WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Intellectual and/or Developmental Disabilities Waiver (IDDW) Renewal Worksheet

Current Language	Revised Centers for Medicare & Medicaid Services (CMS) Application/Technical Language	Revised Drafted Language
Major Changes		

The purpose of this application is to renew WV's IDDW 5-year application. Listed below are the major changes that can be found:

- The West Virginia Department of Health and Human Resources (WV DHHR) has been changed to West Virginia Department of Human Services (WV DoHS) throughout the application. The name change follows the re-organization of the Department into three separate departments, effective January 1, 2024, pursuant to House Bill 2006.
- "Autism" changed to "Autism Level 3"
- B-3-a: Table updated for Year 1
- A-1-b-i. change service plan to "person-centered service plan" and add acronym "PCSP"; Change service plan to "PSCP" in B-1-b-I; C-1-b-I; D-1-b-I; G-1-b-I and I-1-b-i
- QI-b-I (Appendices A, B, C, D, G & I) revised to comply with CMS revision to describe how both individual and systemic deficiencies are identified and remedied.
- Section B-8: updated percentage of English proficiency per 2020 census. (decrease to 97.5%)
- C1/C3:
  - Case Management: updated service definition to include description of case management training regarding the HCBS settings rule and person-centered planning practices.
  - Telehealth: updated service descriptions to reflect current practices regarding the provision of Case Management, RN Services, Behavioral Health Supports, Day Habilitation, PT, OT, Speech and Dietary via telehealth when necessary and appropriate to meet the needs of the individual.
  - Licensed Group Home and Unlicensed Group Home have been expanded to include qualifications for the provision of AMAP services.
  - Addition of new service: Skilled Nursing Medication Administration.
- C-2-b: Updated narrative to include description of current practices to ensure continuity of care in the event that a service provider is substantiated for abuse, neglect, exploitation or in response to a critical incident.
- C-2-d: Updated to reflect safeguards in place to ensure that Legal Authorized Representative (LAR) uses substituted judgment on behalf of the individual served.
- C-2-e: Updated to reflect safeguards in place to ensure that LAR uses substituted judgment on behalf of the individual served. Revised language also includes reference to relevant WV Code Chapter 44a-1-5.
- C-2-g: Updated to reflect current practices described in Chapter 513, IDDW Policy Manual, to allow for provision of direct support services in acute care hospital settings.
- C-3-L: Electronic Monitoring: updated service description to be consistent with current practices described in Chapter 513, IDDW Policy Manual (e.g., placement of cameras, ability of individual to turn system on and off, individual training on system functionality).
- C-3: Occupational Therapy: Updated to describe provision of waiver services authorized beyond EPSDT medical necessity.
- C-3: Physical Therapy: Updated to describe provision of waiver services authorized beyond EPSDT medical necessity.
- C-3: Speech Therapy: Updated to describe provision of waiver services authorized beyond EPSDT medical necessity.
- C-3 Dietary Services: Updated to describe provision of waiver services authorized beyond EPSDT medical necessity.
- C-5: Home and Community-Based Settings: Service description updated to reflect current policies and practices regarding identification and remediation of settings found to be out of compliance with the HCBS settings rule.
- D-1-a: Revised to describe case manager's role in the development of the service plan, including importance of person-centered planning and training on the HCBS settings criteria.
- D-1-b: Description of service plan development safeguards revised to reflect that in the event case management agency is also responsible for service delivery, that agency is the only willing and qualified provider in a given geographic area. In addition, no agency can furnish both case management and provider service without authorization from the state agency.

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• D-1-b: Description of service plan development safeguards revised to reflect that in the event case management agency is also responsible for service delivery, that agency is the only willing and qualified provider in a given geographic area. In addition, no agency can furnish both case management and provider service without authorization from the state agency.
• D-1-d-i: Service Plan Development Process description revised to reflect that the 7-Day IDT plan is limited to an effective duration of 60, unless otherwise authorized by BMS.
• D-1-g: New language included to limit the effective duration of the 7-Day IDT plan to 60 days without state agency authorization.
• D-2-b: Removed language referring to personal attendant (PA) services and replaced with “other services”.
• J-2-d:
  ○ Updated rates and added three new services for Approved Medication Assistive Personnels (AMAPs) in unlicensed residential homes and four new services for AMAPs in licensed group homes.
  ○ Added rate for new service, Skilled Nursing Medication Administration.
  ○ Added a new component for Behavior Support Professional (BSP) Service – BSP I IPP Planning		

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Appendices A-B-C-D-G & I: Sub-assurance QI-b-i Methods for Remediation/Fixing Individual problems.		
All information relating to this assurance is collected by the Operating Agency through the review of individuals receiving services charts. Individual issues/concerns related to this assurance identified during the chart review process are addressed immediately by the Operating Agency with providers during an exit interview. Providers are then required to submit Corrective Action Plans addressing identified issues. All Corrective Action Plans must be approved by the Operating Agency. Services provided that are not documented on the service plan are disallowed and payment is recouped from the provider agency.	**New Waiver Application Language** All Appendices have a Quality Improvement section. The following has been added under b-i Methods for Remediation/Fixing Individual Problems: "and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions."	**The Operating Agency collects all information related to this assurance through the review of individuals receiving services charts. Individual issues/concerns related to this assurance identified during the chart review process are addressed immediately by the Operating Agency with providers during an exit interview. Providers are then required to submit Corrective Action Plans addressing identified issues. The Operating Agency must approve all Corrective Action Plans. Services provided that are not documented on the service plan are disallowed, and payment is recouped from the provider agency.** **The Bureau for Medical Services (BMS) is responsible for building and maintaining the Intellectual and/or Developmental Disabilities Waiver's (IDDW's) Quality Improvement System (QIS). The IDDW provider and the Personal Options vendor are responsible for participating in all activities related to the QIS. The IDDW's QIS is used by BMS and the Utilization Management Contractor (UMC) as a continuous system that measures system performance, tracks remediation activities, and identifies opportunities for system improvement. Achieving and maintaining program quality is an ongoing process that includes collecting and examining information about program operations and outcomes for members receiving services, and then using the information to identify strengths and weaknesses in program performance. This information is used to form the basis of remediation and improvement strategies. The QIS is designed to collect the data necessary to provide evidence that the CMS Quality Assurances are being met and to ensure the active involvement of interested parties in the quality improvement process.** **In addition to the QIS, BMS also engages the Quality Improvement Advisory (QIA) Council to analyze information from individual problems, identify systemic deficiencies, and implement remediation activities. The QIA Council is the focal point of stakeholder input for the IDDW Program and plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies.** **The role of the QIA Council is to advise and assist BMS and UMC staff in program planning, development, and evaluation consistent with its stated purpose. In this role, the QIA Council uses IDDW Performance Indicators as a guide to:** • **Recommend policy changes;** • **Recommend program priorities and quality initiatives;** • **Monitor and evaluate policy changes;** • **Monitor and evaluate the implementation of Waiver priorities and quality initiatives;** • **Serve as a liaison between the Waiver and interested parties; and** • **Establish committees and work groups consistent with its purpose and guidelines.** **The Council membership is composed of persons who formerly utilized IDDW services of the IDDW Program, members who currently are utilizing IDDW services (or their legal representatives), service providers, advocates, and other allies of people with intellectual and/or developmental disabilities.**

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Appendix A: Sub-assurance QI-b-i Methods for Remediation/Fixing Individual Problems p. 27		
See Quality Improvement language at the top of the template to be inserted in each QI sub-assurance section for QI-b-i Methods for Remediation/Fixing Individual Problems.	See Quality Improvement language at the top of the template to be inserted in each QI sub-assurance section for QI-b-i Methods for Remediation/Fixing Individual Problems.	**See Quality Improvement language at the top of the template to be inserted in each QI sub-assurance section for QI-b-i Methods for Remediation/Fixing Individual Problems.**
Appendix B: Sub-assurance QI-b-i Methods for Remediation/Fixing Individual Problems p. 51		
See Quality Improvement language at the top of the template to be inserted in each QI sub-assurance section for QI-b-i Methods for Remediation/Fixing Individual Problems.	See Quality Improvement language at the top of the template to be inserted in each QI sub-assurance section for QI-b-i Methods for Remediation/Fixing Individual Problems.	**See Quality Improvement language at the top of the template to be inserted in each QI sub-assurance section for QI-b-i Methods for Remediation/Fixing Individual Problems.**
B-4-a: Medicaid Eligibility Groups Served in the Waiver p. 35-36		
Check box: SSI recipients only and Other specified groups. Narrative box: Caretaker relatives as specified in 435.118 Pregnant women as specified in 435.116 Children as specified in 435.118	**New Language in Waiver Application** to include three new eligibility groups: • Parents and Other Caretakers • Pregnant Women • Infants and Children under age 19	**New check boxes include groups previously noted in narrative.**

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C-1-d: Remote/Telehealth Delivery of Waiver Services 129-130		
New element. Information needed.	**New waiver application language** requires the State to specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely or via telehealth. Checkbox: Will any in-person visits be required? Y/N All new language includes five assurance checkbox options and fields to explain each assurance. 1. How the remote service will respect privacy (e.g., during toileting, dressing). 2. How telehealth service delivery will facilitate community integration. 3. How telehealth will ensure successful delivery for individuals needing hands-on/physical assistance, including whether the service can be provided without someone physically present or separated from the individual. 4. How the state will support individuals needing help using technology required for telehealth. 5. How telehealth will ensure an individual's health and safety.	**1. The remote service will be delivered in a way that respects the privacy of the individual, especially in instances of toileting, dressing, etc. When providing telehealth services, steps will be taken to ensure the individual's privacy. This includes using appropriate camera angles, providing privacy screens, or obtaining consent for video recording. For example, when assisting someone with dressing via telehealth, the camera will be positioned to focus on the face and upper body, avoiding sensitive areas. If a caregiver needs to be present during a telehealth session, their presence and any recording will be discussed and agreed upon beforehand. For remote monitoring, the equipment will have an indicator to show when it is on and recording, and it can only be turned off by the person(s) indicated in the individual service plan.** **2. Telehealth will be used to support community integration by enabling individuals to participate in community activities and access services from their own homes or community settings. For example, telehealth for Day Habilitation services will be provided in a community setting (e.g., a library, senior center, or park) to enable the member to interact with others and participate in community activities. This allows individuals to engage with their community without requiring transportation or in-person staff presence for every interaction.** **3. For individuals who need hands-on assistance, telehealth will primarily be used in conjunction with in-person support. If in-person support is not possible, telehealth can still be used to provide services but with additional safeguards. This may include providing clear instructions, using visual aids, or having a caregiver present during the telehealth session. For example, when providing telehealth for Nursing services, the nurse will provide clear instructions to the member or their caregiver on how to perform tasks such as taking medication or changing a bandage.** **4. The state will provide training and technical assistance to individuals who need support with the technology used for telehealth. This may include training on using the equipment, troubleshooting common issues, and providing adaptive equipment if needed. The support will be tailored to the individual's needs and preferences and may involve their caregivers as well.** **5. Telehealth services will be delivered in a way that prioritizes the individual's health and safety. This may involve monitoring vital signs, providing emergency response protocols, and ensuring a caregiver is present during the session if needed. Additionally, for remote monitoring, the service will only be used to reduce or replace the amount of in-person support if it is safe and appropriate for the individual.**

