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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **West Virginia** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Mental Retardation/Developmental Disability Waiver

C. Waiver Number:WV.0133
Original Base Waiver Number: WV.0133.

D. Amendment Number:WV.0133.R05.01

E. Proposed Effective Date: *(mm/dd/yy)*
07/01/11

Approved Effective Date: 07/01/11
Approved Effective Date of Waiver being Amended: 07/01/10

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The purpose of the amendment is to add an additional 50 slots to the state fiscal year ended 6/30/2012 - 6/30/2014.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A – Waiver Administration and Operation	
☑ Appendix B – Participant Access and Eligibility	
☐ Appendix C – Participant Services	
☐ Appendix D – Participant Centered Service Planning and Delivery	
☐ Appendix E – Participant Direction of Services	
☐ Appendix F – Participant Rights	

Component of the Approved Waiver	Subsection(s)
☐ Appendix G – Participant Safeguards	
☐ Appendix H	
☐ Appendix I – Financial Accountability	
☑ Appendix J – Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☑ **Increase/decrease number of participants**
- ☑ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☐ **Other**

Specify:

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

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Mental Retardation/Developmental Disability Waiver

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: WV.0133
Waiver Number:WV.0133.R05.01
Draft ID: WV.007.05.01

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/10
Approved Effective Date of Waiver being Amended: 07/01/10

1. Request Information (2 of 3)

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

- ☐ **Hospital**

Select applicable level of care

- ○ **Hospital as defined in 42 CFR §440.10**

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

- **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

- **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

- **Not applicable**
- **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The West Virginia Bureau for Medical Services (BMS) offers a comprehensive scope of services and supports to eligible MR/DD participants. Authorized services must be rendered by enrolled providers within the scope of their licenses and in accordance with all state and federal requirements. BMS also contracts with an Administrative Services Organization (ASO) to perform Waiver operations including annual re-determinations of medical eligibility, annual assessment and budget determinations for active program participants, prior authorization of services, and quality assurance/improvement functions. BMS contracts with a Medical Eligibility Contracted Agent (MECA) to assess and determine initial medical eligibility for program applicants as well as review and approve annual re-determination of eligibility for Waiver services. BMS contracts with a Claims Agent to process Medicaid claims and with a Government Fiscal/ Employer Agent (F/EA) to provide financial support to Waiver members who choose to direct their own services through the participant-directed service options. The Office of Health Facility Licensure and Certification (OHFLAC) provides monitoring and supervision of participants' health and welfare as well as oversight of MR/DD qualified providers.

Members of the MR/DD Waiver may choose from traditional service and participant-directed service options including Agency with Choice (AwC) and Government Fiscal/Employer Agent (F/EA).

The goal of the WV MR/DD Waiver program is to provide services through which qualifying participants may receive person-centered services and supports in the least restrictive manner in the community.

Services available through the MR/DD Waiver program include: Service Coordination; Participant-Centered Support Services; Financial Management Services; Transportation-Trip/Mile; Participant-Directed Goods & Services; Speech Therapy; Occupational Therapy; Physical Therapy; Dietary Therapy; Therapeutic Consultation; Positive Behavior Support Professional; Skilled Nursing-RN/LPN; Crisis Services; Electronic Monitoring/Surveillance System & On-Site Response; Facility-Based Day Habilitation; Supported Employment; Respite; Crisis Services and Environmental Accessibility Adaptations.

3. Components of the Waiver Request

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

A. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

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

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

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

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
Stakeholders had significant and direct input into the development of this waiver application. With assistance of the Bureau for Behavioral Health and Health Facilities (BHHF), BMS conducted 14 open forums in 7 locations statewide to gather input from participants, families, providers and other stakeholders. BHHF has collected oral, written and electronic input from the forums and directly from stakeholders. Quality Assurance & Improvement (QA/I) Council input has been submitted for inclusion in development. A Self Direction Committee composed of program participants and families, advocates and providers has had periodic meetings for the last two years and has provided recommendations for the participant-directed option.

The draft renewal application was posted on the web for a 30-day public period on April 15, 2010.

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

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

7. Contact Person(s)

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

Last Name: Canaday

First Name: Marcus

Title: Office Director Home and Community Based Services

Agency: Bureau for Medical Services

Address: 350 Capitol Street, Room 250

Address 2:

City: Charleston

State: **West Virginia**

Zip: 25301

Phone: (304) 558-4740 **Ext:** ☐ **TTY**

Fax: (304) 558-4398

E-mail: Marcus.Canaday@wv.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **West Virginia**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Cynthia Beane

State Medicaid Director or Designee

Submission Date: May 4, 2012

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Beane

First Name: Cynthia

Title: Deputy Commissioner

Agency: Bureau for Medical Services

Address: 350 Capitol St.

Address 2:

City: Charleston

State: **West Virginia**

Zip: 25301

Phone: (304) 356-4844 **Ext:** ☐ **TTY**

Fax: (304) 558-1451

E-mail: cynthia.e.beane@wv.gov

Attachments

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

It is the goal of BMS to ensure a waiver program that provides quality service and choices to its participants.

1. Since April 2008 the MR/DD Waiver program has been working with a self directed stakeholder committee to develop a self directed

option in the MR/DD Waiver program. The participant directed service model will allow for participants and/or their legal/non-legal representative to have more choice and control of their services and how they are delivered. The move towards this service delivery model has also been necessitated by the need to shift the practice of parents and family members being utilized as independent contractors through the service provider. West Virginia MR/DD Waiver has historically allowed family members to provide services through an independent contractor relationship with the service provider. Community Residential Habilitation was the main service in the previous waiver that was provided to waiver participants in their homes by their families. Current authorizations indicate that 2660 participants are authorized to receive this family-provided service. The renewal addresses the needed changes to this practice by offering two new participant directed service delivery models. The renewed waiver will offer participant direction through Agency with Choice and participant direction through a Government F/EA. Participants will be able to direct the following services: Participant-Centered Support Services, Respite, Transportation, and Participant-Directed Goods and Services.
2. Previously the MR/DD Waiver mandated all participants to receive active treatment (habilitation training). To complement the active treatment requirement, the MR/DD Waiver program developed Adult Companion services to allow for individuals to receive support services without having a training component. Active treatment is still availale, but is no longer required in the MR/DD Waiver program. Participant-Centered Support Services will encompass both habilitation training (formerly known as Community or Agency Residential Habilitation and Community-Based Day Habilitation) and supports (formerly known as Adult Companion).
3. The waiver will be adding seven new services. a.) Electronic Monitoring/ Surveillance and On-site Response which includes the provision of oversight and monitoring within the residential setting of the waiver participant through off-site electronic surveillance. b.) Positive Behavioral Support Professional is a service offered to waiver participants with significant need for intervention for maladaptive behaviors. c.) Therapeutic Consultant was previously a component of Day Habiliation and is now being offered as a service. The Therapuetic Consultant will develop training plans and provide training to the primary care providers. d.) Dietary Therapy was previously offered as a component of Extended State Plan Services and now being offered as a service. Servies offered by a licensed, registered dietician will be available through this service. e.) Participant-Centered Support Service is a new service which is a combination of previous offered services - Community and AgencyResidential Habiliation, Adult Companion and Community Day Habiliation. f.) Crisis Services were previously a component of Day Habiliation and are being offered as a new service and are to be used if there is an extraordinary circumstance requiring a short-term, acute service that utilizes positive behavior support planning, interventions, strategies and direct care. g.) Financial Management Service (FMS) is a new service that will assist self directing participants exercising budget and/or employer authority and provide admimistrative financial services to the participants.
4. The waiver has changed the initial medical eligibility and annual reevaluation processes to include an independent psychologist network for evaluations.
5. The waiver utilizes functional assessments annually to develop an individualized budget in which the Interdisciplinary Team (IDT) purchases services. Upper limit caps on individual services have been established but will still allow for 24 hour services in residential settings (Individual Support Settings).

In anticipation of the renewed waiver in July 2010, 24 statewide forums were held in March 2010. These forums were conducted by the ASO and provided education and outreach to stakeholders regarding the proposed changes in the waiver renewal with regard to participant direction, discontinuation of active treatment requirements, possible new services, changes in medical eligibility, and service caps. 796 people attended the forums and represented participants, family members, advocacy organizations, and providers. These forums were utilized to provide an initial overview of the proposed options in the renewed waiver.

The transition of this program will be completed within a 15 month period which will be broken into a 90 day education/training period followed by a 12 month phase in. This is needed to bring closure to some old service titles, allow for system changes, permit choice of participants for self direction and provide the timely change of staffing choices required to support the new systems. The initial change of services will begin for each participant with the Annual review of their Individual Program Plan (IPP). This is a regulated, anchor date for each participant and would establish the standard transition mark from the previous to the new support services.

Throughout this transition period, the participant's access to the Fair Hearing process will remain the same (Reference Appendix F).

Upon approval of the renewal, additional trainings and outreach activities will be conducted statewide to provide education and outreach to all stakeholders. Forums will be conducted by the ASO in coordination with the Medical Eligibility Contracted Agent (MECA), the Government Fiscal/Employer Agent (F/EA), BMS, and Agency with Choice (AwC) Vendors. Forums will include education regarding the Government F/EA option as well as the AwC option. Educational forums will also highlight all waiver changes including those that most significantly inpact the participants such as no longer requiring active training and the consolidation of Habiliation and Adult Companion codes into one new Participant-Centered Support Services and provide printed materials detailing waiver service and service delivery options as well as new service code definitions.

The elimination of the mandatory requirement of active training necessitates training and education to ensure all participants and their providers understand the implications of this change and appropriately assess and address participants' support needs. An additional statewide specific training conducted by the ASO for Service Coordinators and Therapeutic Consultants regarding their roles under the new Waiver will be conducted in the first 90 days of the approved waiver. This training will highlight the changes regarding the elimination of active habilitation requirement. It will also encompass the addition of participant-directed options for services and the

Service Coordinator's role in monitoring and oversight of health and welfare as well as assisting participants who choose the Agency with Choice option.

The MECA will train and develop the independent psychologist network within the first 90 days of the renewal. Implementation of the Independent Psychologist Network to determine medical eligibility will initiate within 90 days of the renewal notification from CMS.

A new waiver policy manual will be developed and presented to stakeholders detailing all services including definitions, provider qualifications, caps, processes for medical eligibility, and options for self directed services. All stakeholders will be afforded a 30-day comment period regarding the new policy manual which will be effective and accessible via the BMS web site within 90 days of receiving renewal approval.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones. To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A-3: Contracted Entities:

MEDICAL ELIGIBILITY CONTRACTED AGENT (MECA) OVERVIEW AND FUNCTIONS

1. Responsible for psychological evaluations of all applicants to the MR/DD Waiver Program;
2. Training and supervising an independent network of psychologists to perform initial psychological evaluations to determine medical eligibility.
3. Confirming that the independent psychologists understand they will not be allowed to provide direct services to individuals for whom they perform certification evaluations (thus strengthening the objectivity and independence of evaluations).
4. Supervising the network psychologist who will perform psychological testing, conduct an initial functional assessment and review documentation as necessary to determine whether the potential program participant meets diagnostic eligibility criteria.
5. Supervising the network psychologist who will annually redetermine medical eligibility by evaluating the findings of the functional assessment performed by the ASO.

CLAIMS PROCESSING AGENT OVERVIEW AND FUNCTIONS

1. Pay provider claims in accordance with BMS guidelines and as prior authorized by the ASO;
2. Provider education and technical assistance pertinent to claims; and
3. Enrollment of qualified providers as directed by BMS.

GOVERNMENT FISCAL/EMPLOYER AGENT OVERVIEW AND FUNCTIONS

1) Assists Self-directing Participants exercising budget authority;
2. Act as a neutral bank, receiving and disbursing public funds, tracking and reporting on the participant's budget funds (received,

disbursed and any balances);
3. Process and pay invoices for goods and services in the participant's approved service plan;
4. Assists Self-directing Participants exercising employer authority;
5. Assist the participant in verifying workers' citizenship or legal alien status (e.g., completing and maintaining a copy of the BCIS Form I-9 for each support service worker the participant employs);
6. Collect and process support worker's timesheets;
7. Operate a payroll service, (including withholding taxes from workers' pay, filing and paying Federal (e.g., income tax withholding, FICA and FUTA), state (e.g., income tax withholding and SUTA), and, when applicable, local employment taxes and insurance premiums);
8. Distribute payroll checks on the participant's behalf;
9. Executing provider agreements on behalf of the Medicaid agency;
10. Provide orientation/skills training to participants about their responsibilities when they function as the common law employer of their direct support workers; and
11. Provide ongoing information and assistance to participants and/or their legal/non-legal representative.

****

Appendix E-1: Overview
a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The participant-directed service option will be available to every eligible MR/DD Waiver participant with the following exception: Participants living in OHFLAC licensed residential settings. This option will provide each participant with the opportunity to exercise choice and control over the participant-directed services they receive and the individuals and organizations who provide them (employer authority); and/or how the portion of their individualized budget associated with participant-directed services (i.e., their participant-directed budget) will be spent (budget authority). The participant-directed services over which participants will have the opportunity to exercise choice and control are:

• Participant-centered Support Services
• Respite
• Transportation
• Participant-directed "Goods and Services"

Two Financial Management Service (FMS) models are available to participants/legal/non-legal representatives to support their use of participant-directed services. These are the Government Fiscal /Employer Agent (F/EA) FMS and the Agency with Choice (AwC) FMS model. Under the Government F/EA FMS model, the participant or his/her legal/non-legal representative is the common law employer of the qualified support workers he or she hires directly. The Government F/EA FMS and its subagent, acts as the employer agent to the common law employer who is either the participant or his/her legal/non-legal representative. The Government F/EA FMS' subagent has been delegated, and is responsible, for managing the receipt and distribution of individuals' participant-directed budget funds, processing and paying qualified support workers' payroll and vendors' invoices for approved participant-directed goods and service, providing orientation on enrolling with and using the Government F/EA FMS and skills training to participants and representatives, as appropriate.

Since only one Government F/EA FMS and subagent can be operational per IRS requirements, the costs of administrative services provided by the Government F/EA FMS and subagent, and reimbursed using a per member per month rate , will qualify for Federal administrative match. The waiver services provided to participants, and that are paid for by the Government F/EA FMS' subagent, will qualify for FMAP.

