Case Management agency cannot provide any additional CSEDW services.

The ISP must be updated every 90 days or sooner in the case of critical treatment junctures; the member's progress or barriers related to his/her identified treatment plan goals and objectives will be reviewed and updated during these meetings. Additionally, significant treatment successes, setbacks and incidents that have occurred during this time period will be revisited to inform the development process. The CANS instrument will be administered by the Case Manager at any identified "significant life event" (as determined by the MDT) that may alter the member's existing level-of-care status, as well as in preparation for the member's six (6) month MDT meeting. The Case Manager is responsible for scheduling and coordinating MDT meetings, monitoring the implementation of the ISP, for initiating MDT meetings as the needs of the member dictate. The member and parent/caregiver/legal representative of member have the ability to request a meeting of their MDT at any time should needs or circumstances change. The member and parents/caregivers/legal representatives of the member ultimately determine participation in the ISP development, the identification of ISP goals, and the designation of ISP services and supports.

If at the member's six (6) month ISP review the MDT determines he/she has not benefited from waiver enrollment (i.e. no progress has been made on the member's treatment goals and objects), then the MDT will refer the member to the IPN to re-determine level-of-care placement. Likewise, the MDT may determine the member has benefited from waiver enrollment and no longer requires services delivered by this program, at which time discharge planning will commence. Every person must have a re-determination of medical eligibility completed at least annually. The anchor date of the member's annual re-determination is the first day of the month after the initial medical eligibility was established by the MECA. If the reevaluation results in waiver eligibility the final decision will be made by BMS.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

- a) With the facilitation of a Case Manager, the member and their parent/caregiver/legal representative lead the MDT Meeting to develop his/her ISP. The member and his/her parent/caregiver/legal representative, together with other MDT members, will develop the ISP based on a person-centered philosophy. The MDT is comprised of the member and their parent/caregiver/legal representative and their natural support system from the community as well as professionals; team members may include any person the member wants to invite. At minimum, the MDT must consist of the member and his/her parent/caregiver/legal representative, the member's Case Manager, and any CSEDW agencies providing paid support to the individual. The ISP shall be developed within seven (7) days and completed within thirty (30) days of intake. An initial ISP is developed based on intake information within seven (7) days of intake. An annual ISP is developed within 30 days of intake and must be updated at least every 90 days. It must be updated more frequently, at critical treatment junctures, if necessitated by the member's or parent/caregiver/legal representative's needs.
- b) The ISP is the critical document that combines all information from the evaluations to guide the service delivery process as well as information from people who know the member outside the service delivery system. Evaluations include any significant medical, physical therapy, occupational therapy, speech, nutritional, nursing evaluations, and behavior support evaluations in addition to an initial functional assessment administered by the MECA and annual reevaluation by the ASO.
- c) The MCO at the time of enrollment provides the member and his/her parent/caregiver/legal representative education and materials about the available services under the Waiver program and available provider agencies in their geographic area, which would include completion of the Freedom of Choice form. A handbook is also made available to each member that contains the services offered under the Waiver program.
- d) The ISP must be based upon person-centered philosophy. The development of the ISP by the MDT must be guided by the member's needs, wishes, desires, and goals as well as address the needs that are identified in assessments and evaluations. The composition of the team must include the member and their parent/caregiver/legal representative, the Case Manager and other CSEDW agencies that provide paid supports to the member. People the member wants to include who are not paid to provide services may also be invited. The Case Manager has the responsibility for ensuring that the member's goals, needs and preferences as well as the needs that are addressed in the assessment and evaluations are addressed. Another safeguard is that the MCO will monitor health and safety as it relates to request for service authorizations and assure that service needs are addressed through individual service requests.
- e) The ISP specifies services requested by the member and the party responsible for securing and/or offering the service designated on the ISP. The signed ISP is distributed to all members of the MDT within fourteen (14) calendar days. The Case Manager is responsible for ensuring that service providers implement the content of the ISP.
- f) The ISP format specifically addresses the service, frequency of the service, and the responsible party for delivering the services. The Case Manager is required to have a face-to-face contact with the member at least monthly in his/her residence to verify that services are being delivered in a safe environment and in accordance with the ISP. Visits with the member and his/her parent/caregiver/legal representative will be used by the Case Manager to update progress towards obtaining services and resources and discuss progress towards achieving objectives contained in the ISP. The Case Manager will also elicit information from the member and his/her parent/caregiver/legal representative on their assessment of services, achievements, and/or unmet needs.
- g) The ISP shall be developed within seven (7) days and completed within thirty (30) days of intake. The ISP includes the development of the initial ISP, annual ISP and subsequent reviews or revisions of the ISP to include quarterly reviews and critical treatment junctures (as warranted). The ISP is developed on an annual basis. An Initial ISP is developed based on intake information within seven (7) days of intake. An annual ISP is developed within 30 days of intake and must be updated at least every 90 days; the member's progress or barriers related to his/her identified treatment plan goals and objectives will be reviewed and updated during these meetings. Additionally, significant treatment successes, setbacks and incidents that have occurred during this time period will be revisited to inform the process. The Case Manager will also schedule and administer the CANS instrument for use in development of the annual ISP, the six (6) month ISP review and at any identified "significant life event" (as determined by the MDT). It must be updated more frequently, at critical treatment junctures, if necessitated by the member or parent/caregiver/legal representative of the member's needs.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Each ISP is required to contain a crisis plan. Crisis plans are developed in conjunction with the ISP during the MDT meeting based upon the individualized preferences of the member and parent/caregiver/legal representative of member. As with the ISP itself, the member and parent/caregiver/legal representative of member may choose to revise the crisis plan at any time they feel it is necessary. Each crisis plan is individualized to the member; crisis plan to include clinical and non-clinical events. A potential crisis (risk) and appropriate interventions (strategies to mitigate risk) are specific to the member and identified by the MDT. Training provided to the Case Manager highlights the need to identify different levels of intervention on a crisis plan, the different stages of crisis, and how a crisis may be defined differently by each family.

The crisis plan includes action steps as a backup plan if the crisis cannot be averted. The action steps are developed by the MDT and incorporated in the crisis plan. The action steps may involve contacting natural supports, calling a crisis phone line, or contacting the Case Manager. The CSEDW in-home services provider is required to provide 24 hours a day/365 days a year crisis response that is readily accessible to members and parent/caregiver/legal representatives of member. A required component of the crisis plan is the contact information for those involved at all levels of intervention during the crisis. Families are provided a copy of the crisis plan as an attachment to their ISP in order to have access to the identified information should a crisis occur. Should a crisis occur, or support worker not arrive for a scheduled appointment, individual contact information is included on the crisis plan.

In the event that a crisis occurs which results in a critical incident being substantiated, then a prevention plan will be created by the member and the MDT to support the crisis plan and ensure similar incidents will not occur in the future.

Short-term respite services which may be included in an ISP if the MDT deems that the member and parent/caregiver/legal representative need those services to give relief to the caregiver (short-term respite). Because each member is unique, the case management undertaken by the MDT designs a member-specific ISP including a crisis plan and a back-up plan. The backup plan must be an individualized backup plan and include action steps for the individual to follow in the event of an emergency, including the failure of a support worker to appear when scheduled. Should a crisis occur or support worker not arrive for a scheduled appointment, individual contact information is included on the crisis plan. The Case Manager and MDT must ensure that an effective back-up plan is crafted to meet the unique needs and circumstances of each youth.

The crisis plan and backup plan must include the identification of potential risks to the enrolled youth and the development of strategies to mitigate such risks. Critical risks must be addressed by incorporating strategies into the plan to mitigate whatever risks may be present. Strategies to mitigate risk should be designed to respect the needs and preferences of the Waiver member and may include Waiver respite services (short-term respite) or crisis intervention/stabilization services (Medicaid State plan).

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Members will have free choice of providers within the MCO structure and may change providers as often as desired with the effective date being the first day of the month following the date requested. When a member becomes eligible for the CSEDW and is already established with a therapist who is not a member of the network, the MCO is required to make every effort to arrange for the member to continue with the same provider if the member so desires. The provider will be required to meet the same qualifications as other CSEDW providers in the network. In addition, if a member needs a specialized service that is not available through the network, the assigned MCO will arrange for the service to be provided outside the network if a qualified provider is available. Finally, except in certain situations, members will be given the choice between at least two providers. Exceptions involve highly specialized services, which are usually available through only one agency in the geographic area. This information is provided in the MCO member handbooks, which are given to members upon enrollment in the waiver. Member handbooks are also available on the MCOs websites.

CSEDW providers are permitted to offer all CSEDW services, however CSEDW providers are not permitted to deliver the full continuum of services to any single member (i.e., case management). The MCO will ensure each member maintains the described interdependent network of CSEDW providers; this network will also be mandatory members of the MDT.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The initial ISP is developed within the first seven (7) days of waiver enrollment; the annual ISP must be developed within the first thirty (30) days of waiver enrollment. The Case Manager together with the MDT will develop the ISP. The MCO will review all annual ISPs for approval as the BMS' contracted oversight entity. It is the responsibility of the Case Manager to send the ISP to the MCO prior to requesting service authorization. The MCO will review the ISP to determine that requested services are listed on the ISP prior to authorizing payment.