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C-2-b: Abuse Registry Screening p. 132		
WV follows WV Code § 15-2C-1. The West Virginia State Police and Criminal Identification Bureau maintains the Central Abuse Registry. All ADW Providers and in the Personal Options Model, the employer of record, are required to request a Criminal Background Check (Central Abuse Registry) for all direct-care staff. The Central Abuse Registry shall contain, at a minimum, information relating to: Convictions of a misdemeanor or a felony involving abuse, neglect or misappropriations of property, by an individual performing services for compensation, within the scope of the individual's employment or contract to provide services, in a residential care facility, in a licensed day care center in connection with providing behavioral health services, or in connection with the provision of home care services; information relating to individuals convicted of specific offenses. Compliance is monitored by the Operating Agency as part of the periodic review of provider qualifications.	**New waiver application language** regarding narrative included with indication of whether the state requires waiver service provider abuse registry screening, including: States must describe the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry.	**WV follows WV Code § 15-2C-1. The West Virginia State Police and Criminal Identification Bureau maintains the Central Abuse Registry. IDDW provider agencies and the Personal Options Employer of Record are required to request a state and federal fingerprint-based checks background check (Central Abuse Registry) for all employees with direct access to people on the IDDW. The Central Abuse Registry shall contain, at a minimum, information relating to the following: Convictions of a misdemeanor or a felony involving abuse, neglect, or misappropriations of property by an individual performing services for compensation, within the scope of the individual's employment or contract to provide services, in a residential care facility, in a licensed day care center in connection with providing behavioral health services, or in connection with the provision of home care services; information relating to individuals convicted of specific offenses.** **UMC monitors compliance as part of the periodic review of provider qualifications. Backup plans are required for each individual service plan, detailing how services will be rendered in the event the provider is unable to deliver services due to a pending investigation of ANE or substantiation of an allegation of ANE. If a participant's service provider is added to the abuse registry, the team will implement the member's backup plan accordingly.**
C-2-d: Provision of Personal Care or Similar Services by Legally Responsible Individuals p. 132-133		
The legally responsible adult may only provide services that have been identified as necessary in the Extraordinary Care Assessment which is completed initially and at the annual reevaluation of eligibility by the UMC. For individuals who self-direct through Personal Options, a program representative cannot serve in the dual role as the program representative and a paid service provider. The rural nature of the state of West Virginia also makes it problematic for behavioral health agencies to recruit appropriate staff so legal guardians may be paid employees, but someone else will have to serve as the program representative for purposes of self-direction. For children eligible to receive public education services/home schooling/other education alternatives, person-centered support services cannot exceed 7,320 15-minute units per IPP year.	**New waiver application language** regarding narrative to specify information regarding legally responsible individuals including: (a) Types of legally responsible individuals who may be paid and the services they can provide. (b) Method for determining "extraordinary care" beyond ordinary care for a person without a disability or chronic illness, necessary for health, welfare, and avoiding institutionalization.	**The types of legally responsible individuals who may be paid to furnish such services are parents, stepparents, grandparents, step-grandparents, aunts, and uncles. The services they may provide are respite care and family person-centered support services. The method for determining that the amount of personal care or similar services provided by a legally responsible individual is "extraordinary care" is based on the needs of the individual. The state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant are based on the individual's needs and preferences. The state's processes ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgment on behalf of the individual are based on the individual's needs and preferences.**

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The legal guardian of a person who is not eligible for public education services/home schooling/other educational alternatives, is limited to 11,680 15-minute units of person-centered support services. A spouse is not allowed to provide person-centered support services. The IDT must approve all services which are monitored by the Case Manager through at least monthly home visits. If a Behavior Support Professional (BSP) is providing services, then the BSP would also be monitoring any training or support services provided by the legally responsible adult. Additionally, all services are prior authorized through the UMC.	(c) State processes to ensure legally responsible individuals with decision-making authority use substituted judgment for selecting waiver service providers. (d) Limitations on circumstances and amounts for which payment for personal care or similar services may be authorized. (e) Additional safeguards when legally responsible individuals provide personal care or similar services. (f) Procedures for implementing required state oversight.	**The limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made are based on the individual's needs and preferences. The additional safeguards the state implements when legally responsible individuals provide personal care or similar services are based on the individual's needs and preferences. The procedures used to implement required state oversight, such as ensuring payments are made only for services rendered, are based on the individual's needs and preferences.** **The legally responsible adult may only provide services identified as necessary in the Extraordinary Care Assessment, which is completed initially and at the annual reevaluation of eligibility by the UMC. For individuals who self-direct through Personal Options, a program representative cannot serve in the dual role as the program representative and a paid service provider. The rural nature of the state of West Virginia also makes it problematic for behavioral health agencies to recruit appropriate staff, so legal guardians may be paid employees, but someone else will have to serve as the program representative for purposes of self-direction. For children eligible to receive public education services/home schooling/other education alternatives, person-centered support services cannot exceed 7,320 15-minute units per IPP year.** **The legal guardian of a person who is not eligible for public education services/home schooling/other educational alternatives is limited to 11,680 15-minute units of person-centered support services. A spouse is not allowed to provide person-centered support services. The IDT must approve all services which are monitored by the Case Manager through at least monthly home visits. If a Behavior Support Professional (BSP) provides services, then the BSP would also be monitoring any training or support services provided by the legally responsible adult. Additionally, all services are prior authorized through the UMC.**

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C-2-e: Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians p. 133-134		
New Element. Information needed.	**New waiver application language** regarding the narrative to specify additional information regarding services furnished by relatives/legal guardians, including: (a) Method for determining applicable circumstances for services furnished by relatives/legal guardians. (b) Limitations on the amount of services that may be provided by a relative or legal guardian. (c) Additional safeguards when relatives/legal guardians have decision-making authority over selecting waiver service providers. (d) State process for ensuring relatives/legal guardians use substituted judgment on behalf of individuals. (e) Procedures to ensure payments are made only for services provided.	**The legally responsible adult may only provide services that have been identified as necessary in the Extraordinary Care Assessment, which is completed initially and at the annual reevaluation of eligibility by the UMC. For individuals who self-direct through Personal Options, a program representative cannot serve in the dual role as the program representative and a paid service provider. The rural nature of the state of West Virginia also makes it problematic for behavioral health agencies to recruit appropriate staff, so legal guardians may be paid employees, but someone else will have to serve as the program representative for purposes of self-direction. For children eligible to receive public education services/home schooling/other education alternatives, person-centered support services cannot exceed 7,320 15-minute units per IPP year.** **The legal guardian of a person who is not eligible for public education services/home schooling/other educational alternatives, is limited to 11,680 15-minute units of person-centered support services. A spouse is not allowed to provide person-centered support services. The IDT must approve all services which are monitored by the Case Manager through at least monthly home visits. If a Behavior Support Professional (BSP) is providing services, then the BSP would also monitor any training or support services provided by the legally responsible adult. Additionally, all services are prior authorized through the UMC.** **WV Code Chapter 44a-1-5 provides additional safeguards when a guardian furnishes services. This statute provides that a guardian or conservator may not enter into a written contract or other employment relationship with a waiver service program provider without prior approval of a court.**

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C-2-g: State Option to Provide HCBS in Acute Care Hospitals p. 135		
New element. Information needed.	**New waiver application language** requires states to specify whether they will choose the option to provide HCBS in acute care hospitals, and if so, under what conditions: Checkboxes of the four assurances: ➢ The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services; ➢ The HCBS are in addition to, and may not substitute for the services the acute care hospital is obligated to provide; ➢ The HCBS must be identified in the individual's person-centered service plan; and ➢ The HCBS will be used to ensure smooth transitions between acute care settings and community-based settings and to preserve the individual's functional abilities. Additionally, the state must specify: (a) The 1915c HCBS in this waiver can be provided by the 1915c HCBS provider that are not duplicative of services available in the acute care hospital setting. (b) How the 1915c HCBS will assist the individual in returning the community; and (c) whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify in rate methodology in Appendix I-2-a.	**The state does not make payment for 1915c HCBS when a member is receiving services as an inpatient in an ICF/IID facility, a state institution, a nursing facility, a rehabilitation facility, or a psychiatric facility. The state will make payment for 1915c HCBS when a member is receiving services as an inpatient in a Medicaid-certified hospital if the individual is receiving services in a Specialized Family Care Home, an Unlicensed Residential Home, or a Licensed Group Home and is experiencing behavioral issues due to the temporary change in environment. The state also makes payment for case management services when a member is temporarily in a facility and/or has been placed on hold status in order to facilitate returning to their home/community. The 1915c HCBS will assist the individual in returning to the community by providing the individual with the support they need to remain in the community. The rate for 1915c HCBS provided during a hospitalization is the same as the typically billed rate. Individuals may receive HCBS from direct support or other support staff (such as behavioral supports) while receiving medical care and treatment in an acute care hospital so long as the following conditions exist: 1.the waiver service is accurately documented in the person-centered support plan; 2.the waiver service provided meets the need(s) of the individual that are not met through the provision of hospital services; and 3.the waiver service is being provided to ensure a smooth transition between the acute care settings and home and community-based setting and preserve the individual's functional abilities.**
Appendix C: Sub-assurance QI-b-i Methods for Remediation/Fixing Individual Problems p. 150		
See Quality Improvement language at the top of the template to be inserted in each QI sub-assurance section for QI-b-i Methods for Remediation/Fixing Individual Problems.	See Quality Improvement language at the top of the template to be inserted in each QI sub-assurance section for QI-b-i- Methods for Remediation/Fixing Individual Problems.	**See Quality Improvement language at the top of the template to be inserted in each QI sub-assurance section for QI-b-i Methods for Remediation/Fixing Individual Problems.**