Under the AwC FMS model, AwC FMS providers are co-employers, with the participant/legal/non-legal representative, of the qualified support workers recruited and referred by the participant/ legal/non-legal representative to the AwC FMS provider for hire and assignment back to the participant/legal/non legal representative. As the primary or employer of record, the AwC FMS provider is responsible for managing the receipt and distribution of individual's participant-directed budget funds; processing and paying qualified support workers' payroll and vendors' invoices for approved individual-directed goods and services; providing orientation on enrolling with and using the AwC FMS provider and skills training to participants and representatives, as appropriate; and providing orientation, training and management supports to participants' qualified support workers, as needed and requested. As the secondary or managing employer, the participant or legal/non-legal representative is responsible for performing the tasks listed later in this section.

Participants and legal/non-legal representatives using the AwC FMS model will be afforded freedom of choice of qualified AwC FMS

provider. Therefore, the costs of the administrative services provided by the AwC FMS provider and reimbursed using a per member per month rate, will qualify for FMAP along with the waiver services received by participants and paid for by the AwC FMS provider.

The Administrative Service Organization (ASO) will complete an Annual Budgetary Assessment for each eligible MR/DD Waiver participant. The Annual Budgetary Assessment will generate an individualized budget for each eligible participant. The individualized budget represents the total Waiver funds available for the planning and purchase of all services and supports for a participant based on their current assessed needs. The budget amount is adjusted if the participant's needs change. The participant-directed service option will permit a participant to "cash out" only the Medicaid funds associated with their participant-directed services and supports to create a participant-directed budget for each eligible participant. There will be an education component to the Annual Budgetary Assessment that will be conducted by the ASO with each participant/legal/non-legal representative during his/her Annual Budgetary Assessment. The educational component will provide participants and their legal/non-legal representatives with information on participant-directed services; FMS options; the roles, responsibilities of and potential liabilities for each of the key stakeholders related to the delivery and receipt of participant-directed services (i.e., participant, legal/non-legal representative, Government F/EA FMS and subagent, ASO, SC, BMS); and traditional service options available to them in order to inform their decision-making concerning the election of participant-directed services. It also will provide contact information for all service providers, including those entities that provide the two types of FMS (Government F/EA and AwC FMS).

In addition, participants and legal/non-legal representatives will have the opportunity to receive Information and Assistance (I&A) (i.e. through educational sessions) from the ASO Assessment with participation from the Government F/EA FMS' subagent, similar to that provided during the educational component of the Annual Budgetary Assessment. This I&A service will be offered to participants and legal/non-legal representatives statewide on a biennial basis. The information provided will be identical to that provided during the educational component so that participants and legal/non-legal representatives who are considering using participant-directed services after his/her Annual Budgetary Assessment is completed can get the information necessary to make an informed decision about electing to use participant-directed services and FMS.

Government F/EA FMS Option

West Virginia is using the Government F/EA FMS model that delegates certain F/EA FMS tasks to a subagent selected through a Request for Proposals process and under contract to the West Virginia Bureau for Medical Services (BMS). West Virginia has delegated the execution and management of limited Medicaid provider agreements with qualified support workers through a provider contract executed between BMS and the Government F/EA FMS' subagent.

Under the Government F/EA FMS option, the participant or his/her legal/non-legal representative is the common law employer of the qualified support workers he/she hires directly. The participant/legal/non-legal representative has the opportunity to:
• Elect the participant-directed option
• Recruit and hire his /her qualified support worker.
• Provide required and participant-specific training to qualified support worker(s).
• Determine qualified support workers' work schedule and how and when the qualified support worker should perform the required tasks.
• Supervise qualified support workers' daily activities.
• Evaluate his/her qualified support worker's performance.
• Review, sign and submit qualified support worker's time sheets to the Government F/EA FMS' subagent.
• Discharge his/her qualified support worker, when necessary.
• Work with his/her Service Coordinator (SC) to develop an emergency qualified support worker back-up plan to ensure staffing, as needed.
• Notify his/her SC of any changes in service need

As mentioned earlier, the Government F/EA FMS and its subagent is not the employer of the participant's/representative's qualified support worker(s). Rather, the subagent is the employer agent to the common law employer (who is the participant or legal/non legal representative), performing all that is required of an employer for wages paid on their behalf and all that is required of the payer for requirements of back-up withholding, as applicable. The Government F/EA FMS and its subagent operates under §3504 of the IRS code, Revenue Procedure 80-4 and Proposed Notice 2003-70, applicable state and local labor, employment tax and workers' compensation insurance and Medicaid program rules, as required. In addition, the Government F/EA FMS and its subagent:

• Acts as a "bank" and receives, disburses and tracks public funds on behalf of participants and legal/non-legal representatives;
• Monitors participants' spending of public funds including any underage /overage in accordance with participants' approved individualized budgets;
• Develops and manages a customer service system for participants and legal/non-legal representatives (e.g., provides a toll free phone, TYY and fax numbers; provides information in alternate formats and

provides foreign and American Sign Language interpreter services; manages a participant/ legal/non-legal representative call and complaint system that receives, tracks and resolves complaints and links with the organization's mandatory reporting system; conducts and analyzes the results of participant/legal/non-legal representative satisfaction surveys; and conducts paper and/or web-based budget reporting);
• Assists participants and legal/non-legal representatives in enrolling with the Government F/EA FMS/subagent, by assisting with the completion and submission, as required, of support worker's employment forms and maintaining copies in the appropriate files at the Government F/EA FMS/subagent provider;
• Assists in/conducts criminal background checks of prospective qualified support workers;
• Assists in verifying qualified support workers' citizenship and/or legal alien status;
• Collects, processes and maintains qualified support workers' time sheets;
• Processes returned payments (i.e., payroll checks or invoice payments) in accordance with state unclaimed property law;
• Provides participants and legal/non-legal representatives with orientation and employer skills training (e.g., enrolling and using the Government F/EA FMS and employer-related tasks such as, recruiting, hiring, training, managing and discharging qualified support workers, developing emergency qualified support worker backup plans and reporting and managing workplace injuries);
• Generates required financial reports for state and/or local government, as required;
• Implements fiscal accountability and individual protections (e.g., incident/mandatory reporting related to fiscal issues; implementation of internal controls related to F/EA tasks);
• Brokers workers' compensation and/or other insurance, as required; and
• Processes and pays invoices for approved individual-directed goods and services.

The Government F/EA FMS' subagent also will make available Information and Assistance (I&A) services to participants and legal/non-legal representatives to support their use of participant-directed services and to perform effectively as the common law employer of their qualified support workers. I&A provided by the Government F/EA FMS' subagent will include (1) participant/representative orientation sessions once the participant or representative choose to use participant-directed service and enroll with the Government F/EA FMS through its subagent, and (2) skills training to assist participants and legal/non-legal representatives to effectively use participant-directed services and FMS and perform the required tasks of a common law employer of qualified support workers. Participant/legal/non-legal representative orientation will provide information on 1) the roles, responsibilities of and potential liabilities for each of the key stakeholders related to the delivery and receipt of participant-directed services (i.e., participant, legal/non-legal representative, Government F/EA FMS and subagent, ASO, SC, BMS), (2) how to use the Government F/EA FMS and subagent, (3) how to effectively perform as a common law employer of his/her qualified support service workers, (4) how to ensure that the participant/legal/non-legal representative is meeting Medicaid and Government F/EA FMS and subagent requirements, and (5) how a participant would stop using participant-directed services and begin to receive traditional waiver services, if they so desire. Skills training curricula will reinforce Medicaid, Government F/EA FMS and subagent, federal and state labor, tax and citizenship and legal alien status requirements and provide a review of best practices for performing the tasks required of a common law employer of a qualified support worker (i.e., a participant or legal/non-legal representative may be having difficulty reviewing, signing and submitting qualified support workers' time sheets and skills training could be provided to help them improve their performance completing this task).

Agency with Choice (AwC) FMS Option:

Since the CMS HCBS waiver template does not provide space to report on two FMS options, a description of the AwC FMS option being offered to participants and legal/non-legal representatives who wish to use participant-directed services is described here.

The second FMS option available to individuals using participant-directed services is the Agency with Choice (AwC) FMS option. Under this FMS option, Behavioral Health Providers may provide FMS to participants who select the participant-directed service option, and their legal/non-legal representatives, once they are certified as AwC FMS providers by the West Virginia Bureau for Medical Services (BMS). Under the AwC FMS model, the AwC FMS provider and the participant/legal/non-legal representative enters into a co-employer arrangement. The AwC FMS provider is the primary or employer of record while the participant or legal/non legal representative is the secondary or managing employer of the participant's qualified support worker(s). The participant or legal/non-legal representative, as the managing employer, has similar responsibilities as the common law employer under the Government F/EA FMS model, except they:

• Recruit/select and refer their qualified support workers for hire to the AwC FMS provider for assignment back to them rather than hiring them directly as the common law employer; and
• Can select the level of participation in which they are willing and able to engage in employer-related tasks, from fully performing to participating in performing the employer-related tasks.

As the primary or employer of record, the AwC FMS provider is responsible for:

• Meeting Medicaid program requirements;
• Hiring qualified support workers referred by participants/legal/non-legal representatives for assignment back to the participant/representative managing employer and performing the human resource tasks;
• Verifying that support workers meet criteria developed by the State for being qualified support workers;
• Verifying citizenship and legal alien status of qualified support workers;
• Processing payroll and managing the related Federal, State, and local tax filings and payments;
• Processing and paying individual-directed goods and services that are authorized and approved in individual's participant-directed budget;
• Providing employer support as needed and requested by the participant/legal non-legal representative managing employer;
• Providing workers' compensation insurance for qualified support workers; and
• Meeting Medicaid provider requirements.
• Assisting participant/legal/non-legal representatives, as needed and requested in providing emergency back-up qualified support workers and managing those emergency supports.
• Providing orientation to participant/legal/non-legal representatives on using participant directed services and AwC FMS; and
• Providing skills training for participants and/or legal/non-legal representatives to assist them in effectively performing as the managing employer of their qualified support workers and using participant-directed services.

AwC FMS providers may not impose excessive barriers that discourage participants/legal/non-legal representatives from recruiting and referring their qualified support service workers and/or performing as their managing employer. Each AwC FMS provider must be able to respond to inquiries for further information from participants/legal/non-legal representatives as follow-up to the ASO's educational component or interest generated from any other source.

The AwC FMS provider will make available Information and Assistance (I&A) services to participants and legal/non-legal representatives to support their use of participant-directed services and to perform effectively as the co-employer of their qualified support workers. I&A provided by the AwC FMS will include (1) participant/legal/non-legal representative orientation sessions once the participant or legal/non-legal representative choose to use participant-directed service and choose an available AwC FMS provider; and (2) skills training to assist participants and legal/non-legal representatives to effectively use participant-directed services and FMS and perform the required tasks at the level he/she chooses to participate as the co-employer of qualified support workers.

Participant/legal/non-legal representative orientation will provide information on (1) the availability for the participant/legal/non-legal representative to choose the level of participation he/she will engage in as the co-employer of his/her qualified support worker(s); (2) completion of the co-employer agreement between the participant/legal/non-legal representative and the AwC FMS; (3) the roles, responsibilities of and potential liabilities for each of the key stakeholders related to the delivery and receipt of participant-directed services (i.e., participant, legal/non-legal representative, AwC FMS, ASO, SC, BMS); (4) how to use the AwC FMS services; (5) how to effectively perform as a co-employer of his/her qualified support service workers; (6) how to ensure that the participant/lega/non-legal representative is meeting Medicaid requirements and AwC FMS agreements, and (7) how a participant would stop using participant-directed services and begin receiving traditional waiver services, if they so desire. Support and/or skills training also would be available for performing the tasks required of a co-employer of a qualified support worker (i.e., a participant or legal/non-legal representative may be having difficulty supervising a qualified support worker and skills training could be provided to help them improve their performance completing this task).
AwC FMS providers' performance will be monitored in a number of ways. First, BMS will review AWC FMS provider candidates' readiness to perform the required FMS and I&A tasks by having each entity complete an AwC FMS Provider Self Assessment and evaluating the information submitted by the AwC FMS provider. The evaluation of an AWC FMS provider candidate's self assessment will result in the following actions:
• An approval for the agency to immediately provide AwC FMS.
• Should the information provided in the AwC FMS Provider Self Assessment fall short of the requirements for AwC FMS provider certification, the AwC FMS provider will be required to re-submit a full, second self assessment addressing all areas of correction identified by BMS.

Second, the ASO will conduct onsite AWC FMS Provider Performance Reviews at least every two years using a Review Protocol that includes all AwC FMS provider requirements (see description included in ASO responsibilities below).

With regard to the provision of AwC FMS, the ASO, is responsible for:
• Establishing and maintaining training records to ensure the AWC FMS provider is not imposing additional training requirements on participants' qualified support workers.
• Establishing and maintaining current and archived participants', legal/non-legal representatives', qualified support workers, vendors of individual-directed goods and services and AwC FMS files and records, as required and maintain them in a complete, secure and confidential manner.

• Distributing the participant and legal/non-legal representative satisfaction survey, developed by BMS, to AWC FMS providers and receiving and analyzing the survey results and reporting them to BMS annually.
• Conducting on site AWC FMS Provider Performance Reviews at least every two years using a Review Protocol based on the AWC FMS provider requirements.
• Ensuring corrective action occurs for significant and recurring failure to perform the AWC FMS provider requirements (i.e., gross over and under utilization (utilization determined by the utilization criteria in the agreements) of services, fraud, and ongoing and unresolved health and safety issues).

If the ASO finds that an AwC FMS provider is not meeting AwC FMS provider requirements as a result of conducting the AwC FMS Provider Performance Review, the ASO may recommend the following actions to BMS for approval and execution.
• Require a Plan of Correction (POC) be completed while continuing to provide AwC FMS.
• Require a POC be completed, as well as, freezing new enrollees to the AwC FMS provider until notified by the BMS otherwise.
• Require a POC be completed, as well as, applying monetary disallowances of noted AWC FMS administrative reimbursements due.
• Recommend decertification of the AwC FMS provider to BMS with a request to initiate transfer support for participants and legal/non-legal representatives using the AwC FMS provider.