Additionally, as a part of the Quality Improvement system, staff of the ASO will review a representative sample of ISPs annually. Each CSEDW provider agency has at least 10% of files reviewed every year. BMS meets with the ASO monthly to review audits conducted and to finalize a Final Disallowance Report which is sent to the MCO along with instructions related to payment options to re-pay for disallowed services.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

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

Medicaid agency
Operating agency
Case manager
Other
Specify:

Case Manager and MCO

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

In addition to the MCO's oversight, the ASO is responsible for monitoring the implementation of the ISP and member's health and welfare. This monitoring will be conducted annually and consist of both a claims and clinical documentation review. Providers who are found in non-compliance with waiver standards will receive immediate feedback on formulating a plan of correction for the member. The MCO will also conduct ISP monitoring as it relates to their Quality Assurance processes; typically, these reviews are conducted annually.

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

- b. Monitoring Safeguards.** *Select one:*

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

D-aia-1: Percent of CSEDW members whose service plans address all of their assessed needs as indicated in the assessment. Numerator- Number and percent of CSEDW members whose service plans address each of their assessed needs as indicated in the assessment. Denominator- Number of CSEDW service plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

	Ongoing	Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

Performance Measure:

D-aia-2: Percent of CSEDW members receiving services whose service plan reflected the person's desired goals. Numerator- Number and percent of CSEDW members whose service plan reflected desired goals. Denominator- Number of service plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
---	--	--

State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>ASO</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

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

Performance Measure:

D-aia-3: Percent of CSEDW members whose service plan reflected identified health and safety risks. Numerator- Number and percent of CSEDW members whose service plan reflected identified health and safety risks. **Denominator-** Number of service plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

	<div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
--	---	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">ASO</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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

Performance Measures

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

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

Performance Measure:

D-aib-1: Percent of CSEDW members whose service plans were developed according to the processes in the approved waiver. Numerator- Number and percent of CSEDW members whose service plans were developed according to the processes in the approved waiver. **Denominator-** Number of CSEDW service plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<div style="border: 1px solid black; padding: 5px; width: 150px;">ASO</div>	
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>

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

Performance Measures

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

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

Performance Measure:

D-aic-1: Percent of CSEDW members whose service plans were updated/revised every ninety (90) days. Numerator- Number and percent of files of CSEDW members whose service plans were updated/revised every ninety (90) days. Denominator- Number of files reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:

D-aic-2: Percent of CSEDW members with a documented change in need whose

service plan was revised. Numerator- Number and percent of CSEDW participants with a documented change in need whose service plan was revised. Denominator- Number of CSEDW members with a documented change in need.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:

D-aid-1: Percent of CSEDW members who received services in the type, scope, amount, duration, and frequency as specified in the service plan. Numerator- Number and percent of CSEDW members who received services in the type, scope, amount, duration, and frequency as specified in the service plan. Denominator- Number of CSEDW service plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>ASO</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<div style="border: 1px solid black; height: 30px; width: 100%;"></div>

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

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

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

Performance Measure:

D-aie-1: Percent of files of CSEDW members that have a signed and current Freedom of Choice form designating institutional services vs. home and community-based services. Numerator- Number and percent files CSEDW members with a signed and current Freedom of Choice form designating institutional services vs. home and community-based services. **Denominator-** Number of files reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

ASO		
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

D-aie-2: Percent of CSEDW members with a signed and current Freedom of Choice form designating a Case Management Agency in their file. Numerator- Number and percent of CSEDW members with a signed and current Freedom of Choice form designating a Case Management Agency in their file. Denominator- Number of files reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:

D-aie-3: Percent of CSEDW members whose file contains documentation indicating a choice of waiver service providers (does not include Case Management Agency).

Numerator- Number and percent of CSEDW members whose file contains documentation indicating a choice of waiver service providers (does not include Case Management Agency). **Denominator-** Number of CSEDW files reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

All information related to this assurance is collected by the ASO through the review of CSEDW recipients' charts. Individual issues/concerns related to this assurance identified during the chart review process are addressed immediately by the ASO 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 ASO and BMS. Services provided that are not documented on the ISP or are provided by unqualified staff are disallowed and payment is recouped from the Provider agency.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

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

Appendix E: Participant Direction of Services

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

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

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

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

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

The member applying for or receiving CSEDW services and/or their parent/caregiver/legal representative, as applicable, are notified in writing of Medicaid State Fair Hearing rights when:

1. The member's request for entry into the CSEDW program has been denied due to medical eligibility;
2. The member's request for CSEDW services has been denied, reduced, suspended or terminated and they have exhausted all appeal rights;
3. The member's CSEDW case has been closed established policies and procedures. The ASO will notify the MCO when there is a case closure. The ASO maintains all records of case closures.

Medicaid members who are determined to not meet medical eligibility standards for the CSEDW receive notification via a denial letter from the ASO. The letter advises the member and his/her parent/caregiver/legal representative regarding the reason for the denial, listing the areas in which deficiencies were found against predetermined medical eligibility standards. The denial letter also provides the reason for the adverse decision, including appropriate policy manual references, a notice of free legal services, and a Request for Hearing Form to be completed if the member wishes to contest the decision.

Upon enrollment in the CSEDW program and with an MCO, members receive information from their MCO regarding the Appeals Process, Adverse Determinations, and the Medicaid State Fair Hearing Process through multiple avenues. If the member is contesting an eligibility-related decision, fair hearing can be requested through the ASO. Members receive a Member Handbook from their MCO upon enrollment that is included in their welcome packet that provides detailed information regarding Appeals and the Medicaid State Fair Hearing Process, including exhaustion of the internal appeals process with the MCO (for service denials) or ASO (for eligibility denials), applicable timeframes for filing and MCO or ASO response times, instructions on how to file, and who to contact if assistance is needed. In addition, every Notice of Action and Adverse Benefit Determination letter includes detailed information regarding the Medicaid State Fair Hearing Process. At any time, a member can call his/her Case Manager, the ASO or MCO to get additional information and/or assistance with the Medicaid State Fair Hearing Process. The MCOs and the ASO maintain all records related to service requests and denials.

In the case of an Adverse Benefit Determination, members will receive a Notice of Action letter from their MCO, detailing the denial, limitation, reduction, suspension, or termination of the applicable service; the denial, in whole or part, of payment for a service; or the failure of the MCO to act within established time requirements for service accessibility. Notice of Action letters contain information on how to file an appeal, guidelines for verbal and written appeal requests, guidance on filing appeals within 30 days of receipt of the Notice of Action, and information on resolution timeframes. Members are also provided information regarding Expedited Appeals and MCO extension provisions.

After exhausting the ASO's and/or MCO's internal Appeals process, members are provided written notification regarding the Medicaid State Fair Hearing Process that includes information that services will continue throughout the Medicaid State Fair Hearing Process if applicable policy is followed when making the request. Members are provided a Medicaid State Fair Hearing Request Form as an enclosure to the final Adverse Determination communication from their MCO. Information on available advocacy support is also provided, and the member is provided the opportunity for a Pre-Hearing Conference after they have filed a Medicaid State Fair Hearing Request with BMS. If the member has retained legal counsel, then the ASO or MCO will not conduct a Pre-Hearing Conference, and BMS legal counsel and the member's legal counsel may communicate as necessary prior to the occurrence of the Medicaid State Fair Hearing.

If at any time the CSEDW program cannot adequately ensure a member's health and safety through service utilization per their ISP and utilization of additional community resources per referrals from their Case Manager, the member will be referred for institutional services in a PRTF due to the severity of acute psychiatric symptoms contraindicating treatment at a lower level of care, indicators of severe functional impairment in three or more major life domains due to the related psychiatric diagnosis, and failure or lack of progress in a less restrictive level of care despite participation in treatment through the CSEDW. Should a referral be made for institutional services in a PRTF, the member would receive Medicaid State Fair Hearing rights per protocols associated with CSEDW case closure, as described previously.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

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

The MCO is responsible for receiving, reporting, and responding to grievances received for all enrolled members. BMS, in turn oversees this process through the quarterly MCO Grievances and Appeals Report. Complaints are tracked and responded to by the Office of Managed Care. The External Quality Review Organization (Qlarant) conducts an on-site review of grievances and appeals per the Code of Federal Regulations and National Committee for Quality Assurance (NCQA) every three years.

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

The MCO is open to any complaint, concern, or grievance a member has. The MCO staff logs and tracks all complaints, concerns, or grievances. BMS has access to this information at any time. Both members and providers are allowed 180 days to submit a grievance by phone or in writing to the MCO who is contractually obligated to send members an acknowledgement letter within 5 days of receiving the grievance and an acknowledgement letter to providers within 10 days of receipt of the grievance. The MCO will identify the type of grievance filed and works with the appropriate staff to address and resolve each grievance. The MCO will send a grievance resolution notice once the grievance has been resolved. The MCO is contractually obligated to resolve each grievance within 30 days of receipt. The MCO will log and track compliance acknowledgement letters and resolution timeframes and report that data to BMS on a quarterly basis. The report must include a summary of the grievance, the action taken by the MCO to address the grievance, the final disposition resolution, and dates of all actions. This report is reviewed during the quarterly contract management meeting in order to develop strategies for system improvement as needed.