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C-3 New Section: L. Electronic/Remote Monitoring HCBS (All New Section) p. 88-92		
Electronic Monitoring services include the provision of oversight and monitoring within the residential setting through off-site electronic surveillance. Also included is the provision of designated IDDW stand-by intervention staff prepared for prompt engagement with the person who receives services and/or immediate deployment to the residential setting. The use of this service must be designed and implemented to ensure the need for independence and privacy of the person who receives services in their own home/apartment. All of the following requirements must be met: • This service is only to be utilized when there is no paid staff in the home of the person who receives services; • This service may be installed in residential settings in which residing adult persons who receive services, their legal representatives (if applicable), and their IDT requests such surveillance and monitoring in place of paid staff; • All electronic monitoring systems or companies used or contracted by the IDDW provider must meet the standards set by the Bureau for Medical Services (BMS) and must be pre-approved by BMS before providing any services and approved annually thereafter; • The IDDW provider must have written policies and procedures approved by BMS that define emergency situations and details how remote and stand-by staff will respond to each (Ex. fire, prolonged power outage, medical crisis, stranger in the home, violence between persons who receive services, or any other situation that appears to threaten the health and welfare of the person who receives services); • The electronic monitoring system or company must receive notification of smoke/heat activation at the home of the person who receives services; • The electronic monitoring system or company must have 2-way (at minimum, full duplex) audio communication capabilities to allow monitoring base staff to effectively interact with and address the needs of the persons who live in each home, including emergency situations when the member may not be able to use the telephone; • The electronic monitoring system or company must allow the monitoring base staff to have visual (video) oversight of areas in the home of the person who receives services deemed necessary by the IDT; • At the time of monitoring, the monitoring base staff may not have duties other than the oversight and support of persons who receive services at the remote living site;	**New section within technical guide: L. Electronic/Remote Monitoring HCBS** In section Appendix C: Participant Services - C1/C3: Electronic Monitoring - the state needs to explain in the service definition: • Who will be responsible for the remote monitoring activity, including whether they are on-site or on-call. • How the remote monitoring will facilitate community integration. • How the state will ensure that the individual's right to privacy is being met, as well as that of others in the home, and what safeguards will be in place to protect individual rights and privacy. • How the state will ensure that the waiver participant, involved family members and/or guardian has agreed to the use of remote monitoring and that this is documented in the individual's person-centered service plan prior to use. • How the remote monitoring will ensure the individual's needs are being met and that health and welfare needs are being addressed. • The back-up plan in the event of equipment/technology failure (e.g., evaluation of the existence or availability of back-up power sources, alarms, additional person[s] to assist, etc.). For remote monitoring devices/equipment/technology, the state also needs to describe in the waiver application service definition: • Where devices/monitors will be placed, including whether the state will permit placement of video cameras/monitors in bedrooms and bathrooms. If the state will permit video cameras/monitors to be placed in bedrooms and bathrooms, how the state will ensure that this is determined to be necessary on an individual basis and justified in the person-centered service plan.	**Electronic monitoring services include the provision of oversight and monitoring within the residential setting through off-site electronic surveillance. Also included is the provision of designated IDDW agency standby intervention staff prepared for prompt engagement with the member(s) and/or immediate deployment to the residential setting. The use of this service must be designed and implemented to ensure the need for independence and privacy of the member in their own home/apartment. All the following requirements must be met.** • **This service is only to be utilized when there are no paid staff in the member's home.** • **This service may be installed in any area of the residential settings in which residing adult members, their legal representatives (if applicable), and their IDT teams request such surveillance and monitoring in place of paid staff. The IDT and the Human Rights Committee (HRC) will evaluate the appropriateness of placement of electronic monitoring devices in areas such as bathrooms and bedrooms on an individual basis.** • **All electronic monitoring systems or companies used or contracted by the IDDW provider meet the standards set by the BMS and must be pre-approved by the BMS before providing any services and approved annually thereafter.** • **The IDDW provider must have written policies and procedures approved by BMS that define emergency situations and detail how remote and standby staff respond to each. Examples are fire, prolonged power outage, medical crisis, stranger in the home, violence between members, any situation that appears to threaten the health and welfare of the member.** • **The electronic monitoring system or company must receive notification of smoke/heat activation at each member's home.** • **The electronic monitoring system or company must have two-way (at minimum, full duplex) audio communication capabilities. This allows monitoring base staff to effectively interact with and address the needs of the members in each home, including emergency situations when the participant may not be able to use the telephone.** • **The electronic monitoring system or company must allow the monitoring base staff to have visual (video) oversight of areas in the member's home deemed necessary by the IDT.** • **At the time of monitoring, the monitoring base staff may not have duties other than the oversight and support of members at the remote living site.** • **The monitoring base staff will assess any urgent situation at a member's living site and call 911 emergency personnel first if that is deemed necessary, then call the standby staff.** • **The monitoring base staff will stay engaged with the participant(s) at the living site during an urgent situation until the standby staff or emergency personnel arrive.**

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• The monitoring base staff will assess any urgent situation at a living site of a person who receives services and call 911 emergency personnel first if that is deemed necessary, then call the stand-by staff; • The monitoring base staff will stay engaged with the person who receive services at the living site during an urgent situation until the stand-by staff or emergency personnel arrive; • Any member wishing to access this service must first be assessed and approved by the IDDW provider's Human Rights Committee (HRC) to ensure that the health and welfare of the person who receives services would not be harmed by accessing this service. The approval of the HRC must be documented and attached to the IPP; • After the approval of the HRC is obtained, the member and their legal representative (if applicable) and the IDT must give informed consent and document the approval of such support in place of on-site staff or natural supports on the IPP; o The member, their legal representative and all IDT members are made aware of both the benefits and the risks of the operating parameters and limitations. Benefits may include increased independence and privacy, and risks may include not having on-site staff in case of an emergency; • The Case Manager conducts a home visit that includes a programmatic review of the system as well as a drill at 7 days of implementation, again at 14 days, and at least quarterly thereafter. The drill will consist of testing the equipment and response time; • The Case Manager reviews the continued usage of this service at every home visit and during every IPP and makes the IDT aware of any problems or concerns encountered with the use of this system, all of which is documented on the IPP; • The number of program members served by one stand-by intervention staff for on-site response is determined by the IDT and based upon the assessed needs of the member being served in specifically identified locations; and • The IDDW provider has stand-by intervention staff who meet the following standards: ○ Responds by being at the residential living site of the person who receives services: within 20 minutes or less from the time an incident is identified by the remote staff and the stand-by staff acknowledges receipt of the notification by the remote staff. The IDT has the authority to set a shorter response time based on the individual need of the person who receives services; ○ o Assists the member in the home as needed to ensure the urgent need/issue that generated a response has been resolved; o Each time an emergency response is generated, an incident report must be submitted to the West Virginia Incident Management System by the IDDW provider.	The control that the waiver participant will have over the equipment, including whether the waiver participant can turn off the remote monitoring device/equipment, if they choose to do so, and how they are informed of this option and how to do it.	• **Any member wishing to access this service must first be assessed using the identified Risk Assessment and approved by the IDDW provider's HRC to ensure that the member's health and welfare would not be harmed by accessing this service. The approval of the HRC must be documented and attached to the member's IPP.** • **After HRC approval of the HRC is obtained, the member and their legal representative (if applicable) and the IDT must give informed consent and document the approval of such support in place of on-site staff or natural supports on the member's IPP. The member is permitted to turn the remote monitoring system on and off and is instructed by the provider regarding this functionality. The member, their legal representative, and all IDT members are made aware of both the benefits and the risks of the operating parameters and limitations. Benefits may include increased independence and privacy, and risks may include not having on-site staff in case of an emergency. All members who receive the electronic monitoring service are informed of their ability to turn the monitoring system on and off and instructed on how to use this function.** • **The Case Manager conducts a home visit that includes a programmatic review of the system as well as a drill at 7 days of implementation, again at 14 days, and at least quarterly thereafter. The drill will consist of testing the equipment and response time;** • **The Case Manager reviews the continued usage of this service at every home visit and during every IPP and makes the IDT aware of any problems or concerns encountered with the use of this system, all of which is documented on the IPP;** • **The number of program members served by one stand-by intervention staff for on-site response is determined by the IDT and based upon the assessed needs of the member being served in specifically identified locations; and** • **The IDDW provider has stand-by intervention staff who meet the following standards:** ○ **Responds by being at the residential living site of the person who receives services: within 20 minutes or less from the time an incident is identified by the remote staff and the stand-by staff acknowledges receipt of the notification by the remote staff. The IDT has the authority to set a shorter response time based on the individual need of the person who receives services;** ○ **Assists the member in the home as needed to ensure the urgent need/issue that generated a response has been resolved;** ○ **Each time an emergency response is generated, an incident report must be submitted to the West Virginia Incident Management System by the IDDW provider.**

Intellectual and/or Developmental Disabilities Waiver (IDDW) Renewal Worksheet		
Current Language	**Revised Centers for Medicare & Medicaid Services (CMS) Application/Technical Language**	**Revised Drafted Language**
Occupational Therapy is provided directly to the person who receives services by a staff person that is a licensed/certified occupational therapist and may include: • Evaluation and training services in the areas of gross and fine motor function; • Self-care; sensory and perceptual motor function; • Screening; assessments; • Planning and reporting; • Direct therapeutic intervention; • Design, fabrication, training and assistance with adaptive aids and devices; and • Consultation or demonstration of techniques with other service providers and family members. The scope and nature of these services differ from occupational therapy services furnished under the State Plan. Occupational Therapy services provided under the Waiver are for chronic conditions and maintenance while the occupational therapy services furnished under the State Plan are short-term and restorative in nature. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. The occupational therapist may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC if requested by the member or their legal representative (if applicable) The maximum annual units of Occupation Therapy services may not exceed 416 units/104 hours per IPP year. This is in combination with the following services: Traditional and Self-Directed Physical Therapy and Dietary Therapy. A unit is 15 minutes. This service is provided in the occupational therapist's office or in the member's home. The amount of service is limited by the individualized budget of the program member. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Person-Centered or Home-Based Person-Centered Support and In-Home or Out-of-Home Respite and Non-Medical Transportation.	**New Language in Technical Guide:** Relationship of Waiver Services to EPSDT Services: • In waivers for children, services like rehabilitative services, private duty nursing, physical and occupational therapy, and nurse practitioner services cannot be provided as waiver services unless authorized beyond EPSDT's medical necessity. Children's Education Services: • Habilitative services cannot include special education and related services under IDEA. Funding for these services is the responsibility of state and local education agencies. Medicaid-covered services in schools are reimbursable if Medicaid requirements are met, excluding habilitative services.	**Occupational Therapy is provided directly to the person who receives services by a staff person who is a licensed/certified occupational therapist and may include:** • **Evaluation and training services in the areas of gross and fine motor function;** • **Self-care;** • **Sensory and perceptual motor function;** • **Screening; assessments;** • **Planning and reporting;** • **Direct therapeutic intervention;** • **Design, fabrication, training, and assistance with adaptive aids and devices; and** • **Consultation or demonstration of techniques with other service providers and family members.** **The scope and nature of these services differ from occupational therapy services furnished under the State Plan. Occupational Therapy services provided under the Waiver are for chronic conditions and maintenance, while the occupational therapy services furnished under the State Plan are short term and restorative in nature. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Any similar services provided in a school setting may also be eligible for reimbursement under the waiver when Medicaid program requirements are met.** **The occupational therapist may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC if requested by the member or their legal representative (if applicable). The maximum annual units of Occupation Therapy services may not exceed 416 units/104 hours per IPP year. This is in combination with the following services: Traditional and Self-Directed Physical Therapy and Dietary Therapy. A unit is 15 minutes. This service is provided in the occupational therapist's office or in the member's home. The amount of service is limited by the individualized budget of the program member. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Person-Centered or Home-Based Person-Centered Support and In-Home or Out-of-Home Respite and Non- Medical Transportation.**