Appendix E j. Information and Assistant in Support of Participant Direction. In addition to FMS, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (check each that applies):
-Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Service Coordinators (SCs) assist participants/legal/non-legal representatives, upon request, with information or links to information related to participant direction, including participant-directed benefits and responsibilities, and available FMS options and the providers available. SCs will receive training including a scripted presentation regarding the FMS options, which participants/representatives will be asked about in their annual assessment by the ASO to ensure unbiased presentations are being provided by the SCs.

Activities performed by SCs in coordination with the participant/legal/non-legal representative and IDT members should include, but not limited to:
1. Developing participants' IPPs using a person-centered approach and tools. Services must be based on the assessed need and the needs, wishes, and goals of the participant. Services must be within the boundaries of the participant directed budget.
2. Registering services with the claims agent.
3. Completing progress/case notes in each participants' service record.
4. Providing information to participants and legal/non legal representatives in order for them to make an informed decision on using the institutional versus the community living option.
5. Providing information on the participant direction service option to participants and legal/non legal representatives.
6. Initiating and submitting the participant's medical evaluation and associated assessments.
7. Ensuring financial eligibility is being processed at DHHR office.
8. Processing participant reevaluation material for submission of eligibility redetermination.
9. Notifying participant of rights and grievance procedure.
10. Serving as the advocate for the participant.
11. Linking participants to education and community resources.
12. Developing participant's IPP.
13. Evaluating participant's IPP and services.
14. Visiting participant at least monthly, or more if necessary, at residential site.
15. Visiting participant every other month, or more if necessary, at day activity location if applicable.
16. Convening IDT and crisis meetings as required of participant's team to review and/or revise the IPP.
17. Participating in discharge or transfer of participant from MR/DD Wavier services.
18. Identifying participant health and welfare risks.
19. Developing methods and supports where necessary to manage and ensure the health and welfare of the participant (this may include the development of a crisis plan).
20. Travel to and from home visits, facility day habilitation program visits, and other locations necessary to complete duties related to the IPP.

If a participant/representative chooses to participate in the participant directed option for the first time, the Service Coordinator must assist the participant/representative with the transition to an AWC FMS provider or the Government F/EA FMS' subagent. The SC updates the participant's approved and authorized IPP in a timely manner to reflect the needs identified by the team (which includes the

participant and his/her legal/non-legal representative).

The SC must ensure that the person-centered planning process is used to develop participants' IPPs. It is the responsibility of the SC to be knowledgeable of person-centered planning; the guiding principles of self-determination; the minimum guidelines for choice and control; all Federal, state, and local rules and regulations pertaining to Waiver services and the operation of an AwC FMS provider or the Government F/EA FMS' sub ent. SC entities must work cooperatively with AwC FMS providers and the government F/EA sub agent. SC entities are responsible for providing information to participants and their legal/non-legal representatives pertaining to an understanding of:

1. Person-centered planning practices and other choice and control opportunities.
2. Alternative service delivery options to the participant direction and FMS options (i.e., use of traditional service delivery system and providers).

Service Coordination activities specific to Participant Direction include, but are not limited to:
1. Informing participants and legal/non legal representatives of the availability of both participant-directed options.
2. Explaining general rights, risks, responsibilities and the participant/representative right to choose participation in a participant directed option.
3. Determining if a legal/non-legal representative is desired and/or needed.
4. Providing or linking individuals with program materials in a format that they can use and understand.
5. Explaining person-centered planning and thinking to participants and legal/non-legal representatives.
6. Completing participant-directed forms with the participant or legal/non legal representative as required for enrollment in AwC FMS option, or linking them with the Government F/EA FMS' subagent for completion of the necessary paper work for that FMS option.
7. Explaining to the participant/legal/non-legal guardian the support system and roles (e.g., the services through the ASO, the Government F/EA FMS provider, an AwC FMS provider, etc.) which are accessible to participant/legal/non-legal representative in this option.
8. Reviewing and discussing the individualized budget amount with participant/legal/non-legal representative.
9. Providing information on the general process of purchasing associated with the individualized budget and the involved requirements and limitations associated with the process.
10. Ensuring participants know how and when to notify service coordinator about any operational or support concerns or questions.
11. Monitoring the participant's risk management activities and develop and monitor participant-centered back-up plan(s).
12. Ensuring a seamless transition into the participant-directed option chosen.
13. Coordinating with services provided by any traditional provider agency, if involved.
14. Notifying the ASO and Government F/EA FMS' subagent or AwC FMS provider of concerns regarding potential issues which could lead to participant disenrollment by the ASO.
15. Notifying the ASO of concerns about the status of the health and welfare of participants.
16. Provide information or linkage to material regarding abuse, neglect, exploitation and the process involved in reporting such issues.
17. Follow-up with the participant/legal/non-legal representative regarding the submission of critical incidents.

If the AwC FMS option is selected by the participant/representative, the SC activities specific to this option includes, but is not limited to:

1. Discussing and/or helping determine the participant directed budget with the participant/legal/non-legal representative.
2. Providing participants and legal/non legal representatives with list of approved purchases or criteria for selection of participant directed goods and services.
3. Assist with the development of the participant-directed budget and any related purchasing/spending plan.
4. Providing a list of complaints or concerns to ASO for a review of concerns over non-legal representative's ability to perform the required tasks to participant in the Participant Directed option or acting in best interest of the participant.
5. Monitoring and reporting information about over/under expenditures identified by the AwC FMS provider to the ASO.

Appendix A: Waiver Administration and Operation

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

   ◉ **The waiver is operated by the State Medicaid agency.**

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

   ◉ **The Medical Assistance Unit.**

Specify the unit name:
The Bureau for Medical Services (BMS)
(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

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

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   Bureau for Medical Services contracts with the ASO to operate the MR/DD Waiver as described below:
   ASO Overview and Functions

   The ASO will assist BMS with the implementation of the MR/DD Waiver. The ASO will continue to provide assessment,

individualized budgeting and prior authorization as performed under the previous waiver.
The ASO has a well-established process for the annual assessment of each program participant's abilities and needs. This face to face assessment with the participant and his/her chosen respondents (parents/family members; paid staff persons and natural supports) includes a Structured Interview during which the member and respondents are educated about the MR/DD Waiver program including:
• Person centered philosophy;
• Concepts of person centered planning;
• Participant-directed services;
• The individualized budget process;
• Services available through the program and related policy and restrictions;
• Freedom of choice including the right to choose providers, services, and service options;
• Available service providers including locations and contact information;
• The process for negotiating the allocated budget amount;
• The process for fair hearings/appealing eligibility and service decisions.
Efforts to educate each participant and family/guardian will also include access to the ASO's web-based Waiver application. Participants and guardians will have the option of creating a secure user account through which they may view their own case information including:
• Demographic, medical and psychological data;
• Identified critical health and safety issues;
• Assessment and budget information;
• Details of purchased/authorized services;
• Prior claims data in Explanation Of Benefits (EOB)-like format;
• Annual individual program plan (IPP).
In addition to participants' case-specific information, general educational information will also be available to members and guardians through the ASO's MR/DD Waiver web-based application including the West Virginia Title XIX MR/DD Waiver Manual, education and training materials, and FAQ's.
The ASO will be responsible for tracking active enrolled members by performing the following functions in accordance with the waiver policy:
• Processing statements of interest/applications within timeframes established in the waiver manual;
• Ensuring each participant's medical eligibility is initially established and reestablished on an annual basis in coordination with the Medical Eligibility Contracted Agent;
• Notifying participants and their chosen Service Coordination providers of enrollment/reenrollment decisions;
• Maintaining an accurate wait list of certified participants awaiting an available slot.
• Management of eligibility appeals
Through the annual assessment of each program participant, the ASO compiles comprehensive data pertaining to participants' abilities, strengths, and support needs. Statistical analysis of this data results in customized algorithms for adults and children. Through the application of these algorithms against each participant's unique assessment data, an individualized budget is determined.
The participant and his/her chosen Service Coordinator is notified of the budget amount and assessment results a minimum of 45 days prior to the participant's annual team meeting. Following the annual team meeting and subsequent quarterly or critical juncture meetings, services and supports may be purchased from funds allocated in the participant's budget.
Through the ASO's web-based application, each participant's Service Coordinator purchases services as determined necessary by the participant's team. Upon submission of requested services, the ASO reviews the request to ensure services/supports are within policy and program parameters and that the participant's identified health & safety issues are addressed. Requests for services that exceed the participant's budget allocation are negotiated and the budget adjusted as necessary so that the most clinically appropriate services/amounts of services are authorized.
The ASO's web-based application allows the participant's Service Coordinator to submit purchase requests resulting from annual, quarterly and critical juncture team meetings. This ensures that changes in the participant's needs are addressed.
The ASO performs quality and utilization reviews of MR/DD Waiver providers minimally on a 24-month cycle alternating with OHFLAC on-site reviews as specified in the Quality Management Plan (See Appendix H). The scope of reviews will address CMS quality assurance standards and all quality indicators identified in the Waiver Quality Management Plan.
The ASO develops and conducts training for providers and other stakeholders as necessary to improve systemic and provider-specific quality of care and regulatory compliance issues. Training is available through both face-to-face and web-based venues.

See Main 8-B for additional contracted entity functions

No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

Appendix A: Waiver Administration and Operation

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

   ◉ **Not applicable**

   ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
   Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.**Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
   The WV Department of Health and Human Resources Bureau for Medical Services is responsible for assessing the performance of contracted entities with delegated waiver operations and administrative functions.

Appendix A: Waiver Administration and Operation

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

   BMS management staff conduct monthly meetings with its contractors to monitor performance and address identified issues/concerns.

   The quality management data collected through discovery methods is compiled using the Quality Management Report Template and reviewed at least monthly by BMS at its contract meetings. The Quality Management Report is also compiled and reviewed quarterly by the MR/DD QIA Council. A comprehensive report summarizing the findings of provider reviews is compiled at the end of each review cycle, reviewed and analyzed by Waiver staff and presented to the QIA Council for its review and analysis.

   Reports:

   BMS management staff will receive and review the following contract reports:
   (1) ASO Monthly Dashboard Report, Quality Management Report and ad hoc reports as requested.

(2) Participant Directed F/EA Vendor Monthly Report and ad hoc reports as requested.
(3) BHHF Monthly Activity Report and ad hoc reports as requested.
(4) Claims Processing Vendor routine reports on claims data and ad hoc reports as requested.
(5) Medical Eligibility Contracted Agent Vendor Monthly Report and ad hoc reports as requested.
(6) Office of Health Facility Licensure and Certification (OHFLAC) licensure reports aand complaint investigation reports.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.**In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*): In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of Medicaid oversight meetings held where Waiver functions are discussed.
Numerator = Number of Medicaid oversight meetings where Waiver functions are discussed.
Denominator = Number of Wavier meetings.

Data Source (Select one):
Meeting minutes
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = [ ]
☑ **Other** Specify: Administrative Service Organization (ASO) and FE/A	☐ **Annually**	☐ **Stratified** Describe Group: [ ]
	☐ **Continuously and Ongoing**	☐ **Other** Specify: [ ]
	☑ **Other** Specify: Operating Agency and FE/A semi-monthly, ASO monthly	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Administrative Services Organization (ASO) and FE/A	☐ **Annually**

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

Performance Measure:
Number and percent of implemented policies and procedures approved by BMS. Numerator = # of policies and procedures implemented. Denominator = # of policies and procedures approved by BMS.

Data Source (Select one):
Meeting minutes
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of services requested for authorization responded to by the ASO within five business days. Numerator = # of services requested for authorization responded to by the ASO within five business days. Denominator = # of services requested for authorization.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ASO performance monitoring

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Administrative Service Organization	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of formal complaints submitted to the ASO responded to within two business days. Numerator = # of formal complaints submitted to the ASO responded to within two business days. Denominator = # of number of formal complaints submitted to the ASO.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ASO performance monitoring

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Administrative Service Coordination	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants whose individualized assessments and budgets were issued within 45 days prior to the participant's service plan date. Numerator = # of participants whose individualized assessments and budgets were issued within 45 days prior to the participant's service plan date. Denominator = # of participants whose individualized assessment and budgets were issued.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ASO performance monitoring

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Administrative Service Organization	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of satisfaction surveys pertaining to the ASO assessment process in which satisfaction is rated 80% or higher. Numerator = # of satisfaction surveys pertaining to the ASO assessment process in which satisfaction is rated 80% or higher. Denominator = # of satisfaction surveys submitted to the ASO.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ASO performance monitoring

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Administrative Service Organization	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of applicants who receive determination within 30 days of receipt of completed packet. Numerator = # of applicants who receive determination within 30 days of receipt of completed packet. Denominator = # of completed packets received.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Monthly Reports

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of active participants who receive redetermination by MECA within 45 days of receipt of functional assessment. Numerator = # of active participants who receive redetermination by MECA within 45 days of receipt of functional assessment. Denominator = # of functional assessments received.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MECA Performance Monitoring

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of functional assessments reviewed and signed by an independent psychologist within 45 days of receipt of functional assessment. Numerator = # of functional assessments reviewed and signed by an independent psychologist within 45 days of receipt of functional assessment. Denominator = # of functional assessments received.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MECA Performance Monitoring

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of requests to participate in eligibility determination/terminations appeals scheduled within 15 days of request. Numerator = # of requests to participate in eligibility determination/terminations appeals scheduled within 15 days of request. Denominator = # of scheduled hearings.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MECA Performance Monitoring

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of completed Secondary Reviews of initial eligibility packets within 10 days of request. Numerator = # of completed Secondary Reviews of initial eligibility packets within 10 days of request. Denominator = # of initial eligibility packets.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MECA Performance Monitoring

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☑ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☑	**Developmental Disability**	0		☑
	☑	**Intellectual Disability**	0		☑
☐ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

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

In order to be eligible to receive MR/DD Waiver Program Services, an applicant must meet the following medical eligibility criteria:
• Have a diagnosis of mental retardation and/or a related condition,
• Require the level of care and services provided in an ICF/MR (Intermediate Care Facility for the Mentally Retarded) as evidenced by required evaluations and corroborated by narrative descriptions of functioning and reported history. An ICF/MR provides services in an institutional setting for persons with mental retardation or related condition. An ICF/MR facility provides monitoring, supervision, training, and supports.
To be eligible, the member:
• Must have a diagnosis of mental retardation, with concurrent substantial deficits (substantial limitations associated with the presence of mental retardation), and/or
• Must have a related developmental condition which constitutes a severe and chronic disability with concurrent substantial

deficits. Examples of related conditions which may, if severe and chronic in nature, make an individual eligible for the MR/DD Waiver Program include but are not limited to, the following:
• Any condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires services similar to those required for persons with mental retardation.
• Autism
• Traumatic brain injury
• Cerebral Palsy
• Spina Bifida
• Tuberous Sclerosis

Additionally, the member who has a diagnosis of mental retardation and/or related conditions and associated concurrent adaptive deficits must have the following:
• Manifested prior to the age of 22, and
• Likely to continue indefinitely.
• Must have the presence of a least three (3) substantial deficits out of six of the major life areas.