Once the type of grievance is identified by the MCO's grievance coordinator, the grievance staff contact the appropriate department within the MCO to address the grievance. For a grievance concerning quality of care, the MCO's grievance coordinator routes the grievance to a member of the MCOs clinical staff who will investigate the details of the grievance, identify the corrective action needed, and takes any corrective action necessary. When necessary, the MCOs grievance coordinator contacts the provider against whom the grievance was filed to ensure clinical care standards are maintained. The staff person investigates the details of the grievance, and identifies corrective action needed to ensure safety standards are maintained. The responsible MCO staff members report the resolution of the grievances to the grievance coordinator. The same process is followed for all types of grievances (i.e., staff attitudes, quality of service, etc.).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All CSEDW providers and MCOs have policies and procedures for the review, investigation and tracking of critical incidents involving the risk or potential risk to the health and safety of CSEDW members. CSEDW providers are required to report and track incidents using the web-based MCO Incident Management System (MCO IMS). MCOs track critical incidents through their internal MCO IMS and report identified incidents to BMS after investigation.

All incidents are classified as follows:

- “Critical incident” means the alleged, suspected, or actual occurrence of any of the following: abuse; neglect; death due to any cause; attempted suicide; behavior that will likely lead to serious injury or significant property damage; fire resulting in injury, relocation or an interruption of services; any major involvement with law enforcement authorities; injury that requires hospitalization or results in permanent physical damage; life-threatening reaction because of a drug or food; a serious consequence resulting from an apparent error in medication or dietary administration; extended and unauthorized absence of a consumer that exceeds his or her treatment plan for community access; or removal of a member from either residential or program services without the consent of the member or his or her legal representative. (WV Code 64-11-3.12)
- Allegation of abuse, neglect or exploitation:
 - o “Abused child” means a child whose health or welfare is harmed or threatened by: (a) A parent, guardian or custodian who knowingly or intentionally inflicts, attempts to inflict, or knowingly allows another person to inflict, physical injury or mental or emotional injury, upon the child or another child in the home; (b) Sexual abuse or sexual exploitation; (c) the sale or attempted sale of a child by a parent, guardian or custodian in violation of section 16, article 4, chapter 48 of this code; or (d) Domestic violence as defined in section 202, article 27, chapter 48 of this code. In addition to its broader meaning, physical injury may include an injury to the child as a result of excessive corporal punishment. (WV Code 49-1-3(1))
 - o “Neglected child” means a child: (i) Whose physical or mental health is harmed or threatened by a present refusal, failure or inability of the child’s parent, guardian or custodian to supply the child with necessary food, clothing, shelter, supervision, medical care or education, when such refusal, failure or inability is not due primarily to a lack of financial means on the part of the parent, guardian or custodian; or (ii) Who is presently without necessary food, clothing, shelter medical care, education or supervision because of the disappearance or absence of the child’s parent or custodian. (WV Code 49-1-3(11(A)))
 - o Financial Exploitation/Misappropriation of Funds: Illegal or improper use of a person’s or incapacitated adult’s resources. Examples of financial exploitation include cashing a person’s checks without authorization; forging a person’s signature; or misusing or stealing a person’s money or possessions. Another example is deceiving a person into signing any contract, will, or other legal document. (WV BMS Provider Manual, Ch 501, 512)

All critical incidents must be reported by CSEDW Providers and MCOs to Adult Protective Services (APS) for enrollees over the age of 18 per WV Code 9-6-1, or Child Protective Services (CPS) for enrollees under the age of 18 per WV Code 49-6A-2. The WV Code 49-2-803 details persons mandated to report suspected abuse and neglect. Persons required to report suspected abuse or neglect to DHHR immediately but not more than 48 hours after suspecting the abuse or neglect include, but are not limited to: any medical, dental or mental health professional, school teachers or other school personnel, social service workers, child care or foster care workers, emergency medical services personnel, peace officers or law enforcement officials, and circuit court or family court judges. If needed, involvement with emergency services, hospitals, and/or the police must follow the provider’s policies and procedures for handling medical and psychiatric emergencies per WV Code 64-11-7.8a. OHFLAC is responsible for the administration and oversight of the LBHC requirements (including incident reporting and follow-up) for WV; BMS works closely with OHFLAC to provide additional oversight support and compliance monitoring for all members however OHFLAC has presiding authority over these credentials, providers and subsequent regulations.

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

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

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

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The MCOs provide information and resources to all members regarding identification, prevention, and reporting any instances of potential abuse, neglect, or exploitation. Information on these subjects is provided by the MCOs in the Member Handbook and is available for review at any time on the MCO member website. Information provided by the MCOs is consistent with WV's abuse, neglect and exploitation incident and reporting management process.

The ASO also provides information to members and/or their parent/caregiver/legal representative (as applicable) as part of mailed materials sent after the initial medical eligibility determination, as well as during their bi-annual medical eligibility re-evaluation that defines abuse, neglect and exploitation and how to notify the appropriate authorities. The member and/or or their parent/caregiver/legal representative is required to sign-off indicating receipt and understanding of this information.

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

For allegations of abuse, neglect or exploitation, or critical incidents, CSEDW Provider Directors (or designated staff) and MCOs must immediately review each Incident Report and determine whether the incident warrants a full investigation. Providers are required to enter all Incident Reports into the MCO IMS and issue a report to BMS. At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the CSEDW Provider or MCO shall immediately notify APS or CPS as mandated by State Code. The member and/or their parent/caregiver/legal representative may request to review APS or CPS investigation findings at any time, however, those mandated investigative agencies must follow State Code regarding who can be informed of their investigative results. CSEDW providers and MCOs are required to investigate all incidents, including those reports to APS or CPS. Should APS or CPS substantiate the allegation, APS or CPS will inform the member and/or parent/caregiver/legal representative of the outcome.

Per policy, when there has been an allegation of abuse, neglect or exploitation, CSEDW providers must:

1. Take immediate action and any necessary steps to ensure the health and safety of the member while investigating the incident,
2. Revise the member's ISP, in collaboration with the Case Management Agency, if necessary, to implement additional supports, and
3. Implement necessary systems changes, including additional training that might be helpful in preventing future incidents.

CSEDW Providers and MCOs are required to report within 24 hours of learning of the incident. They are required to immediately initiate an investigation of critical incidents and complete their investigation within 14 calendar days. The provider or MCO is responsible for taking appropriate action on both an individual and systemic basis in order to identify potential harms, or to prevent further harm, to the health and safety of all members served. The MCO IMS does not supersede the reporting of incidents to APS or CPS. At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the provider or MCO shall immediately notify APS or CPS. CSEDW provider agencies or the MCO are responsible to investigate all incidents, including those reported to APS or CPS. If requested by APS or CPS, a provider or the MCO shall delay its own investigation and document such request in the web-based MCO IMS.

In any case where the mandated reporter believes that the child suffered serious physical abuse or sexual abuse or sexual assault, the reporter must also immediately report, or cause a report to be made to law enforcement. The report must be made to the State Police and to any law enforcement agency having jurisdiction to investigate the report, which would either be municipal police or the county sheriff's department. This report is in addition to the report made to CPS. (WV CPS Policy, 1.8)

BMS and management staff review a monthly report generated by the MCO of reported allegations of abuse, neglect, critical incidents, and simple incidents submitted through MCO IMS. The MCO monitors Provider Incidents in real time. Reports are evaluated utilizing the following Performance Measure and submitted to BMS on a monthly basis:

- Number and Percent of Critical Incidents that were reported within the required timelines as specified in the approved waiver.
 - o Numerator: # of Critical Incidents that were reported within the required timelines.
 - o Denominator: total number of reported critical incidents in the specified areas.

CSEDW Providers are required to review their incident data and identify and address systemic issues and concerns on a quarterly basis, per WV policy. BMS works closely with OHFLAC to provide additional oversight support and compliance monitoring, however OHFLAC has presiding authority over credentials, providers and subsequent regulations. MCOs are responsible for regular review of the number and types of incidents across settings, providers, and provider types, identifying potential trends and patterns, opportunities for improvement, and the development and implementation of strategies to reduce the occurrence of incidents. The ASO will monitor compliance with this policy during annual on-site provider reviews.

Additionally, the OHFLAC has created Guidelines for Incidents. From these guidelines, OHFLAC states that, "The investigation must begin within 24 hours of the report of the allegation unless otherwise instructed by APS. If the committee is instructed to hold its investigation by APS, the date, time and individuals involved in the instruction shall be documented. A preliminary report must be received within five (5) days by the administrator or designee (may be verbal but must be documented) and a full written report must be completed no later than fourteen (14) days after the incident was identified." From 64 CSR 11 8.2.d, if the administrator's findings and actions on behalf of a consumer regarding a violation of the consumer's rights in unfavorable, insufficient or not forthcoming within a reasonable time, the consumer,

or his or her parent/caregiver/legal representative, may appeal to the governing body of the Center, WV licensure body, the WV advocate or other appropriate resources.

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

The MCO is responsible for the monitoring and oversight of the MCO IMS and performs follow-ups as necessary regarding critical incident investigations. Incidents are entered into the MCO IMS by CSEDW providers. Incidents submitted into the MCO IMS are tracked, aggregated, and summarized by the MCO, which also performs real time monitoring of critical incident investigations. BMS receives a monthly incident report summary from the MCO to identify and address issues or concerns. Quarterly quality incident summary reports are also reviewed by the BMS QIA Council. As part of the Quality Improvement System (QIS), the ASO reviews a representative sample of files annually, including (as applicable) compliance with Incident Management policies. This data is also reviewed and analyzed by BMS, the MCO, the ASO, and the QIA Council. CSEDW Providers and MCOs are also required to analyze incident reports to identify health and safety trends and incorporate their findings into their Quality Management Plans. Identified health and safety concerns and remediation strategies are incorporated into the agency Quality Management Plan to address and remediate any potential concerns related to the population and/or CSEDW recipients.