Intellectual and/or Developmental Disabilities Waiver (IDDW) Renewal Worksheet		
Current Language	**Revised Centers for Medicare & Medicaid Services (CMS) Application/Technical Language**	**Revised Drafted Language**
Physical Therapy is provided directly to the person who receives services by a staff person that is a licensed physical therapist and may include: • Screening and assessments; • Treatment and training programs designed to preserve and improve abilities for independent functioning, such as gross and fine motor skills, range of motion, strength, muscle tone; • Activities of daily living; • Planning and reporting; • Direct therapeutic intervention; • Training and assistance with adaptive aids and devices; and • Consultation or demonstration of techniques with other service providers and family members. The scope and nature of these services differ from Physical Therapy services furnished under the State Plan. Physical Therapy services provided under the IDDW Program are for chronic conditions and maintenance while the Physical Therapy services furnished under the State Plan are short-term and restorative in nature. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. The physical therapist may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC if requested by the member or their legal representative (if applicable). The maximum annual units of Physical Therapy services may not exceed 416 units/104 hours per IPP year. This is in combination with the following services: Traditional and Self-Directed Occupational Therapy and Dietary Therapy. A unit is 15 minutes. This service is provided in the physical therapist's office or in the member's home. The amount of service is limited by the individualized budget of the program member. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Person-Centered or Home-Based Person-Centered Support and In-Home or Out-of-Home Respite and Non-Medical Transportation.	**New Language in Technical Guide:** Relationship of Waiver Services to EPSDT Services: • In waivers for children, services like rehabilitative services, private duty nursing, physical and occupational therapy, and nurse practitioner services cannot be provided as waiver services unless authorized beyond EPSDT's medical necessity. Children's Education Services: • Habilitative services cannot include special education and related services under IDEA. Funding for these services is the responsibility of state and local education agencies. Medicaid-covered services in schools are reimbursable if Medicaid requirements are met, excluding habilitative services.	**Physical Therapy is provided directly to the person who receives services by a staff person who is a licensed physical therapist and may include:** • **Screening and assessments;** • **Treatment and training programs designed to preserve and improve abilities for independent functioning, such as gross and fine motor skills, range of motion, strength, muscle tone;** • **Activities of daily living;** • **Planning and reporting;** • **Direct therapeutic intervention;** • **Training and assistance with adaptive aids and devices; and** • **Consultation or demonstration of techniques with other service providers and family members.** **The scope and nature of these services differ from physical therapy services furnished under the State Plan. Physical Therapy services provided under the Waiver are for chronic conditions and maintenance, while the physical therapy services furnished under the State Plan are short term and restorative in nature. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Any similar services provided in a school setting may also be eligible for reimbursement under the waiver when Medicaid program requirements are met.** **The physical therapist may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC if requested by the member or their legal representative (if applicable).** **The maximum annual units of Physical Therapy services may not exceed 416 units/104 hours per IPP year. This is in combination with the following services: Traditional and Self-Directed Occupational Therapy and Dietary Therapy. A unit is 15 minutes. This service is provided in the physical therapist's office or in the member's home. The amount of service is limited by the individualized budget of the program member. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Person-Centered or Home-Based Person-Centered Support and In-Home or Out-of-Home Respite and Non- Medical Transportation.**

Intellectual and/or Developmental Disabilities Waiver (IDDW) Renewal Worksheet		
Current Language	**Revised Centers for Medicare & Medicaid Services (CMS) Application/Technical Language**	**Revised Drafted Language**
Speech Therapy is provided directly to the person who receives services by a staff person that is a licensed speech pathologist and may include: • Screening and assessments; • Direct therapeutic intervention and treatment for speech and hearing disabilities such as delayed speech, stuttering, spastic speech, aphasic disorders, injuries, lip reading or signing, or the use of hearing aids; • Language stimulation and correction of defects in voice, articulation, rate and rhythm; • Design, fabrication, training and assistance with adaptive aids and devices; and • Consultation or demonstration of techniques with other service providers and family members. The scope and nature of these services differ from Speech Therapy services furnished under the State Plan. Speech Therapy services provided under the Waiver are for chronic conditions and maintenance while the Speech Therapy services furnished under the State Plan are short- term and restorative in nature. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. The Speech Therapist may attend and participate in IDT meetings and the annual assessment of functioning eligibility conducted by the UMC if requested by the member or their legal representative (if applicable). The maximum annual units of service may not exceed 96 units/96 events per IPP year for persons who receive services who are under age 24. A unit is an event. This service is provided in the Speech Therapist's office or in the member's home. The maximum annual units of Speech Therapy services may not exceed 48 units/48 events per IPP year for persons who receive services who are age 24 and over. A unit is an event. This service is in combination with Traditional Speech Therapy. The amount of service is limited by the individualized budget of the program member. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Person-Centered or Home-Based Person-Centered Support and In-Home or Out-of-Home Respite and Non- Medical Transportation.	**New Language in Technical Guide:** Relationship of Waiver Services to EPSDT Services: • In waivers for children, services like rehabilitative services, private duty nursing, physical and occupational therapy, and nurse practitioner services cannot be provided as waiver services unless authorized beyond EPSDT's medical necessity. Children's Education Services: • Habilitative services cannot include special education and related services under IDEA. Funding for these services is the responsibility of state and local education agencies. Medicaid-covered services in schools are reimbursable if Medicaid requirements are met, excluding habilitative services.	**Speech Therapy is provided directly to the person who receives services by a staff person who is a licensed speech pathologist and may include:** • **Screening and assessments;** • **Direct therapeutic intervention and treatment for speech and hearing disabilities such as delayed speech, stuttering, spastic speech, aphasic disorders, injuries, lip reading or signing, or the use of hearing aids;** • **Language stimulation and correction of defects in voice, articulation, rate and rhythm;** • **Design, fabrication, training and assistance with adaptive aids and devices; and** • **Consultation or demonstration of techniques with other service providers and family members.** **The scope and nature of these services differ from Speech Therapy services furnished under the State Plan. Speech Therapy services provided under the Waiver are for chronic conditions and maintenance, while the Speech Therapy services furnished under the State Plan are short term and restorative in nature. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Any similar services provided in a school setting may also be eligible for reimbursement under the waiver when Medicaid program requirements are met. The Speech Therapist may attend and participate in IDT meetings and the annual assessment of functioning eligibility conducted by the UMC if requested by the member or their legal representative (if applicable). The maximum annual units of service may not exceed 96 units/96 events per IPP year for persons who receive services who are under age 24. A unit is an event. This service is provided in the Speech Therapist's office or in the member's home. The maximum annual units of Speech Therapy services may not exceed 48 units/48 events per IPP year for persons who receive services who are age 24 and over. A unit is an event. This service is in combination with Traditional Speech Therapy. The amount of service is limited by the individualized budget of the program member. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Person-Centered or Home-Based Person-Centered Support and In-Home or Out-of-Home Respite and Non- Medical Transportation.**

Intellectual and/or Developmental Disabilities Waiver (IDDW) Renewal Worksheet		
Current Language	**Revised Centers for Medicare & Medicaid Services (CMS) Application/Technical Language**	**Revised Drafted Language**
Dietary Services are provided directly to the person who receives services by a staff person that is a WV licensed, registered dietitian and may include: • Nutritional assessment and therapy for diseases that have a nutrition component; • Preventive health and diet assessment; • Weight management therapy; • Design of menus; • Screening; • Assessments; • Planning and reporting; • Direct therapeutic intervention; and • Consultation or demonstration of techniques with other service providers and family members. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. The Dietary Therapist may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by the UM if requested by the person who receives services or their legal representative (if applicable). The maximum annual units of Dietary Therapy services may not exceed 416 units/104 hours per IPP year. This is in combination with the following services: Traditional and Self-Directed Physical Therapy and Occupational Therapy. A unit is 15 minutes. This service occurs in the office of the Dietary Therapist or in the member's home. The amount of service is limited by the individualized budget of the program member. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Person-Centered or Home-Based Person-Centered Support and In-Home or Out-of-Home Respite and Non-Medical Transportation.	**New Language in Technical Guide:** Relationship of Waiver Services to EPSDT Services: • In waivers for children, services like rehabilitative services, private duty nursing, physical and occupational therapy, and nurse practitioner services cannot be provided as waiver services unless authorized beyond EPSDT's medical necessity. Children's Education Services: • Habilitative services cannot include special education and related services under IDEA. Funding for these services is the responsibility of state and local education agencies. Medicaid-covered services in schools are reimbursable if Medicaid requirements are met, excluding habilitative services.	**Dietary Services are provided directly to the person who receives services by a staff person who is a WV-licensed and registered dietitian and may include:** • **Nutritional assessment and therapy for diseases that have a nutrition component;** • **Preventive health and diet assessment;** • **Weight management therapy;** • **Design of menus;** • **Screening;** • **Assessments;** • **Planning and reporting;** • **Direct therapeutic intervention; and** • **Consultation or demonstration of techniques with other service providers and family members.** **The scope and nature of these services differ from dietary therapy services furnished under the State Plan. Dietary services provided under the Waiver are for chronic conditions and maintenance, while the dietary services furnished under the State Plan are short term and restorative in nature. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Any similar services provided in a school setting may also be eligible for reimbursement under the waiver when Medicaid program requirements are met.** **The Dietary Therapist may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by the UM if requested by the person who receives services or their legal representative (if applicable).** **The maximum annual units of Dietary Therapy services may not exceed 416 units/104 hours per IPP year. This is in combination with the following services: Traditional and Self-Directed Physical Therapy and Occupational Therapy. A unit is 15 minutes. This service occurs in the office of the Dietary Therapist or in the member's home. The amount of service is limited by the individualized budget of the program member. If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Person-Centered or Home-Based Person-Centered Support and In-Home or Out-of-Home Respite and Non- Medical Transportation.**