Functionality
• Substantially limited functioning in three (3) or more of the following major life areas; ("substantially limited" is defined on standardized measures of adaptive behavior scores as three (3) standard deviations below the mean or less than one (1) percentile when derived from non MR normative populations or in the average range or equal to or below the seventy fifth (75) percentile when derived from MR normative populations. The presence of substantial deficits must be supported not only by the relevant test scores, but also the narrative descriptions contained in the documentation submitted for review, i.e., psychological, the IEP, Occupational Therapy evaluation, etc.).
Applicable categories regarding general functioning include:
• Self-care
• Receptive or expressive language (communication)
• Learning (functional academics)
• Mobility
• Self-direction
• Capacity for independent living (home living, social skills, employment, health and safety, community and leisure activities).

Medical Eligibility Criteria: Level of Care
To qualify for ICF/MR level of care, evaluations of the applicant must demonstrate:
• A need for intensive instruction, services, assistance, and supervision in order to learn new skills, maintain current level of skills, and increase independence in activities of daily living,
• A need for the same level of care and services that is provided in an ICF/MR institutional setting. The applicant or legal representative will be informed of the right to choose between ICF/MR services and home and community-based services under the MR/DD Waiver Program and informed of his/her right to a fair hearing at the time of application.

Conditions Ineligible
• Substantial deficits associated with a diagnosis other than mental retardation or a related diagnosis do not meet eligibility criteria.
• Individuals diagnosed with mental illness whose evaluations submitted for medical eligibility determination indicate no previous history of co-occurring mental retardation or developmental disability prior to age 22. The member's clinical evaluators must provide clinical verification through the appropriate eligibility documentation that their mental illness is not the primary cause of the substantial deficits and the mental retardation or developmental disability occurred prior to the age of twenty-two (22).

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

- (●) **Not applicable. There is no maximum age limit**
- ( ) **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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

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

- (●) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ( ) **Other**

    Specify:

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

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

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

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

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

      Specify the formula:

    - ( ) **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	4484
Year 2	4534
Year 3	4534

Waiver Year	Unduplicated Number of Participants
Year 4	4534
Year 5	4634

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	4484
Year 2	4534
Year 3	4534
Year 4	4534
Year 5	4634

Appendix B: Participant Access and Eligibility

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

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

- **Not applicable. The state does not reserve capacity.**
- **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

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

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

- **The waiver is not subject to a phase-in or a phase-out schedule.**
- **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- **Waiver capacity is allocated/managed on a statewide basis.**
- **Waiver capacity is allocated to local/regional non-state entities.**

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

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

When the capacity for members served by the MR/DD Waiver program is reached, applicants for the MR/DD Waiver services are placed on a waiting list. Applicants for entry into the program will be processed on a first-come-first-serve basis based upon the date/time of the determination of medical eligbility as capacity becomes available.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (•) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (•) **No**
   - ( ) **Yes**

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

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

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ( ) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

    Specify percentage:

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

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

- ( ) **No.The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- (•) **Yes.The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

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

Check each that applies:

- [x] **A special income level equal to:**

Select one:

- (•) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount:

- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- [ ] **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- [ ] **Aged and disabled individuals who have income at:**

Select one:

- ( ) **100% of FPL**
- ( ) **% of FPL, which is lower than 100%.**

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☐ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

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

○ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

- ○ **Use spousal post-eligibility rules under §1924 of the Act.**
  (Complete Item B-5-b (SSI State) and Item B-5-d)
- ○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
  (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

◉ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

◉ **The following standard included under the State plan**

Select one:

- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**

(*select one*):

- (●) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of the FBR, which is less than 300%**

  Specify the percentage:
- ( ) **A dollar amount which is less than 300%.**

  Specify dollar amount:
- ( ) **A percentage of the Federal poverty level**

  Specify percentage:
- ( ) **Other standard included under the State Plan**

  Specify:
- ( ) **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- ( ) **The following formula is used to determine the needs allowance:**

  Specify:
- ( ) **Other**

  Specify:

ii. Allowance for the spouse only (*select one*):

- (●) **Not Applicable (see instructions)**
- ( ) **SSI standard**
- ( ) **Optional State supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.
- ( ) **The amount is determined using the following formula:**

  Specify:

iii. Allowance for the family (*select one*):

- (●) **Not Applicable (see instructions)**
- ( ) **AFDC need standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

The State does not establish reasonable limits.

The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as

specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

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

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- (●) **By an entity under contract with the Medicaid agency.**

Specify the entity:

Medical Eligibility Contracted Agent (MECA)

- ( ) **Other**

Specify:

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

Per contract with the MECA, all initial assessments for the determination of medical eligibiity for the MR/DD Waiver are conducted by licensed psychologists.

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

Completed comprehensive psychological evaluation, using the appropriate standardized test(s) based upon age and as necessary to render diagnosis, that includes clinical verification that the mental retardation and/or related condition with associated concurrent adaptive deficits were manifested prior to age 22 and are likely to continue indefinitely.
In order to be eligible to receive MR/DD Waiver Program Services, an applicant must meet
the following medical eligibility criteria:
• Have a diagnosis of mental retardation and/or a related condition,
• Require the level of care and services provided in an ICF/MR (Intermediate Care Facility for the Mentally Retarded) as evidenced by required evaluations and corroborated by narrative descriptions of functioning and reported history. An ICF/MR provides services in an institutional setting for persons with mental retardation or related condition. An ICF/MR facility provides monitoring, supervision, training, and supports.
To be eligible, the member:
• Must have a diagnosis of mental retardation, with concurrent substantial deficits (substantial limitations associated with the presence of mental retardation), and/or
• Must have a related developmental condition which constitutes a severe and chronic disability with concurrent substantial deficits. Examples of related conditions which may, if severe and chronic in nature, make an individual eligible for the MR/DD Waiver Program include but are not limited to, the following:
• Any condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires services similar to those required for persons with mental retardation.
• Autism
• Traumatic brain injury
• Cerebral Palsy

• Spina Bifida
• Tuberous Sclerosis

Additionally, the member who has a diagnosis of mental retardation and/or related conditions and associated concurrent adaptive deficits must have the following:
• Manifested prior to the age of 22, and
• Likely to continue indefinitely.
• Must have the presence of a least three (3) substantial deficits out of six of the major life areas.

Functionality
• Substantially limited functioning in three (3) or more of the following major life areas; ("substantially limited" is defined on standardized measures of adaptive behavior scores as three (3) standard deviations below the mean or less than one (1) percentile when derived from non MR normative populations or in the average range or equal to or below the seventy fifth (75) percentile when derived from MR normative populations. The presence of substantial deficits must be supported not only by the relevant test scores, but also the narrative descriptions contained in the documentation submitted for review, i.e., psychological, the IEP, Occupational Therapy evaluation, etc.).
Applicable categories regarding general functioning include:
• Self-care
• Receptive or expressive language (communication)
• Learning (functional academics)
• Mobility
• Self-direction
• Capacity for independent living (home living, social skills, employment, health and safety, community and leisure activities).

Medical Eligibility Criteria: Level of Care
To qualify for ICF/MR level of care, evaluations of the applicant must demonstrate:
• A need for intensive instruction, services, assistance, and supervision in order to learn new skills, maintain current level of skills, and increase independence in activities of daily living,
• A need for the same level of care and services that is provided in an ICF/MR institutional setting. The applicant or legal representative will be informed of the right to choose between ICF/MR services and home and community-based services under the MR/DD Waiver Program and informed of his/her right to a fair hearing at the time of application

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

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

A request for medical eligibilty is received by the ASO. The ASO contacts the applicant and provides a list of independent psychologists in their geographical area with contact information. The applicant contacts the independent psychologist of their choice and notifies the ASO of the scheduled independent pscychological evaluation (IPE). The independent psychologist completes the IPE which incudes background information, mental status examination, a measure of intelligence, adaptive behavior and acheivement when appropriate. The independent psychologist submits the IPE along wtih all scores electronicallly to the ASO. The ASO thens submits the IPE and scores electronically to the MECA for final determination. The MECA electronically notifies the ASO of determination of medical eligibiity. The ASO notifies the applicant.

For annual reevaluation, the ASO submits diagnosis, annual functional assessments measuring the presence of at least three substanial deficits associated with a diagnosis of mental retardation and/or related condition are utilized and certification within 30 days prior to the anchor "annual date" to the MECA. The MECA reviews the diagnosis, annual assessments and makes eligibility determination. If MECA is unable to make eligibility determination at this time, then the MECA will ask for an independent psychological evaluation before final determination.

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

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

- ○ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ◉ **The qualifications are different.**
  Specify the qualifications:

  The annual reevaluation functional assessments are completed by the ASO utilizing individuals with a minimum of a bachelor's degree in a human service field and 2 years work experience in MR/DD field. Assessments are reviewed by the MECA licensed psychologist who confirms continued medical eligibiilty.

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

Working with the Service Coordinator, the ASO schedules the initial and annual assessment The ASO is responsible for ensuring that annual redetermination functional assessments are completed within 45 days prior to the anchor "annual date".

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
Number and percent of enrollees deemed medically eligible for MR/DD services prior to receiving services. Numerator = # of enrollees deemed medically eligible for MR/DD services prior to receiving services. Denominator = # of enrollees who receive services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ASO performance monitoring

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of referrals who receive LOC determination within established timelines. Numerator = # of referrals who receive LOC determination within established timelines. Denominator = # of referrals applying for medical eligibility.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ASO performance monitoring

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of active program participants who receive determination within twelve months of previous medical eligibility date. Numerator = # of active program participants who receive determination within twelve months of previous medical eligibility date. Denominator = # of active program participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ASO program monitoring

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of active participants/enrollees who receive the determination-redetermination functional assessments. Numerator = # of active participants/enrollees who receive the determination-redetermination functional assessments. Denominator = # of active participants/enrollees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ASO performance monitoring

		Sampling Approach*(check each that applies):*

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of functional assessments reviewed, signed by an independent psychologist. Numerator = # of functional assessments reviewed, signed by an independent psychologist. Denominator = # of functional assessments completed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medical eligibility contracted agent performance monitoring

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of requests to appeal eligibility determinations which are processed within established time frames. Numerator = # of requests to appeal eligibility determinations which are processed within established time frames. Denominator = # of requests to appeal eligibility determinations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medical eligibility contract agent performance monitoring

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Administrative Service Organization	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Information regarding compliance with the Level of Care assurance is reported to the Bureau for Medical Services by the ASO and the MECA. These reports are reviewed by BMS with the contractors. Any individual problems that are identified via these reports are addressed immediately and discussed during regularly scheduled contract meetings with the ASO and the MECA. Remediation strategies including completion timeframes and responsible party (ies) are developed and monitored. Documentation is maintained in contract meeting minutes.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Under the oversight of the MECA, the network member psychologist is responsible for providing the applicant or their legal/non -legal representative an MR/DD Waiver program brochure that details services available to eligible individuals at the time of the initial assessment. This function is performed by the ASO for annual reassessments. At the initial assessment and annual reassessment, applicants/participants or their legal/nonlegal representatives are asked to sign a "freedom of choice" (consent) form indicating their choice of waiver services versus institutional care.

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

The "freedom of choice" forms (consent forms and service delivery model selection forms) are maintained electronically for a minimum of three years by the ASO.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
Per Census 2000, 97.25 percent of West Virginians speak only English. Due to this high percentage, the MR/DD Waiver Program addresses any needs or requests for alternative materials on an individual basis. All materials are currently available in alternate formats for individuals who cannot access standard print material. These formats include large print, audio and braille. In addition the BMS and all contract staff are available to read printed materials upon request.

Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	**Facility Based Day Habilitation**
Statutory Service	**Participant -Centered Support**
Statutory Service	**Respite**
Statutory Service	**Service Coordination**
Statutory Service	**Supported Employment**
Supports for Participant Direction	**Financial Management Services - Participant-Directed (Agency-with-Choice)**
Other Service	**Crisis Services**
Other Service	**Dietary Therapy**
Other Service	**Electronic Monitoring/Surveillance System and On-Site Response**
Other Service	**Enviromental Accessibility Adaptations - Home**
Other Service	**Environmental Accessiblity Adaptation - Vehicle**
Other Service	**Goods and Services - Participant - Directed**
Other Service	**Occupational Therapy**
Other Service	**Physical Therapy**
Other Service	**Positive Behavior Support Professional**

Service Type	Service
Other Service	Skilled Nursing - Nursing Services by a Licensed Practical Nurse
Other Service	Skilled Nursing - Nursing Services by a Licensed Registered Nurse
Other Service	Speech Therapy
Other Service	Therapeutic Consultant
Other Service	Transportation

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Facility Based Day Habilitation

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

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

Service Definition *(Scope):*

Facility Based Day Habilitation is a structured program that is designed to promote the acquisition of skills or maintenance of skills for the participant outside the residential home. The services must be based on assessment, be person-centered/goal oriented, and with meaningful/productive activities that are guided by the participant's needs wishes, desires, and goals. This support must be provided in a licensed Day Habilitation Center, or if community access is incorporated into the participant's support be directed and monitored by the administration of the licensed Day Habilitation Center. Persons providing facility day habilitation services may participate in person-centered planning.

Facility Based Day Habilitation activities in the plan must be developed exclusively to address the habilitation and support needs of the participant consist of programs of instruction/training, supervision and assistance, specialist services and evaluations provided by or under the direct supervision of a Therapeutic Consultant and Positive Behavior Support Professional (if applicable).

Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Facility Based Day Habilitation Program services include, but are not limited to:

• Development of self-care skills

• Use of community services and businesses
• Emergency skills
• Mobility skills
• Nutritional skills
• Social skills
• Communication and speech instruction (prescribed by a Speech Language Pathologist)
• Therapy objectives (prescribed by Physical Therapist, Occupational Therapist, etc.)
• Interpersonal skills instruction
• Functional academics such as recognizing emergency and other public signs, independent money management skills, etc.
• Citizenship, rights and responsibilities, self-advocacy, voting, etc.
• Other habilitation services necessary for a participant to participate in activities in the community settings of his/her choice
• Self medication
• Independent living skills
• Volunteer services (volunteer work cannot replace a paid employment position)
• Training the individual to follow directions and carry out assigned duties
• Assistance to acquire appropriate attitudes and work habits, such as socially appropriate behaviors on the work site
• Assistance to adjust to the production and performance standards of the workplace
• Compliance with workplace rules or procedures
• Attendance to work activity
• Assistance with workplace problem solving
• Instruction in the appropriate use of work-related facilities (e.g., rest rooms, cafeteria/lunch rooms, and break areas.)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The maximum annual units of facility based day habilitation cannot exceed 6,240 units. A unit equals 15 minutes. This limit is combined with other direct care services as described below.

2920 units/hours includes combination with direct supports for Supported Employment, Participant-Centered Supports, Crisis Services and LPN Services.
Based upon average of 8 hours per day annually for natural family/Specialized Family Care home settings for participants eligible to receive public education services/home schooling/other educational alternatives.

4380 units/hours includes combination with direct supports for Supported Employment, Participant-Centered Supports, Crisis Services and LPN Services.
Based upon average of 12 hours per day annually for natural family/Specialized Family Care home settings for participants not eligible to receive public education services/home schooling/other educational alternatives.

8760 hours annually includes combination with direct supports for Supported Employment, Participant-Centered Supports, Crisis Services and LPN Services for participants in ISS and licensed group settings.

Ratios for Facility Based Day Habilitation are 1:1-2, 1:3-4, and 1:5-6. No other ratio combinations can be considered.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Facility Based Day Habilitation

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Provider

Provider Qualifications

License *(specify):*

Agency must have a WV Behavioral Health License.

Certificate *(specify):*

Other Standard *(specify):*

Agency must be an approved WV Medicaid Provider.
Agency staff must have current CPR and First Aid cards, have an acceptable Criminal Investigation Background check, be over the age of 18, be able to perform and tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the Office of Health Facility Licensure and Certification.
Agency staff is verified by the Licensed Behavioral Health Provider.

Frequency of Verification:

Agency behavioral health license is verified biennially.
Agency staff's credentials are verified initally and annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Participant -Centered Support

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

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

Service Definition *(Scope):*
Participant Centered Support (PCS) consists of individually tailored training and/or support activities that enable the participant to live and inclusively participate in the community in which the participant resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments will be designed to foster the acquisition of skills and appropriate behavior that are necessary for the participant to have greater independence, personal choice and allow for maximum inclusion into their community.

PCS may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:
• Self-care
• Receptive or expressive language
• Learning
• Mobility
• Self-direction
• Capacity of Independent Living

PCS services must be assessment based and outlined on the participant's Individual Program Plan. PCS activities may be completed in the individual's residence, public community settings or a licensed day program/workshop (licensed by OHFLAC). Activities must allow the participant to reside and participate in the most integrated setting appropriate to his/her needs. Persons providing PCS services may participate in person-centered planning.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
General Service Limits:

PCS services are available to participants living in all types of residential settings (Group home, ISS, natural family and Specialized Family Care foster homes). Participant Directed PCS services are not available to individuals living in settings licensed by the Office of Health Facility Licensure and Certification which are residential settings with four (4) or more participants or 1-3 person Intensively Supported Settings which are owned or leased by a Behavioral Health Agency. PCS cannot replace the routine care, and supervision which is expected to be provided by a legally responsible caretaker. PCS may not substitute for federally mandated educational services.
The amount of PCS provided must be identified on the participant's individual program plan and may not exceed the participant's annual individualized budget allocation. The annual individualized budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the participant's assessed medical, behavioral, training and/or support needs.

Traditional Service Limits:

Agency staff providing Traditional Participant Centered Support may not be a family member who lives in the participant's home.

2920 units/hours (based upon average of 8 hours per day) annually for natural family/Specialized Family Care home settings for participants eligible to receive public education services/home schooling/other educational alternatives in combination with direct supports for Facility Day Habilitation, Supported Employment, Crisis Services and LPN Services when LPN services are in excess of two hours per day.

4380 units/hours (based upon average of 12 hours per day) annually for natural family/Specialized Family Care home settings for participants not eligible to receive public education services/home schooling/other educational alternatives in combination with direct supports for Facility Day Habilitation, Supported Employment, Crisis Services and LPN Services when LPN services are in excess of two hours per day.

8760 hours annually (based upon an average of 24 hours per day) for participants in ISS and licensed group home settings in combination with direct supports for Facility Day Habilitation, Supported Employment, Crisis Services and LPN Services are in excess of two hours per day.

The above service limits are in combination with all types of Participant-centered Supports, Facility Day Habilitation,

Supported Employment, Crisis Services and LPN Services when LPN services are in excess of two hours per day.

PCS is not available except when the behavioral needs of the participant arise due to the temporary change in environment while the participant is hospitalized in a Medicaid certified hospital.

Traditional Family Service Limits:

Staff providing Family-Traditional Participant Centered Support must be a family member who lives in the participant's home.

2920 units/hours (based upon average of 8 hours per day) annually for natural family/Specialized Family Care home settings for participants eligible to receive public education services/home schooling/other educational alternatives in combination with direct supports for Facility Day Habilitation, Supported Employment, Crisis Services and LPN Services when LPN services are in excess of two hours per day.

4380 units/hours (based upon average of 12 hours per day) annually for natural family/Specialized Family Care home settings for participants not eligible to receive public education services/home schooling/other educational alternatives in combination with direct supports for Facility Day Habilitation, Supported Employment, Crisis Services and LPN Services when LPN services are in excess of two hours per day.

The above service limits are in combination with all types of Participant-centered Supports, Facility Day Habilitation, Supported Employment, Crisis Services and LPN Services when LPN services are in excess of two hours per day.

PCS is not available except when the behavioral needs of the participant arise due to the temporary change in environment while the participant is hospitalized in a Medicaid certified hospital

Participant Directed Service Limits:

The amount of PCS provided to a participant directing his/her services must be identified on the individualized program plan and may not exceed the annual participant-directed budget allocation. The annual participant-directed budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the participant's assessed medical, behavioral, training and/or support needs.

Participant Directed PCS must be based upon assessed needs, address identified health and safety issues and be outlined in the participant's individual program plan.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Participant-directed Employee
Agency	Licensed Behavioral Health Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Participant -Centered Support

Provider Category:

Individual

Provider Type:

Participant-directed Employee

Provider Qualifications

License *(specify):*

Not applicable as the participant is not required to have a WV Behavioral Health License.

Certificate *(specify):*

Not applicable.

Other Standard *(specify):*

Participant-directed employee must have current CPR and First Aid cards, acceptable Criminal Investigation Background check, be over the age of 18 and have the ability to perform the tasks.

Staff providing Participant-Centered Support not be the participant's spouse.

Verification of Provider Qualifications

Entity Responsible for Verification:

The participant-directed employees' qualifications will be verified by the Government Fiscal/Employer Agent.

Frequency of Verification:

The participant-directed employees will be verified at minimum initially and annually.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Participant -Centered Support

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Provider

Provider Qualifications

License *(specify):*

Agency must have a WV Behavioral Health License.

Certificate *(specify):*

Not applicable.

Other Standard *(specify):*

Agency must be an approved WV Medicaid Provider.

Agency staff must have current CPR and First Aid cards, have an acceptable Criminal Investigation Background check, be over the age of 18, be able to perform and tasks and meet training requirements as mandated by Office of Health Facility Licensure and Certification.

Staff who provide Traditional Participant Centered Support may not be a family member who lives in the participant's home.

Staff providing Family-Traditional Particpant Centered Support must be a family member who lives in the particpant's home but may not be the participant's spouse.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by Office of Health Facility Licensure and Certification.

Agency staff's qualifications are verified by the Licensed Behavioral Health Provider.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Agency staff's qualifications will be verified at minimum initally and annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Respite Services are specifically designed to provide temporary substitute care for an individual whose primary care is normally provided by the family or other primary care-giver of a member. The services are to be used on a short-term basis due to the absence of or need for relief of the primary care-giver. Respite is designed to focus on the needs of the care-giver for temporary relief and to help prevent the breakdown of the care-giver due to the physical burden and emotional stress of providing continuous support and care to the dependent member. Respite Care services consist of temporary care services for an individual who cannot provide for all of his/her own needs. Persons providing respite services may participate in person-centered planning.

Respite Care may be used to:

• Allow the primary care-giver to have planned time from the caretaker role for him/herself and/or other family members

• Provide assistance to the primary care-giver or member in crisis and emergency situations

• Ensure the physical and/or emotional well-being of the primary care-giver or the member by temporarily relieving the primary care provider of the responsibility of providing care.

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

General Service Limits:

Respite services are not available to participants living in ISS or licensed group home settings.

Traditional Service Limits:

1,728 hours per year (averages out to 144 hours/month or 4.73 hours/day) combined with all respite services/ratios.

Ratios for Respite are 1:1, 1:2, and 1:3. Specialized Family Care providers may only bill ratios of 1:1 and 1:2. No other ratio combinations can be considered.

Participant Directed Service Limits:

The amount of respite provided to a participant directing his/her services must be identified on the individualized program plan and may not exceed the annual participant-directed budget allocation. The annual participant-directed budget

allocation may be adjusted (increased or decreased) only if changes have occurred regarding the participant's assessed medical, behavioral, training and/or support needs.

Participant Directed respite must be based upon assessed needs, address identified health and safety issues and be outlined in the participant's individual program plan.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Participant-directed Employee
Agency	Licensed Behavioral Health Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:
Participant-directed Employee
Provider Qualifications
License *(specify):*
Not applicable as the particpant is not required to have a WV Behavioral Health License.
Certificate *(specify):*
Not applicable.
Other Standard *(specify):*
Participant-directed employee must have current CPR and First Aid cards, an acceptable Crimial Investigation Background check, be over the age of 18 and have the ability to perform the tasks.
Verification of Provider Qualifications
Entity Responsible for Verification:
The participant-directed employee's qualifications will be verified by the Government Fiscal/Employer Agent.
Frequency of Verification:
The participant-directed employee will be verified at minimum initially and annually.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Licensed Behavioral Health Provider

Provider Qualifications

License *(specify):*
Agency must have a Behavioral Health License.
Certificate *(specify):*
Not applicable.
Other Standard *(specify):*
Agency must be an approved WV Medicaid Provider.
Agency staff must have current CPR and First Aid cards, acceptable Criminal Investigation Background check, be over the age of 18, have the ability to perform the tasks and meet the training requirements mandated by Office of Health Facility Licensure and Certification.

Verification of Provider Qualifications

Entity Responsible for Verification:
Agency is verified by the Office of Health Facility Licensure and Certification.
Agency staff's qualifications are verified by the Licensed Behavioral Health Provider.
Frequency of Verification:
Agency behavioral health license is verified biennially.
Agency staff's credentials are verified at minimum initially and annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Case Management

Alternate Service Title (if any):
Service Coordination

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Service Coordination services are activities to establish, along with the participant, a life-long, person-centered, goal-oriented process for coordinating the supports (both natural and paid), range of services, instruction and assistance needed by persons with developmental disabilities. It is designed to ensure accessibility, accountability and continuity of support and services. This service also ensures that the maximum potential and productivity of a person with developmental

disabilities in making meaningful choices with regard to his/her life and his/her inclusion in the community are achieved.

The Service Coordinator shall perform the following activities:
- Once the participant/legal guardian has chosen a Service Coordination agency, an agency Service Coordinator will be assigned to the participant. The participant/legal representative may request the assignment of a specific Service Coordinator and when possible the agency will honor the request. The participant/legal representative may transfer to a different SC provider at any time and for any reason.
- Assist with application for financial eligibility at the DHHR office in the county where the applicant lives or ensure that the participant and/or their legal/non-legal representative make the financial application.
- Assist the participant and/or their legal/non-legal representative re-establish financial eligibility at the county DHHR office as needed.
- Service Coordination providers must begin the discharge process and provide linkage to services appropriate to the level of need when a participant is found to be ineligible for MR/DD Waiver Services during annual redetermination reviews.
- Provide oral and written information about the MR/DD Waiver Program provider agency's rights and grievance procedures for participants served by the agency.
- Assist with procurement of all medically necessary services for children through the age of twenty one (21) within and beyond the scope of the MR/DD Waiver Program, in accordance with all Federal regulations.
- Inform families or custodians of children less than three (3) years of age about the availability of Birth to Three Services.
- Act as an advocate for the participant. The MR/DD Waiver Program must not be substituted for entitlement programs funded under other Federal public laws such as Special Education under P.L.99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers). Therefore, it is necessary for the Service Coordinator to advocate with these systems to obtain the required and appropriate services.
- Provide education, linkage and referral to community resources.
- Promote a valuable and meaningful social role for the participant in the community while recognizing the member's unique cultural and personal value system.
- Interface with the ASO on behalf of the member in regards to the assessment process, purchase of services, or budget process. Activities may include linkage, submission of information, coordination of choice of appropriate assessment respondents on behalf of the member, education and coordination of the most appropriate assessment setting that best meets the participant's needs.
- The Service Coordinator may also conduct communication with other service providers on the IDT to allow for continuity of services/payment for services, and timely budgeting of services. These activities promote an assessment and budget that reflects the needs of the participant.
- Coordinate evaluations annually to be utilized as a basis of need and recommendation for services in the development of the IPP.
- Notify, convene, coordinate and chair the meeting with the IDT. The Service Coordinator and the participant may wish to coordinate the annual IPP with the planning process for other service systems.
- Coordinate the development of a new IPP at least annually, with a six (6) month up-date or more frequent updates if necessary.
- Access the necessary resources detailed in the IPP, make referrals to qualified service providers and resources, and ensure that service providers implement the instructional (behavioral) and service objectives of the IPP.
- Monitor the instructional (behavioral) and service objectives to ensure that objectives are implemented according to the IPP.
- Disseminate copies of the IPP to the participant and/or their legal/non-legal representative and all provider agencies indicated on the IPP.
- Disseminate evaluations or assessments to provider agencies indicated on the IPP.
- Ensure health and safety of the participant.
- Ensure the implementation of services as indicated on the IPP.
- Visit the participant monthly at his/her residence to personally meet with the individual and service providers to verify that services are being delivered in accordance with the IPP in a safe environment, and check that documentation of services is occurring. Visits with the participant and their legal/non-legal representative will be utilized by the Service Coordinator to update progress towards obtaining services and resources and discuss progress towards achieving objectives contained in the IPP. The Service Coordinator will also elicit information from the participant and/or their legal/non- legal representative on their assessment of services, achievements, and/or unmet needs.
- Advocate on behalf of the participant within the behavioral health service delivery system and community services and resources.
- Provide planning and coordination before, during and after crises.
- Coordinate discharge/transitional planning meetings to ensure the linkage to new service provider and access to services when transferring services from one provider agency to another. Coordination efforts will continue until the transfer of

service coordination is finalized.
- Travel to and from home visits, facility day habilitation program visits (when participant accesses this service), and other locations necessary to complete duties related to the IPP.
-Provides information and assistance regarding participant-directed services options during annual IPP meetings and upon request.
• Service Restrictions
Activities that are an integral component of another covered Medicaid service.
Activities integral to the administration of foster care programs.
Payee services are not reimbursable as a service coordination activity. Example: writing checks, maintaining bank account, paying the electric bill, etc. (linkage to the payee on behalf of the member is an acceptable service coordination activity).
MR/DD Waiver Service Coordinators may not provide services for more than twenty (20) people, inclusive of all people served by the Service Coordinator at any time.
Service Coordinators may not evaluate IPP implementation by means of review of "billing or billing documentation" or other auditing activities. (The Service Coordinator may not function as a billing person/auditor. The Service Coordinator may review/monitor implemented services.)
The Service Coordinator is required to monitor the instructional and service objectives to ensure that objectives are implemented according to the IPP and the SC is to ensure the implementation of services as indicated on the IPP).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
840 (15 minute) units annually.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Service Coordination