Appendix G: Participant Safeguards

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

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

The state does not permit or prohibits the use of restraints

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

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

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

The use of physical restraint as a de-escalation technique and emergency behavioral intervention is allowed only after all less restrictive interventions have been exhausted; the use of chemical and/or mechanical restraints and seclusion are not authorized under this waiver. Regulation governing the use of physical restraint for the CSEDW are found in WV Code of State Rules: §§27-9-1; 27-17-3; 27-1A-4(g); 27-1. Restraint may only be performed by employees of licensed behavioral health centers (LBHC). The OHFLAC requires all LBHCs to have written policy outlining training, documentation and reporting for the use of physical restraint on a member.

Restraint is permitted as an immediate response only in emergency safety situations when needed to help a member regain control of his/her behavior. At all times, the least restrictive, effective intervention must be used. Documentation indicates that the more restrictive techniques, while relieving stress for the adults in charge, usually increase stress for the youths with whom they are applied. The potential therapeutic effects (prevention of self- and other-injury and reinforcement of behavioral boundaries) must be weighed against the counter-therapeutic effects, which include loss of dignity, increased feelings of impotence/helplessness, increased resentment/rage towards authority figures, and, for member's in recovery from physical/sexual abuse, the subjective experience of re-enacting their victimization.

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

The WV DHHR's OHFLAC is the state agency responsible for overseeing the use of restraints and ensuring that WV's safeguards are followed. Each CSEDW agency must be a Licensed Behavioral Health Center (LBHC). In Behavioral Health Centers Licensure, 64 CSR 11, OHFLAC requires each provider agency to establish a Human Rights Committee. This committee's primary function is to assist the provider agency in the promotion and protection of a person's rights, and to review, approve and monitor individual programs designed to manage inappropriate behaviors and other programs that are intrusive or involve risks to the person's protection and rights. All staff involved with the delivery of CSEDW services are mandatory reports and required to report unauthorized use of restraint to the proper authorities (Child Protective Services or Adult Protective Services) immediately; CSEDW providers will also report all unauthorized use of restraint to the Case Manager following the report to CPS/APS. During the site reviews and interviews conducted by the Case Manager, MCO care manager, ASO and OHFLAC, any noted documentation or observation of unauthorized use of restraints will be reported to the proper authorities (Child Protective Services or Adult Protective Services). OHFLAC attends monthly Waiver Contract meetings with BMS and communicates their information and findings. Additional meetings are called if necessary. Incident reports must be sent to OHFLAC by the CSEDW provider agency if restraint is used. Unauthorized use of restraints may be detected during annual retroactive reviews by the ASO and every other year by OHFLAC in addition to reviews of incidences reported through the MCO Incident Management System and Adult and Child Protective Service reports.

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

Appendix G: Participant Safeguards

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

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

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

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

The WV DHHR's OHFLAC is the state agency responsible for overseeing the use of restrictive interventions and ensuring that WV's safeguards are followed by its provider network. Each CSEDW agency must be a Licensed Behavioral Health Center (LBHC) and is overseen by OHFLAC. All staff involved with the delivery of CSEDW services are mandatory reports and required to report the use of restrictive interventions to the proper authorities (Child Protective Services or Adult Protective Services) immediately; CSEDW providers will also report the use of restrictive interventions to the Case Manager following the report to CPS/APS.

Oversight is conducted during site reviews and interviews conducted by the Case Manager, MCO care manager, ASO and OHFLAC; any noted documentation or observation of unauthorized use of restrictive interventions will be reported to the proper authorities (Child Protective Services or Adult Protective Services). OHFLAC attends monthly Waiver Contract meetings with BMS and communicates their information and findings. Additional meetings are called if necessary. Incident reports must also be sent to OHFLAC by the CSEDW provider agency if restrictive interventions are used. Unauthorized use of restrictive interventions may be detected during retroactive reviews by the ASO and OHFLAC in addition to reviews of incidences reported through the MCO Incident Management System and Adult and Child Protective Service reports. Lastly, Behavioral Health Centers Licensure, 64 CSR 11, OHFLAC requires each provider agency to establish a Human Rights Committee. This committee's primary function is to assist the provider agency in the promotion and protection of a person's rights, and to review, approve and monitor individual programs designed to manage inappropriate behaviors and other programs that are intrusive or involve risks to the person's protection and rights.

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

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

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

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

Appendix G: Participant Safeguards

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

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

The state does not permit or prohibits the use of seclusion

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

The WV DHHR's OHFLAC is the state agency responsible for overseeing the use of seclusion and ensuring that WV's safeguards are followed by its provider network. Each CSEDW agency must be a Licensed Behavioral Health Center (LBHC) and is overseen by OHFLAC. All staff involved with the delivery of CSEDW services are mandatory reports and required to report the use of seclusion to the proper authorities (Child Protective Services or Adult Protective Services) immediately; CSEDW providers will also report the use of seclusion to the Case Manager following the report to CPS/APS.

Oversight is conducted during site reviews and interviews conducted by the Case Manager, MCO care manager, ASO and OHFLAC; any noted documentation or observation of unauthorized use of seclusion will be reported to the proper authorities (Child Protective Services or Adult Protective Services). OHFLAC attends monthly Waiver Contract meetings with BMS and communicates their information and findings. Additional meetings are called if necessary. Incident reports must also be sent to OHFLAC by the CSEDW provider agency if seclusion is used. Unauthorized use of seclusion may be detected during retroactive reviews by the ASO and OHFLAC in addition to reviews of incidences reported through the MCO Incident Management System and Adult and Child Protective Service reports. Lastly, Behavioral Health Centers Licensure, 64 CSR 11, OHFLAC requires each provider agency to establish a Human Rights Committee. This committee's primary function is to assist the provider agency in the promotion and protection of a person's rights, and to review, approve and monitor individual programs designed to manage inappropriate behaviors and other programs that are intrusive or involve risks to the person's protection and rights.

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

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

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

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

Appendix G: Participant Safeguards

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

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

- a. Applicability.** Select one:

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

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

- b. Medication Management and Follow-Up**

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

The OHFLAC is responsible for the administration and oversight of the LBHC and AMAP requirements for WV; BMS works closely with OHFLAC to provide additional oversight support and compliance monitoring for all members however OHFLAC has presiding authority over these credentials, providers and subsequent regulations. CSEDW agencies are required to report via the MCO Incident Management System (MCO IMS) all simple and critical incidents involving medication errors. A reportable medication error, as defined by Behavioral Health Centers Licensure 64 CSR 11, involves one or more of the following: (1) medication administered to the wrong person; (2) incorrect medication administered; (3) incorrect dosage administered; (4) medication administered by incorrect route; (5) medication administered at incorrect time and (6) the administration of the medication not properly documented. That medication errors, as defined by, and adverse drug reactions are reported to OHFLAC immediately in accordance with written procedures, including properly recording it in a member's record and notifying the physician who prescribed the drug. Unauthorized use of medications that result in a negative outcome would also result in a critical incident being filed; unauthorized use that does not result in a negative outcome will be documented and reviewed at the member's next therapy service and/or ISP meeting. Additionally, the provider must inform a member, or his or her legal representative, about the medication prescribed: the dosage, purpose, possible side effects, effects of not taking the medication, and about alternate treatments and their effects. All psychotropic drugs are ordered only as part of the treatment plan and with documentation of the diagnosis and the specific behaviors that indicate a need for the medication and the rationale for its choice. Lastly, all medications are administered in compliance with the physician's order and State law and that all orders for medications are reviewed at least every ninety (90) days by the physician.

All medication errors that result in a negative outcome or could potentially result in a negative outcome must be reported to OHFLAC. OHFLAC's regulations require the provider to complete and document an internal investigation of these and other critical incidents. Depending on the case-specific or systemic impact of the error, OHFLAC may follow-up by requesting the results of the provider's internal investigation and/or conducting an on-site investigation.

The MCO is responsible for ongoing monitoring of MCO IMS data to ensure medication errors and other types of incidents are reported to OHFLAC and mandated follow-up activities are performed by the provider. A significant medication error involving a single case can prompt the MCO to request additional information or conduct an on-site investigation; OHFLAC is the state authority responsible for conducting investigations regarding medication errors. Systemic problems pertaining to medication errors at a particular CSEDW agency location or on a statewide level are also monitored by the MCO and aggregate data is reported to BMS on a monthly basis and to the QIA Council on a quarterly basis. Findings may result in the collection of additional data, on-site review(s), and/or QIA Council strategies. These findings will be used to develop ongoing, data-driven quality improvement strategies to better serve the members and their families.

Case Managers are required to meet with the people at their homes at least once a month. This meeting includes a review of incidents that have occurred—including those related to medication errors. The Case Manager is required to summarize these incidents and their outcomes in a note that documents the home visit. Per Behavioral Health Centers Licensure 64 CSR 11, LBHC providers must maintain a Human Rights Committee whose primary function is to assist the Center in the promotion and protection of a consumer's rights, and to review, approve and monitor individual programs designed to manage inappropriate behaviors and other programs that are intrusive or involve risks to a consumer's protection and rights. One responsibility of the Human Rights Committee is to review internal and external investigations of complaints and consumer grievances, including alleged abuse, mistreatment or neglect (such as medication errors).