Intellectual and/or Developmental Disabilities Waiver (IDDW) Renewal Worksheet		
Current Language	**Revised Centers for Medicare & Medicaid Services (CMS) Application/Technical Language**	**Revised Drafted Language**
C-5 Home and Community-based Settings p. 156-158		
Member-Controlled Settings: Member-controlled settings are defined as a home or apartment, owned or leased by a HCBS member or by one of their family members. The following services may be provided in a member-controlled setting: Personal Attendant services (traditional or self-directed), Case Management, Non-Medical Transportation (traditional or self-directed), Skilled Nursing Annual Assessment, Skilled Nursing, Personal Emergency Response Unit (traditional or self-directed), Community Transition, and Pest Eradication (traditional or self-directed). The member's Case Manager is required to complete the approved Member-Controlled Setting Assessment to evaluate the setting at the member's initial home visit and annually thereafter to ascertain that the setting meets HCB Settings requirements. The Case Management Monthly Contact form prompts the Case Manager to ask if the member has moved to a new home/apartment or if there have been changes to the setting that need to be evaluated. If it is determined that a setting does not meet the requirements, the Case Manager will assist the member to remediate the identified issue(s), including transitioning to a setting that does meet requirements. A member that chooses not to comply with the HCB Settings requirements risks losing their services. Provider-Controlled Settings: Provider-controlled settings include (1) a member residing in a home of a paid unrelated caregiver; (2) a member residing in a home that is owned or managed by a provider agency; and (3) an adult Medical Day Care facility. The following services may be provided in a provider-controlled setting: Personal Attendant services (traditional or self-directed), Case Management, Non-Medical Transportation (traditional or self-directed), Skilled Nursing Annual Assessment, Skilled Nursing, Personal Emergency Response Unit (traditional or self-directed), Community Transition, Medical Day Care, and Pest Eradication (traditional or self-directed). All provider-controlled settings are evaluated by BMS or its designee, the Utilization Management Contractor (UMC) initially and annually thereafter using the approved Provider-Controlled Setting Assessment to ascertain that the setting meets the HCB Settings requirements.	**New Language in Wavier Application** for states to include narratives in response to: 1. Description of settings where HCBS are provided. 2. Description of how the state will ensure all settings meet federal HCBS requirements, **now and in the future.** 3. **Assurance checkboxes:** ➢ Are integrated in and support full community access. ➢ Are selected by the individual from among options, including non-disability-specific settings and private units in residential settings. ➢ Ensure rights of privacy, dignity, respect, and freedom from coercion and restraint. ➢ Optimize individual initiative, autonomy, and independence. ➢ Facilitate individual choice regarding services and supports. ➢ Do not include nursing facilities, institutions for mental diseases, ICFs/IID, hospitals, or other institutional settings. ➢ The unit/dwelling is a specific physical place that can be owned, rented, or occupied under legal agreement and provides tenant protections. ➢ Privacy in their sleeping or living unit. ➢ Freedom and support to control their schedules and activities. ➢ Access to food at any time. ➢ Ability to have visitors of their choosing at any time. ➢ A physically accessible setting. ➢ Any modification of conditions for provider-owned/controlled settings must be justified.	**1. HCBS are received in provider-controlled and member-controlled settings. Member-controlled settings are defined as homes or apartments owned or leased by an HCBS member or by one of their family members. Provider-controlled settings are settings where a member resides with a paid unrelated caregiver or with an agency provider who provides HCBS services the majority of the day. Any day settings, such as IDDW facility-based Day Habilitation sites, are defined as provider-controlled settings.** **2. All waiver agencies will be contacted annually to verify the settings owned, leased, or operated by the provider agency. It is the responsibility of the agency to notify BMS of any change in status (e.g., sites are added or removed). When a new setting is added, BMS, or its designee, must review the site to ascertain the site complies before any HCBS may be billed. All home- and community-based settings must have the following qualities, and such other qualities based on the needs of the individual as indicated on their person-centered plan:** **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community—including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community—to the same degree of access as individuals not receiving Medicaid HCBS. The setting is selected by the individual from among setting options, including non-disability-specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. The setting ensures the individual's rights of privacy, dignity and respect, and freedom from coercion and restraint. The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact. The setting facilitates individual choice regarding services and supports and who provides them.**

Intellectual and/or Developmental Disabilities Waiver (IDDW) Renewal Worksheet		
Current Language	**Revised Centers for Medicare & Medicaid Services (CMS) Application/Technical Language**	**Revised Drafted Language**
The Case Management Monthly Contact form prompts the Case Manager to ask if the member has moved to a new home/apartment or if there have been changes to the setting that need to be evaluated. Adult Medical Day Care settings are required to notify the Bureau of Senior Services (BoSS) prior to making any changes to the setting. BoSS will review changes to ensure they meet the HCB Settings requirements and provide technical assistance as needed to remediate any identified issues. If a provider-controlled setting is determined to be non-compliant with any settings requirements, BMS and/or the UMC will provide technical assistance with remediation to attain compliance. A member or provider agency that chooses not to comply with the HCB Settings requirements risks losing services or enrollment as a provider agency.	**New Language in Technical Guide** • Factors to determine if a setting isolates individuals: ✓ Limited community interaction. ✓ Restricted choice of services/activities outside the setting. ✓ Physical separation from and lack of access to the community. • "Opportunities" and supports for community access should be in person-centered plans and setting policies.	**The Case Management Monthly Contact form prompts the Case Manager to ask if the member has moved to a new home/apartment or if there have been changes to the setting that need to be evaluated.** **If it is determined that a setting does not meet requirements, the Case Manager will assist the member to remediate the identified issue(s), including transitioning to a setting that does meet requirements. A member who chooses not to comply with the HCBS settings requirements risks losing their services. Provider-controlled settings include (1) a member residing in a home of a paid unrelated caregiver; (2) a member residing in a home that is owned or managed by a provider agency; and (3) an adult Medical Day Care facility. All provider-controlled settings are evaluated by BMS or its designee and the Utilization Management Contractor (UMC) initially and annually thereafter using the approved Provider-Controlled Setting Assessment to ascertain that the setting meets the HCBS settings requirements. The Case Management Monthly Contact form prompts the Case Manager to ask whether the member has moved to a new home/apartment or if there have been changes to the setting that need to be evaluated. If a provider-controlled setting is determined to be noncompliant with any settings requirements, BMS and/or the UMC will provide technical assistance with remediation to attain compliance. A member or provider agency that chooses not to comply with the HCBS settings requirements risks losing services or enrollment as a provider agency.**
D-1-a: Responsibility for Service Plan Development p. 158		
New narrative box: information needed.	**All New Language Added to Technical Guide and HCBS Waiver Application** Given the importance of the role of the person-centered service plan in HCBS provision, the State should include training or competency requirements for the HCBS settings criteria and person-centered plan development.	**Case management for waiver participants is provided by IDDW waiver agencies. All case managers are trained on person-centered planning and certified by the BMS. Additionally, all case managers are trained on the HCBS settings rule and complete settings rule compliance assessments at least annually.** **In the event that a Case Manager believes that a setting is not compliant with the HCBS settings rule, the Case Manager provides technical assistance and support to address the issue of noncompliance. If the setting remains noncompliant, the individual's ISP is noted as out of compliance. Continued noncompliance results in a referral to the Utilization Management Contractor (UMC) for further corrective action.**

Intellectual and/or Developmental Disabilities Waiver (IDDW) Renewal Worksheet		
Current Language	**Revised Centers for Medicare & Medicaid Services (CMS) Application/Technical Language**	**Revised Drafted Language**
D-1-b: Service Plan Development Safeguards p. 159-161		
The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. Specify: a. The OA/UMC notifies members of all available providers and services upon application. The member signs a Freedom of Choice form and identifies their preferred provider, which will be forwarded to the provider of choice. The member is also informed that they may choose to receive services from a different provider of their choosing at any time while receiving services. b. WV utilizes the following criteria to make determinations regarding geographical exceptions: (1) The number of conflict-free case managers could not meet the capacity for the number of members in the geographical area. (2) The number of conflict-free case managers certified by waiver type could not meet the capacity to serve members by waiver type. (3) Only one provider agency or case management agency serves the geographical area, eliminating the member's opportunity for choice of Case Manager. (4) There were no other providers of HCB services or case management services in a geographical area. Members will be given the opportunity to file a grievance/complaint. OA/UMC oversees grievances/complaints by the members and providers. A member will contact the OA/UMC to dispute the state's assertion that there is not another entity or individual that is not that member's provider to develop the person-centered service plan. The OA/UMC approves applications for exceptions after thorough vetting, including requests for additional information, if needed. Exceptions are awarded for one year, unless another willing and able provider becomes available, to provide agencies with sufficient program operation time before revisiting the continued need for an exception. During the one-year exception period, BMS or their designees have the right to review agency policies and operations. c. WV will monitor the CFCM process via retro-reviews conducted by the state OA/UMC, and may periodically request additional reports from the OA/UMC. d. WV restricts the entity that develops the person-centered service plan from providing services without the direct approval of the state. The BMS will allow for cultural and geographical exceptions based on the availability of willing and qualified providers in the member's catchment area. If a member disagrees with the BMS regarding the availability of willing and qualified providers, this may be grieved through the OA/UMC.	**New Language to Waiver Application** - If entities/individuals responsible for service plan development also provide direct waiver services, the state must establish safeguards to mitigate conflicts of interest. **New safeguards added to waiver application (checkboxes):** ➢ **Full disclosure** to participants and assurance that they are supported in exercising their right to free choice of providers and are informed about the full range of waiver services. ➢ **A clear and accessible dispute resolution process for participants** to challenge the state's assertion that there is no other entity or individual available to develop the service plan. ➢ **Direct oversight or periodic evaluation** by a state agency. ➢ **Restriction** on the entity developing the service plan from providing services without state approval. ➢ **Administrative separation of the plan development function from direct service provider functions** within the agency that develops the plan.	**The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. Specify:** **a. The OA/UMC notifies members of all available providers and services upon application. The member signs a Freedom of Choice form and identifies their preferred provider, which will be forwarded to the provider of choice. The member is also informed that they may choose to receive services from a different provider of their choosing at any time while receiving services.** **b. WV utilizes the following criteria to make determinations regarding geographical exceptions:** **(1) The number of conflict-free case managers could not meet the capacity for the number of members in the geographical area.** **(2) The number of conflict-free case managers certified by waiver type could not meet the capacity to serve members by waiver type.** **(3) Only one provider agency or case management agency serves the geographical area, eliminating the member's opportunity for choice of Case Manager.** **(4) There were no other willing and qualified providers of HCBS services or case management services in a geographical area.** **Members will be given the opportunity to file a grievance/complaint. OA/UMC oversees grievances/complaints by the members and providers. A member will contact the OA/UMC to dispute the state's assertion that there is not another entity or individual that is not that member's provider to develop the person-centered service plan. The OA/UMC approves applications for exceptions after thorough vetting, including requests for additional information, if needed. Exceptions are awarded for one year, unless another willing and able provider becomes available, to provide agencies with sufficient program operation time before revisiting the continued need for an exception. During the one-year exception period, BMS or its designees have the right to review agency policies and operations.** **c. WV will monitor the CFCM process via retro-reviews conducted by the state OA/UMC and may periodically request additional reports from the OA/UMC.** **d. WV restricts the entity that develops the person-centered service plan from providing services without the direct approval of the state. The BMS will allow for cultural and geographical exceptions based on the availability of willing and qualified providers in the member's catchment area. If a member disagrees with the BMS regarding the availability of willing and qualified providers, this may be grieved through the OA/UMC.**