Provider Category:
Agency
Provider Type:
Licensed Behavioral Health Provider
Provider Qualifications
License *(specify):*
Agency must have a WV Behavioral Health License.
Certificate *(specify):*

Other Standard *(specify):*
Agency must be an approved WV Medicaid Provider.
Agency employee must be over the age of 18, have an approved Criminal Investigation Background check, be able to perform the tasks and meet the mandated requirements of the Office of Health Facility Licensure and Certification.
Agency staff must one of the following:
• Four (4) year degree in a human service field and one or more years experience in the MR/DD field.

• Four (4) year degree in a human service field and less than one (1) year of experience in the MR/DD field. (Restrictions - must be under the supervision of the Service Coordinator Supervisor. Clinical supervision involves review of clinical activities, review of case notes and review of treatment plans for six (6) months. This must be verified by supervisory documentation once per month).
• Four (4) year degree in a non-human service field and one (1) year experience in the MR/DD field. (Restrictions - must be under the supervision of the Service Coordinator Supervisor. Clinical supervision involves review of clinical activities, review of case notes, and review of treatment plans for six (6) months. This must be verified by supervisory documentation once per month).
• No degree or two (2) year degree and is a Licensed Social Worker grandfathered in by the WV Board of Social Worker Examiners due to experience in the MR/DD field. (Restrictions - none)
• A Registered Nurse who has one or more years of experience working in the MR/DD field (Restrictions - must be under the supervision of the Service Coordination Supervisor. Clinical supervision involves review of clinical activities, review of case notes, and review of treatment plans for six (6) months. This must be verified by supervisory documentation once per month).

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the Office of Health Facility Licensure and Certification.
Agency staff is verified by the Licensed Behavioral Health Provider.

Frequency of Verification:

Agency behavioral health license is verified biennially.
Agency staff's credentials are verified initially and annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Supported Employment Services are services that enable individuals to engage in paid, competitive employment, in integrated community settings. The services are for individuals who have barriers to obtaining employment due to the nature and complexity of their disabilities, regardless of age or vocational potential. The services are designed to assist individuals for whom competitive employment at or above the minimum wage is unlikely without such support and services and need ongoing post-employment support based upon the member's level of need.

Supported Employment services include, but are not limited to:
• Vocational counseling (Example: Discussion of the member's on- the- job work activities)
• Job development and placement for a specific waiver member with the member present
• On-the-job training in work and work-related skills
• Accommodation of work performance task
• Supervision and monitoring by a job coach
• Intervention to replace inappropriate work behaviors with adaptive work skills and behaviors
• Retraining as jobs change or job tasks change
• Training in skills essential to obtain and retain employment, such as the effective use of community resources
• Transportation to and from job sites when other forms of transportation are unavailable or inaccessible.

Natural work setting supports are to be considered prior to the utilization of Supported Employment.
There must be sufficient numbers of competent, trained staff to provide supported employment services and to protect individual's health and safety.
Supported Employment Services must be supervised by a Therapeutic Consultant. In addition to the standard training requirements, paraprofessionals providing supported employment must have documented training or experience in implementation of Supported Employment plans of instruction. Trainers or job coaches must be employees of community behavioral health providers that are licensed by OHFLAC and are WV Medicaid Providers. Persons providing supported employmeny services may participate in person-centered planning.
Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.)
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The maximum annual units of supported employment cannot exceed 8,320 units. A unit equals 15 minutes. This limit is combined with other direct care services as described below.

2920 units/hours (based upon average of 8 hours per day)annually for natural family/Specialized Family Care home settings for participants eligible to receive public education services/home schooling/other educational alternatives in combination of direct supports for Facility Day Habilitation, Participant-Centered Supports, Crisis Services and LPN Services.

4380 units/hours (based upon average of 12 hours per day) annually for natural family/Specialized Family Care home settings for participants not eligible to receive public education services/home schooling/other educational alternatives in combination with direct supports for Facility Day Habiliation, Participant-Centered Supports, Crisis Services and LPN Services.

8760 hours annually for participants' home/group settings also includes combination with direct supports for Facility Day Habilitation, Participant-Centered Supports, Crisis Services and LPN Services.

Individual services are delivered in a staff/participant ratio of 1:1.
Group services are delivered in a staff/participant ratio of 1:2-4.
No other ratio combinations can be considered.
Federal financial participation is not claimed for incentive payments; subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program.
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to an individual's supported employment program.

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

☐ **Participant-directed as specified in Appendix E**
☑ **Provider managed**

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

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
Licensed Behavioral Health Provider
Provider Qualifications
License *(specify):*
Agency must have a WV Behavioral Health License.
Certificate *(specify):*
Other Standard *(specify):*
Agency must be an approved WV Medicaid Provider.
Agency staff must have current CPR and First Aid cards, an approved Criminal Investigation Background check, be over the age of 18, the ability to perform the tasks and meet the training requirements as mandated by the Office of Health Facility Licensure and Certification.
Agency staff must have documented training or experience in the implementation of Supported Employment plans of instruction.
Verification of Provider Qualifications
Entity Responsible for Verification:
Agency is verified by the Office of Health Facility Licensure and Certification.
Agency staff is verified by the Licensed Behavioral Health Provider.
Frequency of Verification:
Agency behavioral health license is verified biennially.
Agency staff's credentials are verified initally and annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

Financial Management Services - Participant-Directed (Agency-with-Choice)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Participants choosing to direct their services under the Agency with Choice option obtains Financial Management Services through an agency provider that will provide the following services:

1) Assists Self-directing Participants exercising budget authority
• Act as a neutral bank, receiving and disbursing public funds, tracking and reporting on the participant's budget funds (received, disbursed and any balances); and,
• Process and pay invoices for goods and services in the participant's approved service plan.

2) Assists Self-directing Participants exercising employer authority
• Assist the participant in verifying workers' citizenship or legal alien status (e.g., completing and maintaining a copy of the BCIS Form I-9 for each support service worker the participant employs);
• Collect and process support worker's timesheets;
• Operate a payroll service, (including withholding taxes from workers' pay, filing and paying Federal (e.g., income tax withholding, FICA and FUTA), state (e.g., income tax withholding and SUTA), and, when applicable, local employment taxes and insurance premiums); and,
• Distribute payroll checks on the participant's behalf.

3) Assists with additional functions, including:
• Executing provider agreements on behalf of the Medicaid agency
• Provide orientation/skills training to participants about their responsibilities when they function as the common law employer of their direct support workers.
• Provide ongoing information and assistance to participants and/or their legal/non-legal representative

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

Limited to one event per month/12 events per year.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Provider

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Financial Management Services - Participant-Directed (Agency-with-Choice)

Provider Category:
Agency
Provider Type:
Licensed Behavioral Health Provider
Provider Qualifications
License *(specify):*
Agency must have a WV Behavioral Health License
Certificate *(specify):*
Not applicable.
Other Standard *(specify):*
Agency must be an approved WV Medicaid provider.
Agency must be approved by BMS as an Agency with Choice FMS
Verification of Provider Qualifications
Entity Responsible for Verification:
Agency is verified by OHFLAC (Behavioral Health License)
Agency is verified by BMS (FMS)
Frequency of Verification:
Agency Behavioral Health License is verified biennially.
Agency FMS is verified initially and bi-annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Crisis Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

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

Service Definition *(Scope):*
The goal of this service is to respond to a crisis immediately, assess and stabilize the situation as quickly as possible. Crisis services are to be used if there is an extraordinary circumstance requiring a short-term, acute service that utilizes positive behavioral support planning, interventions, strategies and direct care. This service requires medical necessity and must be approved by the ASO within 48 hours of onset of service delivery. This service is a 2:1 ratio (staff to member ratio). The additional staff person is available for assurance of health and safety in the respective setting. Crisis services include formal training, informal training and behavioral support.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
336 units (hours) annually in combination with all other MR/DD services except for Service Coordination, Therapeutic Consultant, Positive Behavioral Support Professional, Physical Therapy, Occupational Therapy, Dietary Therapy and Transportation. Not intended for use as emergency response for ongoing behavioral challenges. Staff member ratio is 2:1 which cannot be combined with other direct care services. Available in all residential settings, i.e. natural family, Specialized Family Care, Individual Support Settings and group homes). A participant may not receive person-centered supports, facility based day habilitation, supported employment, respite and/or more than two hours of nursing services per day when receiving crisis services.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Services

Provider Category:
Agency
Provider Type:
Licensed Behavioral Health Provider
Provider Qualifications
License *(specify):*
Agency must have a WV Behavioral Health License.
Certificate *(specify):*

Other Standard *(specify):*
Agency must be an approved WV Medicaid Provider.
Agency staff must have current CPR and First Aid cards, an approved Criminal Investigation Background check, be over the age of 18, have the ability to perform the tasks and meet the training requirements as mandated by the Office of Health Facility Licensure and Certification.

Verification of Provider Qualifications

Entity Responsible for Verification:
Agency is verified by the Office of Health Facility Licensure and Certification.
Agency staff is verified by the Licensed Behavioral Health Provider

Frequency of Verification:
Agency behavioral health license is verified biennially.
Agency staff's qualifications are verified initially and annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

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

Service Title:
Dietary Therapy

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Dietary Services are provided directly to the member by a 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; consultation or demonstration of techniques with other service providers and family members; participating on the interdisciplinary team, when appropriate, for the development of the plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
416 15-minute units annually in combination with Physical Therapy and Occupational Therapy.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietary Therapy

Provider Category:
Agency
Provider Type:
Licensed Behavioral Health Provider
Provider Qualifications

License *(specify):*
Agency must have a WV Behavioral Health License.
Agency staff must be a registered, licensed dietitian.

Certificate *(specify):*

Other Standard *(specify):*
Agency must be an approved WV Medicaid Provider.
Agency staff must be over the age of 18, have an acceptable Criminal Investigation Background check, be able to perform the tasks and meet the mandated requirements of the Office of Health Facility Licensure and Certification.

Verification of Provider Qualifications

Entity Responsible for Verification:
Agency is verified by the Office of Health Facility Licensure and Certification.
Agency staff is verified by the Licensed Behavioral Health Provider.
Frequency of Verification:
Agency behavioral health license is verified biennially.
Agency staff's qualifications are verified initially and annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

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

Service Title:

Electronic Monitoring/Surveillance System and On-Site Response

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Electronic Monitoring/Surveillance System and On-Site Response may be installed in residential settings in which all residing participants, their guardians and their support teams request such surveillance and monitoring in place of on-site staffing.

Use of the system may be restricted to certain hours through the Individual Program Plans of the participants involved.

To be reimbursed for operating an electronic monitoring and surveillance system, a provider must adhere to the following:

• The system to be installed must be reviewed and approved by the Bureau of Medical Services.

• The Electronic Monitoring/Surveillance System and On-Site Response system must be designed and implemented to ensure the health and welfare of the participant in his/her own home/apartment and achieve this outcome in a cost neutral manner.

• The participant's service coordinator will review the use of the system at seven (7) days, and again at fourteen (14) days post installation.

• Services provided to waiver participants or otherwise reimbursed by the Medicaid program is subject to the oversight/approval from OHFLAC.

The following procedures must be followed regarding assessment and informed consent:

• Initial Assessment: Participants requesting this service must be preliminarily assessed by their Interdisciplinary Team (IDT) for appropriateness in ensuring the health and welfare of the participant and have written approval by the Human Rights Committee (HRC). These actions must be documented in the Individual Program Plan (IPP).

• Informed Consent: Each participant, guardian and IDT must be made aware of both the benefits and risks of the operating parameters and limitations. Informed consent documents must be acknowledged in writing, signed and dated by the participant, guardian, service coordinator, and provider agency representative, as appropriate. A copy of the consent shall be maintained in the participant home, in their agency file and with the ASO.

• Annual assessment updates: At least annually, the IDT must assess and determine the continued usage of the electronic monitoring system will ensure the health and welfare of the participant. The results of this assessment must be documented in the IPP. A review of all incident reports and other relevant documentation must be part of this assessment.

The system must be designed as follows:

• The provider must have safeguards and/or backup system such as battery or generator for the electronic devices in place at the monitoring base and the participant's residential living site in the event of electrical outages.

• The provider must have backup procedures for system failure (e.g. prolonged power outages)l, fire or weather emergency, participant medical issue or personal emergency in place and detailed in writing for each site utilizing the system as well as in each participant's IPP. The plan should specify the staff person or persons to be contacted by monitoring base staff who will be responsible for responding to these situations and traveling to the participant's living site.