WV State Code 16-50 and Legislative Rule 64 CSR 60, as governed by OHFLAC, require non-licensed employees of Licensed Behavioral Health Centers who are responsible for medication administration to people to be certified Approved Medication Assistive Personnel (AMAPs). This Agency staff employee must meet the eligibility requirements to become an AMAP (including have a high school diploma or GED), must have successfully completed the required training and competency testing and has been deemed competent by the supervising RN to administer medications to people.

AMAPs are required to have monitoring and retraining quarterly by a Registered Nurse; each AMAP must undergo recertification every two (2) years. Methods of oversight/retraining include observation and assessment of the AMAP passing medication. All medications administered by an AMAP must be documented on a Medication Administration Record (MAR) which is reviewed and signed by the supervising RN each month. This documentation system provides communication among all providers that administer medication and the monitoring of medication side effects and/or medication errors. The MAR and ongoing RN oversight serve a

means to detect potentially harmful practices. Additionally, an RN must be available (on call) for AMAPs at all times.

The system for medication administration must include a storage and accountability of all medication, provisions for a medication administration record procedure and compliance with state and federal requirements. The process for prescribing and administering medications shall ensure:

- *That all orders for medications are reviewed at least every ninety (90) days by the physician;
- *That psychotropic drugs are ordered only as part of the treatment plan and with documentation of the diagnosis and the specific behaviors that indicate a need for the medication and the rationale for its choice;
- *That all medications are administered in compliance with the physician's order and WV law; and
- *That medication errors, as defined by this rule, and adverse drug reactions are reported immediately in accordance with written procedures, including properly recording it in a person's record and notifying the physician who prescribed the drug.
- *The provider agency must note changes in a person's condition, including adverse reactions, as a result of receiving a medication.
- *A person to the extent capable shall administer his or her own medication.
- *The provider agency shall provide locked storage for the medication that is not administered by people.
- *The provider agency shall inform the person, or his or her parent/caregiver/legal representative, about the medication prescribed: the dosage, purpose, possible side effects, effects of not taking the medication, and about alternate treatments and their effects.

The CSEDW agency is reviewed annually by the ASO and OHFLAC during which individual records will be retrospectively reviewed; the ASO performs annual reviews and OHFLAC biennially. All medication errors that result in serious consequences are considered to be Critical Incidents according to Behavioral Health Centers Licensure 64 CSR 11. Each provider agency must maintain a policy for critical incident reporting and demonstrate that it uses the policy to improve treatment planning and services. CSEDW agency staff shall immediately notify a supervisor of any critical incident and clear other people from the area. Each provider agency must have policies and procedures for handling medical and psychiatric emergencies that ensures communication with the nearest medical emergency services, hospital and police; a twenty-four (24) hour telephone response system, toll-free to a person; and an investigation of any incident that results in serious injury or death, as reported by the CSEDW agency to appropriate authorities and a written report on it.

The ASO and OHFLAC perform routine periodic on-site reviews of providers to ensure compliance with all policies & procedures including those pertaining to the handling and administration of medications and tracking/reporting medication errors. These on-site reviews are conducted on an annual basis by OHFLAC and the ASO staff. Any identified deficiencies are cited in a written exit report to which the provider must respond with a written plan of correction. Citations that indicate a serious and immediate threat to a person's health and safety may result in suspension of the provider's ability to administer medications, temporary or permanent revocation of the provider's license, etc. OHFLAC is responsible for the administration and oversight of the LBHC and AMAP requirements for WV; BMS works closely with OHFLAC to provide additional oversight support and compliance monitoring for all members however OHFLAC has presiding authority over these credentials, providers and subsequent regulations.

BMS, OHFLAC, ASO, and the MCO meet at least monthly to review program performance including data related to medication administration. The ASO and OHFLAC are each responsible for providing BMS with the findings of ad hoc and routine monitoring and evaluation activities. These findings will be used to develop ongoing, data-driven quality improvement strategies to better serve the members and their families.

The data from the MCO IMS, which includes critical incidents related to medication errors, is reported by the MCO to BMS at regular monthly contract meetings.

The second-line monitoring that is conducted concerning the use of behavior modifying medications is as follows:

1. The Physician must prescribe the medication and it must be a part of a treatment plan; Physician must review every 90 days.
2. Member/Parent/caregiver/legal representative must be informed about the drug. Each member has the right to appropriate medication.
3. Provider must conduct periodic evaluations of achievement related to medication prescribed and this must be documented on the ISP.
4. The ISP must provide for the review of drug dosages and types and must explain the rationale for changes or

continuation of psychotropic drug regimens.

5. Psychotropic drugs are ordered only as part of the treatment plan and with documentation of the diagnosis and the specific behaviors that indicate a need for the medication and the rationale for its choice.

6. All orders for medications are reviewed at least every ninety (90) days by the physician.

7. The LBHC shall inform a consumer, or his or her parent/caregiver/legal representative, about the medication prescribed: the dosage, purpose, possible side effects, effects of not taking the medication, and about alternate treatments and their effects.

8. There shall be documentation in a consumer's record of periodic evaluations of educational achievement in relation to medications and psychotherapeutic needs.

9. Each person has the right to medication that is not used as punishment, for the convenience of staff, as a substitute for programming, or in quantities that interfere with the treatment program.

10. All Person-Centered Support staff, respite staff or day services staff who administer medications must be licensed AMAP under the direction and supervision of a Registered Nurse and must follow the AMAP policy.

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

The CSEDW agency's Registered Nurse oversees AMAP medication administration. This oversight ensures medications are managed appropriately and harmful practices are identified (e.g. medication errors). All medications are recorded and communicated on a central document, the Medication Administration Record (MAR). The RN follows up if any medication errors are indicated, and can take action to ensure the health and welfare of the person, up to and including revocation of the CSEDW agency's staff AMAP status.

Any medication error that results in serious consequence must be reported as a Critical Incident via the MCO IMS and possibly to Adult or Child Protective Services or to OHFLAC for follow-up. The MCO and OHFLAC report to BMS on a monthly basis or more frequently if necessary. At least quarterly, a report is presented to BMS and the CSEDW QIA Council during which trends are discussed and actions are recommended.

On a state level, OHFLAC is responsible for policy implementation and ongoing monitoring of the AMAP program. Ongoing monitoring activities include:

- * Biennial on-site provider reviews which include review of AMAP policies/procedures and their implementation
- * Providers are required to submit all medication/treatment errors into the MCO Incident Management System, which is monitored by the MCO. Medication errors that result in serious outcome must be further reported to Adult Protective Services, Child Protective Services and OHFLAC as neglect
- * AMAPS failing to meet requirements and/or responsibilities are reported by the supervising RN and no longer certified as AMAP's through OHFLAC.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

CSEDW provider agencies must follow CHAPTER 16 of the WV STATE CODE SUB-SECTION 50 (or a more current version when it becomes available) which specifies that:

Administration of medication shall be performed only by:

1. Registered professional nurses;
2. Other licensed health care professionals; or
3. Facility staff members who have been trained and retrained every two years and who are subject to the supervision of and approval by a registered professional nurse.

Subsequent to assessing the health status of an individual resident, a registered professional nurse, in collaboration with the resident's attending physician and the facility staff member, may recommend that the facility authorize a facility staff member to administer medication if the staff member:

1. Has been trained pursuant to the requirements of this article;
2. Is considered by the registered professional nurse to be competent;
3. Consults with the registered professional nurse or attending physician on a regular basis; and
4. Is monitored or supervised by the registered professional nurse

The program developed by the department shall require that any person who applies to act as a facility staff member authorized to administer medications pursuant to the provisions of this article shall:

1. Hold a high school diploma or general education diploma;
2. Be trained or certified in cardiopulmonary resuscitation and first aid;
3. Participate in the initial training program developed by the department;
4. Pass a competency evaluation developed by the department; and
5. Subsequent to initial training and evaluation, participate in a retraining program every two years.

A registered nurse who is authorized to train facility staff members to administer medications in facilities shall:

1. Possess a current active WV license in good standing to practice as a registered nurse;
2. Have practiced as a registered professional nurse in a position or capacity requiring knowledge of medications for the immediate two years prior to being authorized to train facility staff members; and
3. Be familiar with the nursing care needs of residents of facilities as described in this article.

Oversight of medication administration by unlicensed personnel:

- a. Each facility in which medication is administered by unlicensed personnel shall establish in policy an administrative monitoring system. The specific requirements of the administrative policy shall be established by the department through rules proposed pursuant to section eleven of this article.
- b. Monitoring of facility staff members authorized pursuant to this article shall be performed by a registered professional nurse employed or contracted by the facility.

Withdrawal of authorization:

The registered professional nurse who monitors or supervises the facility staff members authorized to administer medication pursuant to this article may withdraw authorization for a facility staff member if the nurse determines that the facility staff member is not performing medication administration in accordance with the training and written instructions. The withdrawal of the authorization shall be documented and shall be relayed to the facility and the department in order to remove the facility staff member from the list of authorized individuals.