Intellectual and/or Developmental Disabilities Waiver (IDDW) Renewal Worksheet		
Current Language	**Revised Centers for Medicare & Medicaid Services (CMS) Application/Technical Language**	**Revised Drafted Language**
e. For providers granted an exception to the conflict-free requirements, the State has ensured conflict of interest protections, certifying that case managers employed by that provider remain neutral during the development of the person-centered service plan and including the requirement that the provider separate direct care services and case management into distinct functions, with separate oversight. (1) Case management agencies must have a policy to ensure there will not be a conflict of interest if an exception has been made. a. Include a basic description of the duties of the HCB services supervisor(s) and the case management supervisor(s). b. Explain how case managers are selected. c. Explain how members are given a choice of HCB services and other natural supports or services offered in the community. d. Explain how the agency ensures that the Case Manager is free from the influence of direct service providers regarding member care plans. (2) Any Case Manager working for a case management agency that will also be providing personal attendant services will need to sign a CM Conflict of Interest Assurance form. a. The completed and signed form must be placed in the member file at the CM Agency. Failure to have the form in the file when reviewed will result in sanctions. (3) Evidence of administrative separation on organizational chart that includes position titles and names of staff (4) Attestation/Conflict of Interest Exception Application for Home and Community-Based Waiver Services by agency owner/administrator of the following:		**e. For providers granted an exception to the conflict-free requirements, the State has ensured conflict of interest protections, certifying that case managers employed by that provider remain neutral during the development of the person-centered service plan and including the requirement that the provider separate direct care services and case management into distinct functions, with separate oversight.** **(1) Case management agencies must have a policy to ensure there will not be a conflict of interest if an exception has been made.** **a. Include a basic description of the duties of the HCBS services supervisor(s) and the case management supervisor(s).** **b. Explain how case managers are selected.** **c. Explain how members are given a choice of HCBS services and other natural supports or services offered in the community.** **d. Explain how the agency ensures that the Case Manager is free from the influence of direct service providers regarding member care plans.** **(2) Any Case Manager working for a case management agency that will also be providing personal attendant services will need to sign a CM Conflict of Interest Assurance form.** **a. The completed and signed form must be placed in the member file at the CM Agency. Failure to have the form in the file when reviewed will result in sanctions.** **(3) Evidence of administrative separation on organizational chart that includes position titles and names of staff.** **(4) Attestation/Conflict of Interest Exception Application for Home- and Community-Based Waiver Services by agency owner/administrator of the following:**

Intellectual and/or Developmental Disabilities Waiver (IDDW) Renewal Worksheet		
Current Language	**Revised Centers for Medicare & Medicaid Services (CMS) Application/Technical Language**	**Revised Drafted Language**
D-1-d-i: Service Plan Development Process p. 162-165		
a. The Service Plan is referred to as the Individual Program Plan (IPP). The IPP is an outline of proposed activities that focus on the establishment of a potentially life-long, person-centered, goal-oriented process for coordinating the range of services, instruction and assistance needed by the member with an intellectual and/or developmental disability. The IDT process is designed to ensure accessibility, accountability, and continuity of support and services. The IDT process also ensures that member with an intellectual and/or developmental disability has opportunities to make meaningful choices with regard to their life and inclusion in the community. The IPP 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. The development of the IPP is the process by which the member and their legal representative (if applicable) lead the meeting with the help of a case manager who facilitates the meeting. The member and their legal representative (if applicable) with assistance from other team members will develop a plan based on a person-centered philosophy. The IDT is comprised of the member and their legal representative (if applicable) and his/her "Circle of Support". The circle of support must include the Case Manager and all other agencies that provide paid supports to the member. The circle of support may include other people the member wants to invite. Some suggestions are other professionals, direct care providers, family members, and significant friends and acquaintances in the member's life with and without a vested interest in the member. At minimum, the IDT must consist of the member and their legal representative (if applicable, the member's case manager and any IDDW agencies providing paid support to the member. The content of the IPP must be guided by the member's needs, wishes, desires, and goals. The team which is led by the member and their legal representative (if applicable) with assistance from the member's case manager collaborates in the IPP meeting for the purpose of review of assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support, outline of service options and training goals, and preparation of interventions or strategies necessary to implement a person-centered plan. The case manager assumes the role of Facilitator; however, the team is directed by the member and their legal representative (if applicable) utilizing a person-centered approach to planning. The Individual Program Plan includes the development of the initial IPP, annual IPP and subsequent reviews or revisions of the IPP (to include quarterly reviews as warranted).	**New Language to Technical Guide** - States must describe procedures for developing temporary interim service plans and their duration (not to exceed 60 days) Inclusion of "provisional" plan along with interim plan	**a. The Service Plan is referred to as the Individual Program Plan (IPP). The IPP is an outline of proposed activities that focus on the establishment of a potentially life-long, person-centered, goal-oriented process for coordinating the range of services, instruction and assistance needed by the member with an intellectual and/or developmental disability. The IDT process is designed to ensure accessibility, accountability, and continuity of support and services. The IDT process also ensures that member with a intellectual and/or developmental disability has opportunities to make meaningful choices with regard to their life and inclusion in the community. The IPP 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. The development of the IPP is the process by which the member and their legal representative (if applicable) lead the meeting with the help of a case manager who facilitates the meeting. The member and their legal representative (if applicable) with assistance from other team members will develop a plan based on a person-centered philosophy. The IDT is comprised of the member and their legal representative (if applicable) and his/her "Circle of Support". The circle of support must include the Case Manager and all other agencies that provide paid supports to the member. The circle of support may include other people the member wants to invite. Some suggestions are other professionals, direct care providers, family members, and significant friends and acquaintances in the member's life with and without a vested interest in the member. At minimum, the IDT must consist of the member and their legal representative (if applicable, the member's case manager and any IDDW agencies providing paid support to the member. The content of the IPP must be guided by the member's needs, wishes, desires, and goals. The team which is led by the member and their legal representative (if applicable) with assistance from the member's case manager collaborates in the IPP meeting for the purpose of review of assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support, outline of service options and training goals, and preparation of interventions or strategies necessary to implement a person-centered plan. The case manager assumes the role of Facilitator; however, the team is directed by the member and their legal representative (if applicable) utilizing a person-centered approach to planning. The Individual Program Plan includes the development of the initial IPP, annual IPP and subsequent reviews or revisions of the IPP (to include quarterly reviews as warranted).**

Intellectual and/or Developmental Disabilities Waiver (IDDW) Renewal Worksheet		
Current Language	**Revised Centers for Medicare & Medicaid Services (CMS) Application/Technical Language**	**Revised Drafted Language**
b. The case manager will coordinate evaluations annually or as needed to be utilized as a basis of need and recommendation for services in the development of the IPP. Evaluations include any significant medical, physical therapy, occupational therapy, speech, nutritional, nursing evaluations and behavior support evaluations in addition to an annual functional assessment administered by the UMC. c. The UMC at the time of the annual assessment provides the member and their legal representative (if applicable) 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 IPP must be based upon person-centered philosophy. The development of the IPP by the IDT 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 legal representative (if applicable), the case manager and other IDDW agencies that provide paid supports to the person. People the member wants to include who are not paid to provide services may also be invited by the member. 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 UMC 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 IPP specifies services requested by the member and the party responsible for securing and/or offering the service designated on the IPP. The IPP is distributed to all members of the IDT within fourteen calendar days. The case manager is responsible for ensuring that service providers implement the content of the IPP.		**b. The case manager will coordinate evaluations annually or as needed to be utilized as a basis of need and recommendation for services in the development of the IPP. Evaluations include any significant medical, physical therapy, occupational therapy, speech, nutritional, nursing evaluations and behavior support evaluations in addition to an annual functional assessment administered by the UMC.** **c. The UMC at the time of the annual assessment provides the member and their legal representative (if applicable) 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 IPP must be based upon person-centered philosophy. The development of the IPP by the IDT 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 legal representative (if applicable), the case manager and other IDDW agencies that provide paid supports to the person. People the member wants to include who are not paid to provide services may also be invited by the member. 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 UMC 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 IPP specifies services requested by the member and the party responsible for securing and/or offering the service designated on the IPP. The IPP is distributed to all members of the IDT within fourteen calendar days. The case manager is responsible for ensuring that service providers implement the content of the IPP.**

Intellectual and/or Developmental Disabilities Waiver (IDDW) Renewal Worksheet		
Current Language	**Revised Centers for Medicare & Medicaid Services (CMS) Application/Technical Language**	**Revised Drafted Language**
f. The IPP 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 at his/her residence to verify that services are being delivered in accordance with the IPP in a safe environment. Visits with the member and legal representative (if applicable) will be used by the case manager to update progress towards obtaining services and resources and discuss progress towards achieving objectives contained in the IPP. The case manager will also elicit information from the member and legal representative (if applicable) on their assessment of services, achievements, and/or unmet needs. The case manager will visit the person at his/her day activity a minimum of every other month to verify that services are being delivered in a safe environment and in accordance with the IPP. g. The Individual Program Planning includes the development of the initial IPP, annual IPP and subsequent reviews or revisions of the IPP (to include quarterly reviews and critical junctures as warranted). The IPP is to be developed on an annual basis. Minimally, the annual IPP must be reviewed at six-month intervals. IPP reviews may occur more often if needed. The IDT is also required to convene: Seven Day IDT Meeting This meeting is mandatory when a member receives an IDDW slot. This is the initial meeting that occurs within the first 7 calendar days of admission/intake by a new provider agency and must include IDDW services as well as other support services a person needs to live successfully in the community. This IPP document must reflect a full range of planned services: Medicaid, non-Medicaid, and natural supports. This meeting must be documented on the Initial IPP (WV-BMS-I/DD-4) by the case manager. If services can be finalized at this meeting and a full range of planned services are documented, the Thirty Day IDT meeting will not be necessary. Thirty Day IDT Meeting The Initial IPP must be finalized within 30 calendar days. The resulting IPP (WV-BMS-I/DD-5) completed by the case manager identifies the comprehensive array of services necessary to fully support the member who receives IDDW services. This document must be reviewed annually and at least every 180 days.		**f. The IPP 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 at his/her residence to verify that services are being delivered in accordance with the IPP in a safe environment. Visits with the member and legal representative (if applicable) will be used by the case manager to update progress towards obtaining services and resources and discuss progress towards achieving objectives contained in the IPP. The case manager will also elicit information from the member and legal representative (if applicable) on their assessment of services, achievements, and/or unmet needs. The case manager will visit the person at his/her day activity a minimum of every other month to verify that services are being delivered in a safe environment and in accordance with the IPP.** **g. The Individual Program Planning includes the development of the initial IPP, annual IPP and subsequent reviews or revisions of the IPP (to include quarterly reviews and critical junctures as warranted). The IPP is to be developed on an annual basis. Minimally, the annual IPP must be reviewed at six-month intervals. IPP reviews may occur more often if needed. The IDT is also required to convene:** **Seven Day IDT Meeting** **Seven Day IDT Meeting. This meeting is mandatory when a member receives an IDDW slot. This is the initial meeting that occurs within the first seven calendar days of admission/intake by a new provider agency and must include IDDW services as well as other support services a person needs to live successfully in the community. This IPP document must reflect a full range of planned services: Medicaid, non-Medicaid, and natural supports. This meeting must be documented on the Initial IPP (WV-BMS-I/DD-4) by the Case Manager. If services can be finalized at this meeting and a full range of planned services is documented, the Thirty-Day IDT meeting will not be necessary. The IPP developed during the Seven-Day IDT Meeting may not be effective for more than 60 days without approval from BMS.** **Thirty Day IDT Meeting** **The Initial IPP must be finalized within 30 calendar days. The resulting IPP (WV-BMS-I/DD-5) completed by the case manager identifies the comprehensive array of services necessary to fully support the member who receives IDDW services. This document must be reviewed annually and at least every 180 days.**