• The electronic monitoring system must receive notification of smoke/heat alarm activation at each participant's living site.

• The electronic monitoring system must have two way (at minimum, full duplex) audio communication capabilities to allow monitoring base staff to effectively interact with and address the needs of participants in each living site, including

emergency situations when the participants may not be able to use the telephone.
• The electronic monitoring system must allow the monitoring base staff to have visual (video) oversight of areas in participant's residential living site deemed necessary by the IDT.
• A monitoring base may not be located in a participant's living site.
• A secure (HIPAA compliant) network system requiring authentication, authorization and encryption of data must be in place to ensure access to computer vision, audio, sensor or written information is limited to authorized staff including the parent/guardian, provider agency, ASO, BMS, OHFLAC, service coordinator and participant.
In situations involving electronic monitoring of participants needed 24 hour support when the participant indicates that he/she wants the electronic monitoring system to be turned off, the following protocol will be implemented:
• The electronic caregiver will notify the provider to request an on-site staff.
• The system would be left operating until the on-site staff arrives.
• The electronic caregiver would turn off the system at the site once relieved by an on-site staff.
• A visible light on the control box would signal when the system is on and when it is off.
Monitoring base staff will meet the following standards:
• At the time of monitoring, the monitoring base staff may not duties other then the oversight and support of participants at remote living sites.
• The monitoring base staff will assess any urgent situation at a participant's residential living site and call 911 emergency personnel first if that is deemed necessary, and then call the float staff person. The monitoring base staff will stay engaged with the participant(s) at the living site during an urgent situation until the float staff or emergency personnel arrive.
• If computer vision or video is used, oversight of a participant's home must be done in real time by an awake-staff at a remote location (monitoring base) using telecommunication/broad band, the equivalent or better, connection.
• The monitoring base (remote station) shall maintain a file on each participant in each home monitored that includes a current photograph of each participant which must be updated if significant physical changes occur and at least annually. The file shall also include pertinent information on each participant noting facts that would aid in ensuring the participant's safety.
• The monitoring base staff must have detailed and current written protocols for responding to needs of each participant at each remote living site, including contact information for staff to supply on-site support at the participant's residential living site when necessary.
Stand-by intervention staff (float staff) shall meet the following standards:
• The float staff shall respond and be at the participant's residential living site within 20 minutes or less from the time the incident is identified by the remote staff and float staff acknowledges receipt of the notification by the monitoring base staff. The IDT has the authority to set a shorter response time based on the individual participant need.
• The service must be provided by one (1) float staff for on-site response, the number of participants served by the one (1) float staff is to be determined by the IDT based up on the assessed needs of the participants being served in specifically identified locations.
• Float staff will assist the participant in the home as needed to ensure the urgent need/issue that generated a response has been resolved. Relief of float staff, if necessary, must be provided by the residential provider.
Retention of written documentation is required for 7 years.
Retention of video/audio records, including computer vision, audio and sensor information, shall be retained for 7 years if an Incident Report is filed.
To be reimbursed, the provider must prepare and be able to produce the following:
• Status as a BMS approved provider.
• Approval of the specific electronic monitoring/surveillance system by the BMS MR/DD Program Manager
• Case notes regarding the assessment and approval by both the IDT of each participant and the HRC will be documented within both the ASO system and in the participant's IPP.
• Informed consent documents must be acknowledged in writing, signed and dated by the participant and/or their legal guardian, service coordinator and provider agency representative, as appropriate. Copies of the consent documentation will be maintained by the service coordination agency, the ASO, the guardian (if applicable) and in the participant's home file.
• Utilization of the electronic monitoring device must be outlined in the IPP and individualized assessed budgets of each participant in a setting, including typical hours of electronic monitoring. Each remote site will have a written policy and procedures approved by BMS (and available to OHFLAC) that defines emergency situations and details how remote and float staff will respond to each. Examples include:

o Fire, medical crises, stranger in the home, violence between participants, and any other situations that appears to threaten the health or welfare of the participant.

o Emergency Response drills must be carried out once per quarter per shift in each home equipped with and capable of utilizing the electronic monitoring service. Documentation of the drills must be available for review upon request.
The remote monitoring base staff shall generate a written report on each participant served in each participant's residential living site on a daily basis. This report will follow documentation standards of each Person-Centered Support Service. This

report must be transmitted to the primary residential provider daily.
Each time an emergency response is generated, an incident report must be submitted to the ASO per the Incident Management System.
At least every 90 days, the appropriateness of continued use of the monitoring system must be reviewed by the IDT; the results of these reviews must be documented in the individual's IPP. Areas to be reviewed include but are not limited to the number and nature of responses to the home as well as damage to the equipment.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The budget will be completed for each participant based upon the number of participants residing within the residence and rates will be developed the following ratios:
1 participant per home
2 participants in a home
3 participants in a home
4 participants in a home
ACTIVITIES NOT ALLOWED:
Electronic monitoring and surveillance systems which have not received specific approval by the Program Manager of the MR/DD Waiver at BMS.
Electronic Monitoring may not be used in Specialized Family Care Homes.
Electronic Monitoring systems intended to monitor direct care staff.
Electronic Monitoring serves as a replacement for Person-Centered Support Services (PCS), therefore,
Electronic Monitoring and PCS are not billable during the same time period.
Electronic Monitoring systems used in place of in-home staff to monitor minor, i.e. participants unde the age of 18.
Installation costs related to video and/or audio equipment.

Services furnished to a minor by a parent(s), step-parent(s), or legal guardian.
Services furnished to a participant by the participant's spouse

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavaioral Health Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Electronic Monitoring/Surveillance System and On-Site Response

Provider Category:
Agency
Provider Type:
Licensed Behavaioral Health Provider
Provider Qualifications
License *(specify):*
Agency must have a WV Behavioral Health License.
Certificate *(specify):*
Not applicable.
Other Standard *(specify):*

Agency must be an approved WV Medicaid Provider.
Electronic Monitoring/Surveillance Systems must be approved by Bureau for Medical Services.

Verification of Provider Qualifications

Entity Responsible for Verification:
Agency is verified by Office of Health Facility Licensure and Certification.

Frequency of Verification:
Agency behavioral health license is verified biennially.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:
Enviromental Accessibility Adaptations - Home

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Environmental Accessibility Adaptations are physical adaptations to the private residence of the participant or the participant's family home, required by the participant's plan of care or IPP, which are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. The purpose of this service is accessibility to the home only. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modifications of bathroom facilities or the installation of specialized electric and plumbling systems that are necessary to accomodate the medical equipment and supplies that are necessary for the welfare of the participant. Additionally, these adaptations enable the participant to function with greater independence in the home and without which the participant would require a more restrictive environment. Medicaid funds will be used only after all other non-family funding sources have been exhausted.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
$1000 per State Fiscal Year (July 1 – June 30) in conjunction with Environmentally Accessibility Adaptations - Vehicle and/or Participant-Directed Goods and Services.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or

remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Computers, communication devices, palm pilots, and other technologies are not considered eligible for this service.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Enviromental Accessibility Adaptations - Home

Provider Category:
Agency
Provider Type:
Licensed Behavioral Health Provider
Provider Qualifications
License *(specify):*
Agency must have a WV Behavioral Health License.
Certificate *(specify):*
Not applicable.
Other Standard *(specify):*
Agency must be an approved WV Medicaid Provider.
Verification of Provider Qualifications
Entity Responsible for Verification:
Agency is verified by the Office of Health Facility Licensure and Certification.
Frequency of Verification:
Agency behavioral health license is verified biennially.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:

Environmental Accessiblity Adaptation - Vehicle

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

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

Service Definition *(Scope):*
Environmental Accessibility Adaptations are physical adaptations to the vehicle, required by the participant's plan of care or IPP, which are necessary to ensure the health, welfare and safety of the participant. The purpose of this service is accessibility to the vehicle only. Computers, communication devices, palm pilots, and other technologies are not considered eligible for this service. Additionally, these adaptations enable the participant to function with greater independence in the community and without which the participant would require a more restrictive environment. Medicaid funds will be used only after all other non-family funding sources have been exhausted. The following are specifically excluded: Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; purchase or lease of a vehicle; and regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
$1000 per State Fiscal Year (July 1 – June 30) in conjunction with Environmentally Accessibility Adaptations - Home and/or Participant-Directed Goods and Services.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessiblity Adaptation - Vehicle

Provider Category:
Agency

Provider Type:
Licensed Behavioral Health Provider
Provider Qualifications
License *(specify):*
Agency must have a WV Behavioral Health License.
Certificate *(specify):*
Not applicable.
Other Standard *(specify):*
Agency must be an approved WV Medicaid Provider.
Verification of Provider Qualifications
Entity Responsible for Verification:
Agency is verified by the Office of Health Facility Licensure and Certification.
Frequency of Verification:
Agency behavioral health license is verified biennially.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Goods and Services - Participant - Directed

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Participant-Directed Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the IPP and meet the following requirements:
-An item or service that would decrease the need for other Medicaid services and/or promote inclusion in the community and/or increase participant's safety in the home environment.
-The participant does not have the funds to purchase the item or service or the item or service is not available through another source.
-Participant-directed Goods and Services are purchased from the participant-directed budget.

-Experimental or prohibited treatments are excluded.
-Participant-Directed Goods and Services are documented in the IPP.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Maximum of $1,000 per member IPP year in combination with EAA.
The following represents non-permissible Participant-Directed Goods and Services:
Goods, services or supports covered by the State Plan, Medicare, other third-parties, including education, home-based schooling and vocational services; or goods, services and supports available through another source; Goods, services or supports provided to or benefiting persons other than the individual participant; Room and board; and Personal items and services not related to the qualifying disability.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

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

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Participant-directed Employee
Agency	Licensed Behavioral Health Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Goods and Services - Participant - Directed

Provider Category:
Individual
Provider Type:
Participant-directed Employee
Provider Qualifications
License *(specify):*
Not applicable as the participant is not required to have a WV Behavioral Health License.
Certificate *(specify):*
Not applicable.
Other Standard *(specify):*
The participant directed worker must have current CPR and First Aid cards, acceptable Criminal Investigation Background check, be over the age of 18 and have the ability to perform the tasks.
Verification of Provider Qualifications
Entity Responsible for Verification:
The participant-directed worker will be verified by the Government FE/A.
Frequency of Verification:
The participant-directed worker will be verified at minimum initially and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Goods and Services - Participant - Directed

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Provider

Provider Qualifications

License *(specify):*

Agency must have a WV Behavioral Health Provider.

Certificate *(specify):*

Other Standard *(specify):*

Agency must be an approved WV Medicaid Provider.

Agency employee must have current CPR and First Aid cards, have an acceptable Criminal Investigation Background check, be over the age of 18, have the ability to performs the tasks and meet the training requirements as mandated by the Office of Health Facility Licensure and Certification.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the Office of Health Facility Licensure and Certification.

Agency employee's qualifications are verified by the provider agency.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Agency employee is verified at minimum initially and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Occupational Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*
Occupational Therapy is provided directly to the member by a licensed/certified occupational therapist and may include: Evaluation and training services in the areas of gross and fine motor function; self-care and sensory and perceptual motor function; screening; assessments; planning and reporting; direct therapeutic intervention; design, fabrication, training and assistance with adaptive aids and devices; consultation or demonstration of techniques with other service providers and family members; participating on the interdisciplinary team, when appropriate, for the development of the plan.
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.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
416 units annually in combination with Physical Therapy and Dietary Therapy.
Occupational Therapy services will not duplicate State Medicaid plan services. WV attests that no duplication of occupational therapy service on the MR/DD Waiver and EPSDT services will be permitted and will ensure that each child has access to all services to which he/she is entitled through EPDST.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:
Agency
Provider Type:
Licensed Behavioral Health Provider
Provider Qualifications
License *(specify):*
Agency must have a WV Behavioral Health License.
Agency staff must be a Licensed Occupational Therapist
Certificate *(specify):*
Other Standard *(specify):*
Agency must be an approved WV Medicaid Provider.
Agency staff must be over the age of 18, have an acceptable Criminal Investigation Background check, be able to perform the tasks and meet the mandated requirements of the Office of Health Facility Licensure and Certification
Verification of Provider Qualifications
Entity Responsible for Verification:
Agency is verified by the Office of Hedlath Facility Licensure and Certification.
Agency staff is verified by the Licensed Behavioral Health Provider.
Frequency of Verification:

Agency behavioral health license is verified biennially.
Agency staff's qualifications are verified initially and annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Physical Therapy

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Physical Therapy is provided directly to the participant by 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; consultation or demonstration of techniques with other service providers and family members; participating on the interdisciplinary team, when appropriate, for the development of the plan.

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.

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

416 15-minute units annually in combination with Occupational Therapy and Dietary Therapy.

Physical Therapy services will not duplicate State Medicaid plan services.WV attests that no duplication of physical therapy service on the MR/DD Waiver and EPSDT services will be permitted and will ensure that each child has access to all services to which he/she is entitled through EPDST.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:
Agency
Provider Type:
Licensed Behavioral Health Provider
Provider Qualifications
License *(specify):*
Agency must have a WV Behavioral Health License.
Agency staff must be a licensed physical therapist.
Certificate *(specify):*

Other Standard *(specify):*
Agency must be an approved WV Medicaid Provider.
Agency staff must be over the age of 18, have an acceptable Criminal Investigation Background check, be able to perform the tasks and meet the mandated requirements of the Office of Health Facility Licensure and Certification
Verification of Provider Qualifications
Entity Responsible for Verification:
Agency is verified by the Office of Health Facility Licensure and Certification.
Agency staff is verified by the Licensed Behavioral Health Provider.
Frequency of Verification:
Agency behavioral health license is verified biennially.
Agency staff's qualifications are verified initally and annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Positive Behavior Support Professional

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

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

Service Definition *(Scope):*
This service is provided to members with the primary need for significant maladaptive behavior interventions. Positive Behavior Support Professional is responsible to identify targeted maladaptive behaviors; develop hypotheses and positive behavior support plans; and provides training in the person-specific aspects and method of a plan of intervention to the primary care providers (i.e., family, therapeutic consultants, service coordinators, participant-centered support providers, facility day habilitation providers, supportive employment providers and respite providers). The Positive Behavior Support Specialist also provides evaluation/monitoring of the effectiveness of the plan of intervention. The plan of intervention must require a full Positive Behavior Support Plan as recommended by the participant's need.