Limitations on medication administration:

The following limitations apply to the administration of medication by facility staff members:

- a. Injections or any parenteral medications may not be administered;
- b. Irrigations or debriding agents used in the treatment of a skin condition or minor abrasions may not be administered;
- c. No verbal medication orders may be accepted, no new medication orders shall be transcribed and no drug dosages may be converted and calculated; and
- d. No medications ordered by the physician or a health care professional with legal prescriptive authority to be given "as needed" may be administered unless the order is written with specific parameters which preclude independent judgment.

Self-administration of medication:

Supervision of self-administration of medication by facility staff members who are not licensed health care professionals may be permitted in certain circumstances, when the substantial purpose of the setting is other than the provision of health care.

iii. Medication Error Reporting. *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report

medication errors to a state agency (or agencies).

Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

All medication errors that result in a negative outcome or could potentially result in a negative outcome must be reported to OHFLAC. Medication errors are reported to BMS through the MCO Incident Management System. The MCO is responsible for ongoing monitoring of the MCO IMS and preparing summary reports to BMS and other contracted entities.

Medication errors resulting in negative outcomes (medical follow-up, hospitalization, etc.) for the person must be reported as neglect to OHFLAC, Adult Protective Services and/or Child Protective Services.

(b) Specify the types of medication errors that providers are required to *record*:

All medication errors are required to be recorded. Medication errors are defined as: (1) incorrect route of administration; (2) incorrect time of administration; (3) incorrect dosage; (4) incorrect drug; (5) medication administered to the incorrect person; and (6) incorrect or failure to document administration of medication.

(c) Specify the types of medication errors that providers must *report* to the state:

All medication administration errors that result in critical incidents or abuse, neglect or exploitation must be reported to BMS through the MCO IMS. Additionally, medication errors that result in abuse, neglect, exploitation, or negative outcomes for the person must be reported to APS or CPS as well as OHFLAC.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

BMS monitors program performance utilizing data that is obtained through a variety of sources including the ASO; MCO; OHFLAC; MECA; WV's fiscal agent and Adult & Child Protective Services agencies. The type of data and frequency at which it is collected and reported is driven by the SED Waiver Quality Plan, which includes performance indicators pertaining to CMS Quality Assurances as well as performance indicators identified by BMS and the QIA Council.

Examples of the types of data collected include: Incident data reported by providers through the MCO Incident Management System (MCO IMS); data pertaining to program policies and procedures collected during routine on-site reviews of provider agencies; data regarding the volume and types of grievances and complaints filed by people; claims data; etc.

The ASO is responsible for coordinating the collection of data and using it to prepare monthly reports that are submitted to BMS and reviewed during the CSEDW Contract Management meetings. These meetings are held at least monthly and include representatives from BMS, the ASO, MCOs, OHFLAC, and MECA. Others are invited to attend as needed. Based upon a review of the performance indicators and all corresponding data the group may determine (1) the findings are satisfactory and do not require further action at this time; (2) a more detailed evaluation of the findings is needed and additional information/data may be requested; or (3) the findings are not satisfactory or indicate there is an opportunity for improvement. Further action will be taken which may include formation of a QI workgroup through the QIA Council.

On a quarterly basis, data pertaining to performance indicators and other program activities are presented to the QIA Council. Performance Indicator data failing to achieve desired outcomes are addressed through various methods including the formation of QI workgroups with members chosen from the Council, persons receiving services & family members, and other stakeholders.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance: *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)***

Performance Measures

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

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

Performance Measure:

G-a-1: Number and percent of substantiated cases of abuse, neglect, exploitation and misappropriation of funds where recommended actions to protect health and welfare were implemented. N-Number of substantiated cases where recommended actions to

protect health and welfare were implemented. D-Total number of substantiated cases where there were recommended actions to protect health and welfare.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="ASO, OHFLAC"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

G-a-2: Number and percent of deaths with a determined need for investigation that were reported to the proper authorities (Law Enforcement and OHFLAC) for investigation. N: Number of deaths with a determined need for investigation that were reported to the proper authorities (Law Enforcement and OHFLAC) investigated. D: Total number of deaths with a determined need for investigation.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px;">ASO, OHFLAC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

Performance Measure:

G-a-3: Number and percent of deaths with a determined need for investigation that were internally investigated. Numerator: Number of deaths with a determined need for investigation that were internally investigated. Denominator: Total number of deaths with a determined need for investigation.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
---	--	--

State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div></div>
Other Specify: <div>MCO</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:

G-b-1: Number and percent of critical incidents that were reported within the required time frames as specified in the waiver application. N: Number of critical incidents reported in the required time frames as specified in the waiver application. D: Total number of reported critical incidents in the specified areas.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

<div>MCO</div>		<div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

Performance Measure:

G-b-2: Number and percent of critical incident reviews/investigations that were completed as specified in the approved waiver. Critical incidents related to Abuse; Neglect; Exploitation; and Misappropriation of Funds. N: Number of critical incident reviews/investigations that were completed as specified in the approved waiver. D: Total number of critical incident reviews/investigations.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:

G-b-3: # and % of members with a critical incident who had a plan of prevention or documentation of a plan, developed as a result of the incident. Related to 1) Abuse; 2) Neglect; 3) Exploitation; and 4) Misappropriation of Funds. N: # of members with a critical incident who had a plan of prevention or documentation of a plan, developed as a result of the incident. D: Total # of critical incidents.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		<div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

- c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

Performance Measures

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

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

Performance Measure:

G-c-1: Number and percent of instances of unapproved restraint, seclusion or other

restrictive interventions with a prevention plan developed as a result of the incident.
Numerator: Number of instances with a prevention plan developed as a result of the incident. **Denominator:** Total number of instances that required development of a prevention plan developed as a result of the incident.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly

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

- d. Sub-assurance:** *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

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

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

Performance Measure:

G-d-1: Number and percent of participants reviewed with an identified need for medication administration whose service plan includes a plan for medication administration. N: Total number of participant records reviewed with an identified need for medication administration whose service plan includes a plan for medication administration. D: Total number of participant records reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>MCO</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<div style="border: 1px solid black; height: 30px; width: 100%;"></div>

Performance Measure:

G-d-2: Number and percent of providers reviewed who administer medications hold a current AMAP certification. Numerator: Number of providers reviewed who administer medications hold a current AMAP certification. Denominator: Total number of provider records reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

--	--	--

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

All information related to this assurance is collected and monitored by BMS, the ASO, and the MCOs. The ASO will collect and monitor this assurance using the MCO IMS and will collect and monitor this assurance using results of MCO reported incidents, Provider reviews, and CSEDW recipient record reviews. Provider issues/concerns such as failure to meet requirements are addressed immediately upon identification by the ASO and/or MCO. Providers may be required to submit Plans of Correction addressing identified issues that must be approved by the ASO and/or the MCO.

ii. Remediation Data Aggregation

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

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The ASO and MCOs are responsible for monitoring the quality of CSEDW services and implementing and evaluating quality improvement strategies. The CSEDW QIA Council utilizes an evidence-driven Quality Improvement System (QIS) and incorporates a broad base of stakeholders in active roles in the process.

Discovery and remediation activities focus on the collection of data necessary to monitor the quality indicators established to provide evidence related to the CMS assurances and sub-assurances. Specific data sources include provider monitoring, claims data, incident management reports, contract oversight meetings and reports, people/family focus groups and interviews, and other stakeholder feedback and input.

The primary mechanism for involving stakeholders in the CSEDW's quality improvement initiative is the CSEDW QIA Council. The Council strives for a minimum of fifteen (15) members comprised of at least five (5) current program participants (or family/parent/caregiver/legal representatives), CSEDW agency staff/providers, advocates and other interested stakeholders. The Council serves as a forum for people and/or their parent/caregiver/legal representative and the public to raise and address program issues and concerns affecting the quality of Waiver services and to make recommendations to BMS.

The Council:

1. Reviews findings from discovery activities
2. Recommends program priorities and quality initiatives
3. Recommends policy changes
4. Monitors and evaluates the implementation of Waiver priorities and quality initiatives
5. Monitors and evaluates policy changes
6. Serves as a liaison between the Waiver and its stakeholders
7. Establishes committees and work groups consistent with its purpose and guidelines

The purpose of the CSEDW QIA Council is to provide guidance and feedback to BMS in the development of an ongoing quality assurance and improvement system for the CSEDW program. The Council works with BMS to develop and strengthen the CSEDW program through the following methodologies:

- Collect data and assess member experiences in order to assess the ongoing implementation of the CSEDW program, identifying strengths and opportunities for quality improvement
- Act in a timely manner to remediate specific problems or concerns as they arise
- Use data and quality information to engage in actions that lead to continuous improvement in the CSEDW program

The MCOs receive and/or report incidents from providers or MCO staff within 24-hours becoming aware of the incident. The incident is entered into the MCO incident management system (MCO IMS). The MCO reviews reports and initially follows up with the provider to administer technical assistance (i.e. review timelines and policy). The MCO verifies that investigations are completed by the provider within appropriate timelines and that appropriate referrals have been made to APS or CPS, law enforcement, etc. The MCO compiles information on a monthly basis and provides reports to BMS. Although the report is sent to BMS on a monthly basis from the MCO, the MCO is responsible for reporting all critical incidents to BMS within 48 hours of the occurrence as an informal report. The MCO also generates monthly reports to identify and monitor incident trends. On a quarterly basis, information is reviewed by the CSEDW QIA Council for possible suggested policy/procedural changes.