Intellectual and/or Developmental Disabilities Waiver (IDDW) Renewal Worksheet		
Current Language	**Revised Centers for Medicare & Medicaid Services (CMS) Application/Technical Language**	**Revised Drafted Language**
Transfer/Discharge IDT Meeting This meeting is held when a member who receives services transfers from one IDDW provider to another, chooses a different Service Delivery Model, or when the person who receives services no longer meets medical or financial eligibility. The transfer-from agency is responsible for coordinating the meeting and documenting the transfer. The member who receives services or their legal representative, as well as the transfer-to agency, must agree to the transfer. The transfer-from agency must send the resulting IPP to the transfer-to agency within 14 calendar days. The transfer-from agency must also send a Transfer/Discharge Form (WV-BMS-I/DD-10) to the UMC within 7 calendar days. If the resulting IPP is found to be not valid because necessary team members did not attend or necessary services were not addressed, the authorizations may be rolled back to the transfer-from agency until a valid IPP is held. When a member who receives services transfers from one residential provider to another or from one day setting to another, a 7-day IDT meeting must occur to outline the services and supports needed to successfully access the new setting and services. A Thirty Day IDT must occur to finalize these services. The Case Manager must transfer the member who receives services in the UMC web portal by the effective date of the transfer. A member who receives services may choose to self-direct their services at any time through the Self- Directed Service Delivery Model by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The case manager will enter the information into the UMC web portal within 2 business days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that can be self-directed will be referred to the Personal Options FMS and a self-directed budget will be developed while all Traditional services will remain with the IDDW provider(s). A member who receives services may choose to stop directing their own services at any time by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The case manager will enter the information into the UMC's web portal within 2 business days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that were self-directed will be referred to the chosen Traditional service agency who will request authorization for necessary services available under the Traditional service delivery model.		**Transfer/Discharge IDT Meeting** **This meeting is held when a member who receives services transfers from one IDDW provider to another, chooses a different Service Delivery Model, or when the person who receives services no longer meets medical or financial eligibility. The transfer-from agency is responsible for coordinating the meeting and documenting the transfer. The member who receives services or their legal representative, as well as the transfer-to agency, must agree to the transfer. The transfer-from agency must send the resulting IPP to the transfer-to agency within 14 calendar days. The transfer-from agency must also send a Transfer/Discharge Form (WV-BMS-I/DD-10) to the UMC within 7 calendar days. If the resulting IPP is found to be not valid because necessary team members did not attend or necessary services were not addressed, the authorizations may be rolled back to the transfer-from agency until a valid IPP is held.** **When a member who receives services transfers from one residential provider to another or from one day setting to another, a 7-day IDT meeting must occur to outline the services and supports needed to successfully access the new setting and services. A Thirty Day IDT must occur to finalize these services. The Case Manager must transfer the member who receives services in the UMC web portal by the effective date of the transfer.** **A member who receives services may choose to self-direct their services at any time through the Self-Directed Service Delivery Model by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The case manager will enter the information into the UMC web portal within 2 business days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that can be self-directed will be referred to the Personal Options FMS and a self-directed budget will be developed while all Traditional services will remain with the IDDW provider(s).** **A member who receives services may choose to stop directing their own services at any time by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The case manager will enter the information into the UMC's web portal within 2 business days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that were self-directed will be referred to the chosen Traditional service agency who will request authorization for necessary services available under the Traditional service delivery model.**

Intellectual and/or Developmental Disabilities Waiver (IDDW) Renewal Worksheet		
Current Language	**Revised Centers for Medicare & Medicaid Services (CMS) Application/Technical Language**	**Revised Drafted Language**
Critical Juncture IDT Meeting This meeting is held as soon as possible when there is a significant change in assessed needs and/or planned services of the person who receives services. A Critical Juncture may be the result of a change in the medical/physical status, behavioral status, or availability of natural supports. The IPP must be updated to include IDT recommendations, minutes, and signatures of all IDT members indicating their attendance and agreement or disagreement. A face-to-face meeting must be held under any of the following circumstances: • All team members do not agree with services or service mix. • A new goal will be implemented for the person who receives services. • The team is discussing implementation of a Positive Behavior Support plan, where one was not previously required. • The person who receives services changes residential setting (example: moves from Natural Family to ISS); • The person who receives services and lives in an ISS, group home or Specialized Family Care Home moves to a different location. • The person who receives services goes into crisis placement, • The person who receives services has a change in legal representative status, • The primary caregiver changes or passes away, • The person who receives services elects to change Service Delivery Model, and or, • A new service not previously received is added. Annual, Quarterly, and Six-Month IDT Meetings The IDT must meet up to 30 days prior to the annual anchor date to develop the IPP. The effective date of the annual IPP will remain the annual anchor date even if the IPP was held 30 days earlier. The anchor date sets the clock for scheduling all subsequent IPPs. The IPP must be reviewed and approved by the IDT at least every 90 days unless otherwise specified in the plan, however the time between reviews shall not exceed 180 days. The IPP must be reviewed at Critical Juncture meetings. Medley Class Members are required to have IDT meetings every quarter, however, the Medley Advocate may choose to only attend the Annual and Six-Month IDT meetings.		**Critical Juncture IDT Meeting** **This meeting is held as soon as possible when there is a significant change in assessed needs and/or planned services of the person who receives services. A Critical Juncture may be the result of a change in the medical/physical status, behavioral status, or availability of natural supports. The IPP must be updated to include IDT recommendations, minutes, and signatures of all IDT members indicating their attendance and agreement or disagreement. A face-to-face meeting must be held under any of the following circumstances:** **• All team members do not agree with services or service mix.** **• A new goal will be implemented for the person who receives services.** **• The team is discussing implementation of a Positive Behavior Support plan, where one was not previously required.** **• The person who receives services changes residential setting (example: moves from Natural Family to ISS);** **• The person who receives services and lives in an ISS, group home or Specialized Family Care Home moves to a different location.** **, however, the Medley Advocate may choose to only attend the Annual and Six-Month IDT meetings.** **• The person who receives services goes into crisis placement,** **• The person who receives services has a change in legal representative status, • The primary caregiver changes or passes away,** **• The person who receives services elects to change Service Delivery Model, and or,** **• A new service not previously received is added.** **Annual, Quarterly, and Six-Month IDT Meetings** **The IDT must meet up to 30 days prior to the annual anchor date to develop the IPP. The effective date of the annual IPP will remain the annual anchor date even if the IPP was held 30 days earlier. The anchor date sets the clock for scheduling all subsequent IPPs. The IPP must be reviewed and approved by the IDT at least every 90 days unless otherwise specified in the plan, however the time between reviews shall not exceed 180 days. The IPP must be reviewed at Critical Juncture meetings. Medley Class Members are required to have IDT meetings every quarter, however, the Medley Advocate may choose to only attend the Annual and Six-Month IDT meetings.**

Intellectual and/or Developmental Disabilities Waiver (IDDW) Renewal Worksheet		
Current Language	**Revised Centers for Medicare & Medicaid Services (CMS) Application/Technical Language**	**Revised Drafted Language**
D-1-g: Process for Making Service Plan Subject to the Approval of the Medicaid Agency p. 166		
It is the responsibility of the Case Manager to upload the IPP into the UMC web portal prior to requesting authorizations for services. The UMC will review the IPP to determine that requested services are listed on the IPP prior to issuing authorizations for payment. No services can be reimbursed by the Claims Payer unless there is a current prior authorization in place for the billed service. As a part of the Quality Improvement System, staff of the UMC will review a representative sample of IPPs. The annual review process includes assessment of individual IPPs for person-centered planning requirements. Each IDDW provider agency has at least 10% of files reviewed every other year. BMS meets with the UMC monthly to review audits conducted and to finalize a Final Disallowance Report which is sent to the IDDW provider along with Remittance Forms and payment options to re-pay BMS for disallowed services.	**New Language to Technical Guide** • The state's **sample of service plans must be representative of the demographic makeup** of the waiver population. **New Language in CMS Review Criteria** • The waiver includes a review process to ensure a practice of person-centered service planning in accordance with § 441.301(c). The state ensures that the sample of service plans is representative of the demographic makeup of the waiver population.	**It is the responsibility of the Case Manager to upload the IPP into the UMC web portal prior to requesting authorizations for services. The UMC will review the IPP to determine that requested services are listed on the IPP prior to issuing authorizations for payment. No services can be reimbursed by the Claims Payer unless there is a current prior authorization in place for the billed service. As a part of the Quality Improvement System, UMC staff will review a sample of IPPs that is representative of the demographic makeup of the waiver population. The annual review process includes assessment of individual IPPs for person-centered planning requirements. Each IDDW provider agency has at least 10% of files reviewed every other year. BMS meets with the UMC monthly to review audits conducted and to finalize a Final Disallowance Report, which is sent to the IDDW provider along with Remittance Forms and payment options to repay BMS for disallowed services.**
D-2-b: Monitoring Safeguards p. 167-170		
The Case Manager has the primary responsibility for the development of the IPP, facilitating the IDT Meeting and evaluating the implementation of the IPP and service delivery under all service delivery options (Traditional and Personal Options). These responsibilities allow the Case Manager to monitor the health and welfare of the person. There is an additional health and welfare safeguard through the UMC which conducts on-site provider reviews. The UMC also conducts desk audits of staff credentialing as monitored during provider self-reviews. The UMC will prior authorize all services with the claims agent including responding to emergency requests for service changes resulting from critical junctures--i.e. medical, behavioral or other emergent needs. The UMC will monitor health and welfare as it relates to requests for service authorizations. The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. Specify:	**New Language to Waiver Application** • **Change:** Providers of HCBS or those with interests in/employed by a provider cannot monitor service plan implementation unless they are the only willing and qualified entity in the area AND the state has conflict of interest protections.	**The Case Manager has the primary responsibility for the development of the IPP, facilitating the IDT Meeting and evaluating the implementation of the IPP and service delivery under all service delivery options (Traditional and Personal Options). These responsibilities allow the Case Manager to monitor the health and welfare of the person. There is an additional health and welfare safeguard through the UMC which conducts on-site provider reviews. The UMC also conducts desk audits of staff credentialing as monitored during provider self-reviews.** **The UMC will prior authorize all services with the claims agent including responding to emergency requests for service changes resulting from critical junctures--i.e. medical, behavioral or other emergent needs. The UMC will monitor health and welfare as it relates to requests for service authorizations.** **The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the member.** **Specify:**