The Council will work with BMS, the ASO, MCOs, and CSEDW providers to ensure that the CSEDW supports the desired outcomes outlined in the six (6) focus areas of the Quality Framework developed by CMS:

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers and governments by developing and spreading new health care delivery systems.

The QMR, which incorporates data from discovery and remediation activities, is reviewed and analyzed by BMS staff through regular meetings with contractors. The report is also reviewed quarterly with the QIA Council in

order to identify trends and to monitor the effectiveness of quality improvement activities.

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

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: CSEDW Provider Agencies, ASO, MCO	Other Specify:

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The CSEDW Quality Improvement System (QIS) is designed to: 1) Collect the data necessary to provide evidence that all CMS assurances and sub-assurances are being met, and 2) Ensure the active involvement of stakeholders in the quality improvement process. The primary sources of discovery include provider reviews, incident management reports and complaints, administrative reports, oversight of delegated administrative functions, and stakeholder input.

Provider Reviews:

The primary means of monitoring the quality of CSEDW services are provider reviews conducted by staff from the ASO and the Office of Health Facility Licensing and Certification (OHFLAC).

To become a CSEDW Agency, an agency must apply for a Certificate of Need (CON) through an expedited Summary Review process and be approved by the WV Health Care Authority. Then, the agency must obtain a Behavioral Health License through OHFLAC. Licensure of a new agency involves an initial onsite OHFLAC review followed by a six-month comprehensive on-site review (as necessary) to ensure all certification standards are substantially met.

OHFLAC licenses are issued as follows:

- An initial six (6) month license shall be issued to CSEDW agencies establishing a new program or service for which there is insufficient individual participation to demonstrate substantial compliance with certification standards;
- A provisional license shall be issued when a CSEDW agency seeks a renewal license, and is not in substantial compliance with certification standards, but does not pose a significant risk to the rights, health and safety of the CSEDW program individual. It shall expire not more than six (6) months from date of issuance, and not be consecutively reissued, unless the provisional recommendation is that of the WV fire marshal.
- A renewal license shall be issued when a CSEDW agency is in substantial compliance with certification standards and shall expire not more than two (2) years from date of issuance.

The ASO performs on-site provider reviews annually to validate certification documentation. One hundred percent (100%) of Providers are reviewed each year via an on-site review to validate certification documentation. Targeted on-site provider reviews may be conducted based on Incident Management Reports and complaint data.

A statewide representative sample of files are reviewed every 12 months. Files are reviewed by staff of the ASO using the Quality and Utilization Review Tool. This tool has been developed to ensure that the critical data necessary to monitor CMS assurances are collected. Random sampling ensures that at least one person's chart from each Provider site is reviewed.

Another key source for monitoring the quality of CSEDW services is the MCO Incident Management System (MCO IMS). All incidents are tracked, including: 1) Simple Incidents, 2) Critical Incidents, and 3) Abuse, Neglect, and Exploitation. The online system gives CSEDW agencies the ability to generate specific reports to identify and monitor trends. All CSEDW providers are required to report all incidents to the MCO IMS.

The MCO also operates a toll-free hotline allowing people to contact them directly to report and address concerns with their services. Data from these calls are compiled and analyzed for trends. The MCO also employs a Member & Family Liaison to whom people and their parent/caregiver/legal representatives may report concerns with their services. The Liaison is responsible for providing education and assistance to the person/parent/caregiver/legal representatives and periodically compiles aggregate reports regarding concerns/complaints, which are analyzed for trends.

Reports:

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

- (1) MCO Monthly Program Report, Monthly Discovery and Remediation Report, Monthly Activity Report, semi-monthly Tracking Report, and ad hoc reports as requested
- (2) Claims Vendor routine reports on claims data and ad hoc reports as requested
- (3) Eligibility Vendor Monthly Report and ad hoc reports as requested
- (4) MCO Reports

Contract Oversight Meetings:

BMS management staff conducts monthly oversight meetings with each of its contractors to monitor performance

and address identified issues/concerns.

Quality management data collected through discovery method is compiled using the Discovery and Remediation Report Template and reviewed at least monthly by BMS and the MCO at its contract meetings. The Discovery and Remediation Report is also compiled and reviewed quarterly by the CSEDW QIA Council. A comprehensive report summarizing the findings of provider reviews is compiled at the end of each review cycle, reviewed and analyzed by CSEDW staff, and presented to the QIA Council for review and analysis.

The QIA Council:

The QIA Council is the focal point of stakeholder input for the CSEDW and plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies. The Council should be comprised of 15 members with at least five (5) being current or former CSEDW members (or their parent/caregiver/legal representatives) and meets on at least a quarterly basis.

The Council provides BMS, the ASO, MCO, and CSEDW staff feedback and guidance regarding quality improvement initiatives. The Council reviews and analyzes data, identifies trends and priorities, and develops the annual Quality Management Plan in which specific quality improvement goals and objectives are established.

The Council may establish work groups consisting of Council members and others wishing to participate in the process to address specific improvement goals and objectives.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The goals and objectives outlined in the Quality Management Plan are continuously monitored by the CSEDW QIA Council, with regular updates being provided at each quarterly meeting. The CSEDW QIA Council also monitors the Quality Management Plan on a monthly basis, as additional data is collected and aggregated related to Critical Incidents and other quality of care concerns. An annual planning meeting is held to review progress toward the goals and objectives of the plan and to update the plan as indicated by quality management data.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

- b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services,

including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

A statewide representative sample of files are reviewed to verify documentation of services billed. When the CSEDW agency's documentation does not support services billed or when services have been provided by unqualified staff, the CSEDW agency is required to submit Corrective Action Plans, which must be approved by the MCO and BMS. MCO Program Integrity reviews would address any services billed without supporting documentation or provided by unqualified staff. The MCO would then recoup funds paid out for any services deemed inappropriate. The Medicaid Program (which would include the CSEDW) is audited annually under the WV Statewide Single Audit, which is conducted by Ernst & Young, LLP.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

I-ai-1: Percent of clean claims paid for CSEDW services within the timeframes specified in the contract. Numerator- Number and percent of clean claims paid for CSEDW services within the timeframes specified in the contract. Denominator- Total number of clean claims submitted for CSEDW services.

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

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

State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="MCO"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

Performance Measure:

I-ai-2: Percent of CSEDW claims paid using the correct rate as specified in the Waiver application. Numerator- Number and percent of CSEDW claims paid using the correct rate as specified in the Waiver application. **Denominator-** Total number of CSEDW claims paid.

Data Source (Select one):

Financial audits

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; padding: 5px; width: 150px; margin-top: 10px;">MCO</div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 10px;"></div>

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

Performance Measures

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

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

Performance Measure:

I-b-3: Capitation rates inclusive of CSEDW members will be certified and approved by CMS. Numerator – number and percent of capitation rates inclusive of CSEDW members certified and approved by CMS. Denominator – number of capitation rates inclusive of CSEDW members.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Managed Care Actuarial Rate Certification Documents

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

Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div></div>
Other Specify: <div>MCO</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

Evidence relating to this assurance is collected through the MCOs' prior authorization systems and through the MCOs' Quality and Utilization Review process. All providers must initially submit request for and receive prior authorization through the CSEDW recipient's applicable MCO prior to billing for any Waiver service. Any issues identified at the prior authorization stage are identified and resolved immediately (prior to services being authorized). This sometimes leads to a request by the MCO for the provider to submit additional information/documentation to support the request for service authorization.

All information relating to this assurance is collected through the review of files by the MCO and the review and analysis of claims data. Evidence collected via claims data is reviewed and analyzed by BMS and the claims processing entity in order to identify any system issues. The Mountain Health Trust is WV's contractual agreement between each MCO and DHHR, and BMS is beginning specialized managed care for children and youth; both outline expectations for Medicaid service execution; this contract will ensure that CSEDW services and billings are provided as defined in the waiver. The MCO is expected to meet or exceed all objectives and standards, as set forth in the contract. All areas of responsibility and all contract requirements will be subject to performance evaluation by DHHR. The MCO agrees that failure to comply with all provisions of the Contract may result in the assessment of remedies and/or termination of the Contract, in whole or in part.

ii. Remediation Data Aggregation

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

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No

Yes

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The current rate structure has been developed to reflect service definitions, provider requirements, operational service delivery, and administrative considerations. The following components were used to determine the current CSEDW rates: Bureau for Labor Statistics wage information; employee-related expenses; productivity adjustment factor; and administrative overhead. This methodology was applied to all HCPCS Level II codes and were last updated in November 2006; for HCPCS Level I codes RBRVS reimbursement rates were applied (RBRVS rates are updated on January 1 of each year). Mileage reimbursement is based on the approved mileage rate as published by the WV Division of Purchasing, Travel Management Office. The described rate methodology is consistently applied to all Waiver services. The current rate methodology provides consistency with the provisions of section 1902(a)30(A) and 42 CFR section 447.200-205. WV does not use a formula to base increase for inflation, and at this time does not anticipate rate increases.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billings flow directly from Waiver providers to the MCOs claims payment system (included in the PMPM).

Appendix I: Financial Accountability

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

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

No. state or local government agencies do not certify expenditures for waiver services.

Yes, state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

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

Certified Public Expenditures (CPE) of Local Government Agencies.

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

Appendix I: Financial Accountability

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

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

Each claim is subjected to a series of edits to ensure that the member is eligible on the date of service, that the CSEDW agency has a valid enrollment status, and that the service is eligible for payment. If the claim passes these initial edits, further assurances are provided through prior authorization of Waiver services based on the person's approved ISP. Post-payment review activities are conducted by the MCO and BMS to ensure that services are provided as defined in the waiver. All information relating to this assurance is collected through the review of files by the MCO and the review and analysis of claims data. Evidence collected via claims data is reviewed and analyzed by BMS and the claims processing entity in order to identify any system issues.

The Mountain Health Trust is WV's contractual agreement between each MCO and DHHR, and BMS is beginning specialized managed care for children and youth; both outline expectations for Medicaid service execution; this contract will ensure that CSEDW services and billings are provided as defined in the waiver. The MCO is expected to meet or exceed all objectives and standards, as set forth in the contract. All areas of responsibility and all contract requirements will be subject to performance evaluation by DHHR. The MCO agrees that failure to comply with all provisions of the Contract may result in the assessment of remedies and/or termination of the Contract, in whole or in part.

- e. Billing and Claims Record Maintenance Requirement.*** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (select one):

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Payments are made to the MCO on a PMPM; the monthly payment is based on a capitation roster effective the first of the month.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the

entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

All services included in the waiver will also be included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select

one:

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

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

There is no reduction or return of the monthly capitated payment to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the

Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

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

Appendix I: Financial Accountability

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

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

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

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

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

Other Local Government Level Source(s) of Funds.

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

Appendix I: Financial Accountability

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

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

or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

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

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	89721.00	19695.00	109416.00	186855.00	19695.00	206550.00	97134.00
2	78676.00	20285.85	98961.85	186855.00	20285.85	207140.85	108179.00
3	48842.00	20894.43	69736.43	186855.00	20894.43	207749.43	138013.00

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 7)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Hospital	
Year 1	500		500
Year 2	1000		1000
Year 3	2000		2000

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 7)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Estimate for average length of stay is derived from research conducted that showed twelve (12) month would be the most appropriate timeframe; WV currently has no historical claims experience.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 7)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

The estimates for Factor D are derived from projected trends of claims experience adjusted for anticipated increases in utilization and definition of service.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for Factor D' are derived from projected trends of claims experience adjusted for anticipated increases in utilization.

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for Factor G are derived from projected trends of claims experience adjusted for anticipated increases in utilization.

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for Factor G' are derived from projected trends of claims experience adjusted for anticipated increases in utilization.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 7)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Case Management	
In-Home Family Support	
Independent Living/Skills Building	
Job Development	
Respite Care, In-Home	
Supported Employment, Individual	

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment, Individual Total:							789000.00
Supported Employment, Individual		15 minutes	100	1500.00	5.26	789000.00	
Assistive Equipment Total:							125000.00
Assistive Equipment		\$1.00	250	500.00	1.00	125000.00	
Community Transition Total:							1500000.00
Community Transition		\$1.00	500	3000.00	1.00	1500000.00	
In-Home Family Therapy Total:							18890400.00
In-Home Family Therapy		50 minutes	500	480.00	78.71	18890400.00	
Mobile Response Total:							5786000.00
Mobile Response		15 minutes	500	2200.00	5.26	5786000.00	
Non-Medical Transportation Total:							1026000.00
Non-Medical Transportation		1 mile	500	3800.00	0.54	1026000.00	
Peer Parent Support Total:							504960.00
Peer Parent Support		15 minutes	500	192.00	5.26	504960.00	
Respite Care, Out-of-Home Total:							1440375.00
Respite Care, Out-of-Home		15 minutes	500	575.00	5.01	1440375.00	
Specialized Therapy Total:							125000.00
Specialized Therapy		\$1.00	250	500.00	1.00	125000.00	
GRAND TOTAL:							44860610.00
Total: Services included in capitation:							44860610.00
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							500
Factor D (Divide total by number of participants):							89721.00
Services included in capitation:							89721.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 7)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User,

and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							8477800.00
Case Management	<input type="checkbox"/>	<input type="text" value="15 minutes"/>	<input type="text" value="1000"/>	<input type="text" value="874.00"/>	<input type="text" value="9.70"/>	8477800.00	
In-Home Family Support Total:							9594240.00
In-Home Family Support	<input type="checkbox"/>	<input type="text" value="15 minutes"/>	<input type="text" value="950"/>	<input type="text" value="1920.00"/>	<input type="text" value="5.26"/>	9594240.00	
Independent Living/Skills Building Total:							6312000.00
Independent Living/Skills Building	<input type="checkbox"/>	<input type="text" value="15 minutes"/>	<input type="text" value="800"/>	<input type="text" value="1500.00"/>	<input type="text" value="5.26"/>	6312000.00	
Job Development Total:							1183500.00
Job Development	<input type="checkbox"/>	<input type="text" value="15 minutes"/>	<input type="text" value="150"/>	<input type="text" value="1500.00"/>	<input type="text" value="5.26"/>	1183500.00	
Respite Care, In-Home Total:							1872487.50
Respite Care, In-Home	<input type="checkbox"/>	<input type="text" value="15 minutes"/>	<input type="text" value="650"/>	<input type="text" value="575.00"/>	<input type="text" value="5.01"/>	1872487.50	
Supported Employment, Individual Total:							1183500.00
Supported Employment, Individual	<input type="checkbox"/>	<input type="text" value="15 minutes"/>	<input type="text" value="150"/>	<input type="text" value="1500.00"/>	<input type="text" value="5.26"/>	1183500.00	
Assistive Equipment Total:							250000.00
Assistive Equipment	<input type="checkbox"/>	<input type="text" value="\$1.00"/>	<input type="text" value="500"/>	<input type="text" value="500.00"/>	<input type="text" value="1.00"/>	250000.00	
Community Transition Total:							1800000.00
Community Transition	<input type="checkbox"/>	<input type="text" value="\$1.00"/>	<input type="text" value="600"/>	<input type="text" value="3000.00"/>	<input type="text" value="1.00"/>	1800000.00	
In-Home Family Therapy Total:							35891760.00
In-Home Family Therapy	<input type="checkbox"/>	<input type="text" value="50 minutes"/>	<input type="text" value="950"/>	<input type="text" value="480.00"/>	<input type="text" value="78.71"/>	35891760.00	
Mobile Response Total:							8100400.00
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							78675823.00 78675823.00 1000 78676.00 78676.00 <div><input type="text" value="365"/></div>

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Mobile Response		15 minutes	700	2200.00	5.26	8100400.00	
Non-Medical Transportation Total:							1231200.00
Non-Medical Transportation		1 mile	600	3800.00	0.54	1231200.00	
Peer Parent Support Total:							656448.00
Peer Parent Support		15 minutes	650	192.00	5.26	656448.00	
Respite Care, Out-of-Home Total:							1872487.50
Respite Care, Out-of-Home		15 minutes	650	575.00	5.01	1872487.50	
Specialized Therapy Total:							250000.00
Specialized Therapy		\$1.00	500	500.00	1.00	250000.00	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							78675823.00 78675823.00 1000 78676.00 78676.00 365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 7)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							16955600.00
Case Management		15 minutes	2000	874.00	9.70	16955600.00	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							97683161.00 97683161.00 2000 48842.00 48842.00 365

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Family Support Total:							11109120.00
In-Home Family Support		15 minutes	1100	1920.00	5.26	11109120.00	
Independent Living/Skills Building Total:							6706500.00
Independent Living/Skills Building		15 minutes	850	1500.00	5.26	6706500.00	
Job Development Total:							1578000.00
Job Development		15 minutes	200	1500.00	5.26	1578000.00	
Respite Care, In-Home Total:							2160562.50
Respite Care, In-Home		15 minutes	750	575.00	5.01	2160562.50	
Supported Employment, Individual Total:							1578000.00
Supported Employment, Individual		15 minutes	200	1500.00	5.26	1578000.00	
Assistive Equipment Total:							300000.00
Assistive Equipment		\$1.00	600	500.00	1.00	300000.00	
Community Transition Total:							2250000.00
Community Transition		\$1.00	750	3000.00	1.00	2250000.00	
In-Home Family Therapy Total:							41558880.00
In-Home Family Therapy		50 minutes	1100	480.00	78.71	41558880.00	
Mobile Response Total:							8679000.00
Mobile Response		15 minutes	750	2200.00	5.26	8679000.00	
Non-Medical Transportation Total:							1539000.00
Non-Medical Transportation		1 mile	750	3800.00	0.54	1539000.00	
Peer Parent Support Total:							807936.00
Peer Parent Support		15 minutes	800	192.00	5.26	807936.00	
GRAND TOTAL:							97683161.00
Total: Services included in capitation:							97683161.00
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							2000
Factor D (Divide total by number of participants):							48842.00
Services included in capitation:							48842.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							365

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care, Out-of-Home Total:							2160562.50
Respite Care, Out-of-Home		15 minutes	750	575.00	5.01	2160562.50	
Specialized Therapy Total:							300000.00
Specialized Therapy		\$1.00	600	500.00	1.00	300000.00	
GRAND TOTAL:							97683161.00
Total: Services included in capitation:							97683161.00
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							2000
Factor D (Divide total by number of participants):							48842.00
Services included in capitation:							48842.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							365