Intellectual and/or Developmental Disabilities Waiver (IDDW) Renewal Worksheet		
Current Language	**Revised Centers for Medicare & Medicaid Services (CMS) Application/Technical Language**	**Revised Drafted Language**
a. The OA/UMC notifies members of all available providers and services upon application. The member signs a Freedom of Choice form then identifies their preferred provider, which will be forwarded to the provider of choice. The members are also informed that they may choose to receive services from a different provider of their choosing at any time while receiving services. b. WV utilizes the following criteria to make determinations regarding geographical exceptions: (1) The number of conflict-free case managers could not meet the capacity for the number of members in the geographical area. (2) The number of conflict-free case managers certified by waiver type could not meet the capacity to serve members by waiver type. (3) Only one provider agency or case management agency serves the geographical area, eliminating the member's opportunity for choice of Case Manager. (4) There were no other willing and qualified providers of HCB services or case management services in a geographical area. Members will be given the opportunity to file a grievance/complaint. OA/UMC oversees grievances/complaints by the members and providers. A member will contact the OA/UMC to dispute the state's assertion that there is not another entity or individual that is not that member's provider to develop the person-centered service plan. The OA/UMC approves applications for exceptions after thorough vetting, including requests for additional information, if needed. Exceptions are awarded for one year, unless another willing and able provider becomes available, to provide agencies with sufficient program operation time before revisiting the continued need for an exception. During the one-year exception period, BMS or their designee have the right to review agency policies and operations. c. WV will monitor the CFCM process via retro-reviews conducted by the state OA/UMC and may periodically request additional reports from the OA/UMC. d. WV restricts the entity that develops the person-centered service plan from providing services without the direct approval of the state. The BMS will allow for cultural and geographical exceptions based on the availability of willing and qualified providers in the member's catchment area. If a member disagrees with the BMS regarding the availability of willing and qualified providers, this may be grieved through the OA/UMC.	**Checkboxes:** ➢ Entities/individuals monitoring the service plan CANNOT provide other direct waiver services to the participant. ➢ Entities/individuals monitoring the service plan CAN provide other direct waiver services due to being the only option, and the state has safeguards in place. **Safeguards include**: • Full disclosure to participants and support for their right to free choice of providers. • A clear dispute resolution process if a participant challenges the state's assertion of no other monitoring entity. • Direct oversight or periodic evaluation by a state agency. • Restriction on the monitoring entity from providing services without state approval. • Administrative separation of plan development and direct service provider functions within the monitoring agency.	**a. The OA/UMC notifies members of all available providers and services upon application. The member signs a Freedom of Choice form then identifies their preferred provider, which will be forwarded to the provider of choice. The members are also informed that they may choose to receive services from a different provider of their choosing at any time while receiving services.** **b. WV utilizes the following criteria to make determinations regarding geographical exceptions:** **(1) The number of conflict-free case managers could not meet the capacity for the number of members in the geographical area.** **(2) The number of conflict-free case managers certified by waiver type could not meet the capacity to serve members by waiver type.** **(3) Only one provider agency or case management agency serves the geographical area, eliminating the member's opportunity for choice of Case Manager.** **(4) There were no other willing and qualified providers of HCBS services or case management services in a geographical area.** **Members will be given the opportunity to file a grievance/complaint. OA/UMC oversees grievances/complaints by the members and providers. A member will contact the OA/UMC to dispute the state's assertion that there is not another entity or individual that is not that member's provider to develop the person-centered service plan. The OA/UMC approves applications for exceptions after thorough vetting, including requests for additional information, if needed. Exceptions are awarded for one year, unless another willing and able provider becomes available, to provide agencies with sufficient program operation time before revisiting the continued need for an exception. During the one-year exception period, BMS or its designee has the right to review agency policies and operations.** **c. WV will monitor the CFCM process via retro-reviews conducted by the state OA/UMC and may periodically request additional reports from the OA/UMC.** **d. WV restricts the entity that develops the person-centered service plan from providing services without the direct approval of the state. BMS will allow for cultural and geographical exceptions based on the availability of willing and qualified providers in the member's catchment area. If a member disagrees with the BMS regarding the availability of willing and qualified providers, this may be grieved through the OA/UMC.**

Intellectual and/or Developmental Disabilities Waiver (IDDW) Renewal Worksheet		
Current Language	**Revised Centers for Medicare & Medicaid Services (CMS) Application/Technical Language**	**Revised Drafted Language**
e. For providers granted an exception to the conflict-free requirements, the State has ensured conflict of interest protections, certifying that case managers employed by that provider remain neutral during the development of the person-centered service plan and including the requirement that the provider separate direct care services and case management into distinct functions, with separate oversight. (1) Case management agencies must have a policy to ensure there will not be a conflict of interest if an exception has been made. a. Include a basic description of the duties of the HCB services supervisor(s) and the case management supervisor(s). b. Explain how members are assigned a Case Manager. c. Explain how members are given a choice of HCB services and other natural supports or services offered in the community. d. Explain how the agency ensures that the Case Manager is free from the influence of direct service providers regarding member care plans. (2) Any Case Manager working for a case management agency that will also be providing personal attendant services will need to sign a CM Conflict of Interest Assurance form. a. The completed and signed form must be placed in the member file at the CM Agency. Failure to have the form in the file when reviewed will result in sanctions. (3) Evidence of administrative separation on organizational chart that includes position titles and names of staff (4) Attestation/Conflict of Interest Exception Application for Home and Community-Based Waiver Services by agency owner/administrator of the following: a. The agency has administrative separation of supervision of case management and PA services. b. The attached organization chart shows two separate supervisors, one for case management and one for PA services. c. Case management members are offered a choice for PA services between and among available service providers. d. Case management members are not limited to PA services provided only by this agency. e. Case management members are provided case managers within the agency.		**e. For providers granted an exception to the conflict-free requirements, the State has ensured conflict of interest protections, certifying that case managers employed by that provider remain neutral during the development of the person-centered service plan and including the requirement that the provider separate direct care services and case management into distinct functions, with separate oversight.** **(1) Case management agencies must have a policy to ensure there will not be a conflict of interest if an exception has been made.** **a. Include a basic description of the duties of the HCBS services supervisor(s) and the case management supervisor(s).** **b. Explain how members are assigned a Case Manager.** **c. Explain how members are given a choice of HCBS services and other natural supports or services offered in the community.** **d. Explain how the agency ensures that the Case Manager is free from the influence of direct service providers regarding member care plans.** **2) Any Case Manager working for a case management agency that will also be providing other waiver services will need to sign a CM Conflict of Interest Assurance form.** **a. The completed and signed form must be placed in the member file at the CM Agency. Failure to have the form in the file when reviewed will result in sanctions.** **(3) Evidence of administrative separation on organizational chart that includes position titles and names of staff** **(4) Attestation/Conflict of Interest Exception Application for Home and Community-Based Waiver Services by agency owner/administrator of the following:** **a. The agency has administrative separation of supervision of case management and other waiver services.** **b. The attached organizational chart shows two separate supervisors, one for case management and one for other waiver services.** **c. Case management members are offered choices among available providers.** **d. Case management members are provided case managers within the agency.** **e. Disputes involving case management and other waiver providers are resolved.**

Intellectual and/or Developmental Disabilities Waiver (IDDW) Renewal Worksheet		
Current Language	**Revised Centers for Medicare & Medicaid Services (CMS) Application/Technical Language**	**Revised Drafted Language**
f. Disputes between case management and PA services units are resolved. g. Members are free to choose or deny PA services without influence from the internal agency Case Manager and PA agency. service staff. h. Members choose how, when, and where to receive their approved PA services. i. Members are free to communicate grievance(s) regarding case management and/or PA services delivered by the agency. j. The grievance/complaint procedure is clear and understood by members and legal representatives. k. Grievances/complaints are resolved in a timely manner.		**f. Members are free to choose or deny other waiver services without influence from the internal agency Case Manager** **g. Members choose how, when, and where to receive their approved waiver services.** **h. Members are free to communicate grievance(s) regarding case management and/or other waiver services delivered by the agency.** **i. The grievance/complaint procedure is clear and understood by members and legal representatives.** **j. Grievances/complaints are resolved in a timely manner.**
Appendix D: Sub-assurance QI-b-i- Methods for Remediation/Fixing Individual Problems p. 182-183		
See Quality Improvement language at the top of the template to be inserted in each QI sub-assurance section for QI-b-i Methods for Remediation/Fixing Individual Problems.	See Quality Improvement language at the top of the template to be inserted in each QI sub-assurance section for QI-b-i Methods for Remediation/Fixing Individual Problems.	**See Quality Improvement language at the top of the template to be inserted in each QI sub-assurance section for QI-b-i Methods for Remediation/Fixing Individual Problems.**
Appendix G: Sub-assurance QI-b-i- Methods for Remediation/Fixing Individual Problems p. 233-234		
See Quality Improvement language at the top of the template to be inserted in each QI sub-assurance section for QI-b-i Methods for Remediation/Fixing Individual Problems.	See Quality Improvement language at the top of the template to be inserted in each QI sub-assurance section for QI-b-i Methods for Remediation/Fixing Individual Problems.	**See Quality Improvement language at the top of the template to be inserted in each QI sub-assurance section for QI-b-i Methods for Remediation/Fixing Individual Problems.**
Appendix I: Sub-assurance QI-b-i- Methods for Remediation/Fixing Individual Problems p. 244-245		
See Quality Improvement language at the top of the template to be inserted in each QI sub-assurance section for QI-b-i Methods for Remediation/Fixing Individual Problems.	See Quality Improvement language at the top of the template to be inserted in each QI sub-assurance section for QI-b-i Methods for Remediation/Fixing Individual Problems.	**See Quality Improvement language at the top of the template to be inserted in each QI sub-assurance section for QI-b-i Methods for Remediation/Fixing Individual Problems.**

Intellectual and/or Developmental Disabilities Waiver (IDDW) Renewal Worksheet		
Current Language	**Revised Centers for Medicare & Medicaid Services (CMS) Application/Technical Language**	**Revised Drafted Language**
Appendix J: p. 258-281		
Addition of new service codes		**Rate changes reflecting the recent amendment** **Unlicensed Residential Person-Centered Support: Service code used for staff administering medication who are AMAP certified in an unlicensed residential setting.** • **S5125 UP AMAP** • **S5125 HI AMAP** • **S5125 UN AMAP** **Licensed Residential Person-Centered Support: Service code used for staff administering medication who are AMAP certified in a licensed residential setting.** • **S5125 U1 AMAP** • **S5125 U2 AMAP** • **S5125 U3 AMAP** • **S5125 U4 AMAP** **Behavior Support Professional: Service code used for staff who qualify as a BSP I to conduct IPP Planning.** • **T2024 HI** **Skilled Nursing Medication Administration: Service code used by a Licensed Practical Nurse and/or Licensed Registered Nurse and provides the administration of medication within the scope of practice under state law and rule. This service is meant to ensure the member's medical needs are met in supplementation to the AMAP program.** • **T1003 TE**