Positive Behavior Support Professional Core Job Functions:
• Responsible for all aspects of positive behavior support services
• Behavioral assessment or evaluation consisting of activities such as functional analysis of targeted behavior or analysis of behavioral data
• Design a Positive Behavioral Support Plan addressing behavioral protocols and behavioral guidelines.
• Training of providers to implement Positive Behavioral Support Plan.
• Development of behavioral protocols and behavioral guidelines for direct care staff or families.
• Development of methodology for intervention with the individual.
• Assessment, evaluation and monitoring of the effectiveness of positive behavior support plan.

A component of the Positive Behavior Support Professional Service is IPP Planning which includes attending Individual Program Plan meetings to present assessments or evaluations completed for purpose of integrating recommendations, training goals and intervention strategies into the particpant's IPP.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Positive Behavior Support Professional - 960 (15 minute) units annually in combination with Therapeutic Consultant Services.

IPP Planning - Positive Behavior Support Professional is limited to a maximum of 18 units annually.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Positive Behavior Support Professional

Provider Category:
Agency
Provider Type:
Licensed Behavioral Health Provider
Provider Qualifications

License *(specify):*
Agency must have a WV Behavioral Health License.
Certificate *(specify):*

Other Standard *(specify):*
Agency must be an approved WV Medicaid Provider.
Agency staff must meet at least one of the following:
-Board Certified Assistant Behavior Analyst Certificate-BCaBA (Bachelor's degree)
-Board Certified Behavior Analyst Certificate- BCBA(Master's degree)
-BA/BS degree in human services field and 2 years experience in the MR/DD field and documented evidence of successful completion of APBS Standards of Practice coursework/training.
-BA/BS degree in human services field and evidence of successful completion of all coursework required for the BCaBA exam and 1 year experience in the MR/DD field.
Agency staff must be over the age of 18, have an approved Criminal Investigation Background check, be able to perform the tasks and meet the mandated requirements of the Office of Health Facility Licensure and Certification.

Verification of Provider Qualifications

Entity Responsible for Verification:
Agency is verified by the Office of Health Facility Licensure and Certification.
Agency staff is verified by the Licensed Behavioral Health Provider.
Frequency of Verification:
Agency behavioral health license is verified biennially.
Agency staff's qualifications are verified intially and annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Skilled Nursing - Nursing Services by a Licensed Practical Nurse

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

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

Service Definition *(Scope):*
Nursing services listed in the service plan are within the scope of the State's Nurse Practice Act and are provided by a licensed practical nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services that must be provided by a Licensed Practical Nurse (LPN) include but are not limited to:(Note: Reimbursement of these activities is at the LPN rate)
• Routine monitoring (data collection) of specific medical symptoms such as seizures, bowel habits, blood pressure, diet and exercise;
• Taking off physician orders if only nurses are administering medication;
• Ensuring physician orders are current, properly documented and communicated to direct care staff and others per agency policy;
• Direct nursing care including medication/treatment administration;
• Monitoring and review of MARs, medication storage and documentation (when no AMAPs are administering medication);
• Ensure medical appointments have been kept and information communicated to all others per agency policy;
• Assist in obtaining informed consent for medication and/or treatments;
• Facilitate procurement of and monitoring of medical equipment;
• Keeping emergency sheets updated and accurate;
If the member receives eight or more hours of skilled nursing services, then LPN is responsible for providing supports and training through participant-centered supports and the LPN may participate in the IPP and bill the LPN code.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
17,520 units/4,380 hours annually.

Combination of all LPN codes. Ratio codes are 1:1, 1:2 and 1:3.

The above service limits are in combination with all types of Participant-centered Supports, Facility Day Habilitation, Supported Employment and Crisis Services.

The nurse is also expected to provide training/supports when the participant receives 8 hours or more of skilled nursing services per day. In participant Individualized Staffed Settings or group homes, the total number of service units may exceed 24 hours per day when the LPN also passes medication. An LPN works under the supervision and monitoring of a Registered Nurse (RN).

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing - Nursing Services by a Licensed Practical Nurse

Provider Category:
Agency
Provider Type:
Licensed Behavioral Health Provider
Provider Qualifications
License *(specify):*
Agency must have a WV Behavioral Health License.
Agency staff must be a WV Licensed Practical Nurse or WV Registered Nursing License.
Certificate *(specify):*

Other Standard *(specify):*
Agency must be an approved WV Medicaid Provider.
Agency staff must be at least 18 years of age, have an approved Criminal Investigation Background check, be able to perform the tasks and meet the mandated requirements of the Office of Health Facility Licensure and Certification.

Verification of Provider Qualifications
Entity Responsible for Verification:
Agency is verified by the Office of Health Facility Licensure and Certification.
Agency staff is verified by the Licensed Behavioral Health Provider.
Frequency of Verification:
Agency behavioral health license is verified biennially.
Agency staff's qualifications are verified initally and annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Skilled Nursing - Nursing Services by a Licensed Registered Nurse

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

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

Service Definition *(Scope):*
Nursing services listed in the service plan are within the scope of the State's Nurse Practice Act and are provided by a licensed registered nurse licensed to practice in the State. Nursing services are services which only a licensed Registered Nurse (RN) can perform. Nursing services consists of nursing care which can be provided safely in the recipient's residence, day habilitation program, etc. The service must be provided by a registered nurse under the direction of a physician or a licensed practical nurse under the supervision of a registered nurse and under the direction of a physician. Services must be provided within the scope and standards of the West Virginia Nurse Practice Act.
RN Skilled Nursing Services are restricted to those nursing services that are outside the scope and practice of a LPN. If the RN provides a Skilled Nursing service that is within the scope of practice for a LPN, the RN must utilize the LPN code.

A component of Nursing Services by a Licensed Registered Nurse is IPP Planning which includes attending Individual Program Plan meetings to present assessments or evaluations completed for purpose of integrating recommendations, training goals and intervention strategies into the particpant's IPP.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Nursing Services by a Licensed Registered Nurse - 480 units annually.
If the Registered Nurse (RN) provides a skilled nursing service that is within the scope of practice for a Licensed Practical Nurse (LPN), the RN must utilize the LPN code/rate. This is a 1:1 ratio.

IPP Planning - Licensed Registered Nurse is limited to a maximum of 18 units annually.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing - Nursing Services by a Licensed Registered Nurse

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Provider

Provider Qualifications

License *(specify):*

Agency must have a WV Behavioral Health Liense

Agency staff must have a WV Registered Nursing License

Certificate *(specify):*

Other Standard *(specify):*

Agency must be an approved WV Medicaid Provider.

Agency staff must be at least 18 years old, have an approved Criminal Investigation Background check, be able to perform the tasks and meet the mandated requirements of the Office of Health Facility Licensure and Certification.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the Office of Health Facility Licensure and Certification.

Agency staff is verified by the Licensed Behavioral Health Provider.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Agency staff's qualifications are verified initially and annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Speech Therapy

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Speech Therapy is provided directly to the member by 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 adpative aids and devices; consultation or demonstration of techniques with other service providers and family members; participating on the interdisciplinary team, when appropriate, for the development of the plan.
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.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Speech therapy is limited to 1 event per day.
96 units per year for participants below age 24.
48 units per year for participants over age 24.
Speech Therapy services will not duplicate State Medicaid plan services.
WV attests that no duplication of speech therapy service on the MR/DD Waiver and EPSDT services will be permitted and will ensure that each child has access to all services to which he/she is entitled through EPDST.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech Therapy

Provider Category:
Agency
Provider Type:
Licensed Behavioral Health Provider
Provider Qualifications
License *(specify):*
Agency must have a WV Behavioral Health License.
Agency staff must have a speech therapist license.
Certificate *(specify):*
Other Standard *(specify):*
Agency must be an approved WV Medicaid Provider.
Agency staff must be over the age of 18, have an acceptable Criminal Investigation Background check, be able to perform the tasks and meet the mandated requirements of the Office of Health Facility Licensure and Certification
Verification of Provider Qualifications
Entity Responsible for Verification:

Agency is verified by the Office of Health Facility Licensure and Certification.
Agency staff is verified by the Licensed Behavioral Health Provider.
Frequency of Verification:
Agency behavioral health license is verified biennially.
Agency staff's qualifications are verified initally and annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Therapeutic Consultant

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Therapeutic Consultant develops training plans and provides training in the person-specific aspects and method of a plan of intervention or instruction to the primary care providers (i.e., participant centered support workers, facility day habilitation providers and supportive employment providers. Also, the Therapeutic consultant provides training for respite providers (if applicable for “respite-relevant” training objectives or health or safety training objectives only). This service is provided to members with the primary need for adaptive skills training and minimal maladaptive behaviors. The level of maladaptive behavior should only require a plan of intervention such as a behavioral guideline or general response protocol by the primary care providers. The Therapeutic Consultant also provides evaluation/monitoring of the effectiveness of the plan of intervention or instruction. Therapeutic Consultant travels to and from sites to observe individual prior to developing a training plan and to follow up once the plan has been implemented to observe progress, training participant-centered support workers, facility habilitation workers, supported employment workers and respite workers in plan implementation.

Skills/Support Development Functions:
Development of task analysis and person specific strategy or methodology for implementation of intervention or instruction plans for an individual (habilitation plans or staff/caretaker directions/guidelines). Example: How may the staff/caretaker create a successful environment for the person?

Evaluate environment(s) for implementation of the plan which creates the optimal environment for learning. The Therapeutic Consultant should select the most suitable environment for the participant's learning needs. For example, if the participant has an aversion to noisy environments, the Therapeutic Consultant would be aware of this and would steer the participant/team from training in such environments as possible)
Train primary care providers (i.e., participant centered support workers, day habilitation providers, supported employment and respite providers) in person-specific aspects and methods of intervention or instruction plans (habilitation plans or guidelines).
Assessment, evaluation and monitoring of the effectiveness of intervention or instruction plans (habilitation plans or behavioral guidelines) for habilitation training.
Job placement activities with a limit of 20 units per quarter (for members receiving supported employment services only)
Supported employment training
Collect and evaluate data around targeted behaviors to generate a recommendation for a Positive Behavior Support plan.

A component of the Therapeutic Consultant Service is IPP Planning which includes attending Individual Program Plan meetings to present assessments or evaluations completed for purpose of integrating recommendations, training goals and intervention strategies into the particpant's IPP.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Therapeutic Consultant - 960 (15 minute) units annually in combination with positive behavior support professional.

IPP Planning - Therapeutic Consultant is limited to a maximum of 18 units annually.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Consultant

Provider Category:
Agency
Provider Type:
Licensed Behavioral Health Provider
Provider Qualifications
License *(specify):*
Agency must have a WV Behavioral Health License.
Certificate *(specify):*

Other Standard *(specify):*
Agency must be an approved WV Medicaid Provider.
Agency staff must be 18 years old.
Acceptable CIB.
Agency staff must have minimum of bachelors degree in human services field and minimum of two years experience working with MR/DD population.

Verification of Provider Qualifications

Entity Responsible for Verification:
Agency is verified by the Office of Health Facility Licensure and Certification.
Agency staff is verified by the Licensed Behavioral Health Provider.

Frequency of Verification:
Agency Behavioral Health License is verified biennially.
Agency staff's qualifications are verified initally and annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:
Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Transportation services are provided to a MR/DD Waiver participant for mileage or trips to and from services and activities as identified in participant's IPP.

May be billed concurrently with Therapeutic Consultant, Participant Centered Support Services, Respite, Supported Employment and Facility Based Day Habilitation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
GENERAL SERVICE LIMITS:
Participant must be present in vehicle if mileage is billed.
Must be related to an activity or service identified in the IPP.
4 one way trips per day, 874 trips annually provided in an agency-owned and operated 8-passenger or larger van.

TRADITIONAL SERVICE LIMITS:
800 miles per month maximum.
874 trips annually.

PARTICIPANT DIRECTED SERVICE LIMITS:
The amount of transportation provided to a participant directing his/her services must be identified on the individualized program plan and may not exceed the annual participant-directed budget allocation. The annual participant-directed budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the participant's assessed medical, behavioral, training and/or support needs.

Participant Directed transportation must be based upon assessed needs, address identified health and safety issues and be outlined in the participant's individual program plan.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Provider
Individual	Participant-directed Employee

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:
Licensed Behavioral Health Provider
Provider Qualifications

License *(specify):*
Agency must have a WV Behavioral Health License.
Certificate *(specify):*

Other Standard *(specify):*
Agency must be an approved WV Medicaid Provider.
Agency staff must have current CPR and First Aid cards, an acceptable Criminal Investigation Background check, be over the age of 18, valid driver's license, proof of current vehicle insurance and registration, have the ability to perform the tasks and meet the training requirements as mandated by the Office of Health Facility Licensure and Certification.

Verification of Provider Qualifications

Entity Responsible for Verification:
Agency is verified by the Office of Health Facility Licensure and Certification.
Agency staff is verifed by the provider agency.
Frequency of Verification:
Agency behavioral health license is verified biennially.
Agency staff's qualifications are verified at minimum initally and annually.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Individual
Provider Type:
Participant-directed Employee
Provider Qualifications
License *(specify):*
Not applicable as the participant is not required to have a WV Behavioral Health License.
Certificate *(specify):*
Not applicable.
Other Standard *(specify):*
Participant-directed employee must have current CPR and First Aid cards, an acceptable Criminal Investigation Background check, be over the age of 18, have a valid driver's license, proof of current vehicle insurance and registration and have the ability to perform the tasks.
Verification of Provider Qualifications
Entity Responsible for Verification:
The participant-directed employee's qualifications will be verified by the Government Fiscal/Employer Agent.
Frequency of Verification:
The participant-directed employee will be verified at minimum initally and annually.

Appendix C: Participant Services

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

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

- **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - **As an administrative activity.** *Complete item C-1-c.*

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

Appendix C: Participant Services

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

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

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

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

Criminal Investigation Background (CIB) checks are to be conducted by provider agencies and Government F/EA for each direct care staff or any staff providing direct services under all service options (Traditional, Agency with Choice & Government F/EA) prior to service delivery. The CIB check must be at minimum state-wide. Provider agencies and the Government F/EA are required to provide the ASO and OHFLAC evidence of the CIB checks as part of the periodic review of the provider's qualifications.

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

- (●) **No. The State does not conduct abuse registry screening.**
- ( ) **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

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

Appendix C: Participant Services

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

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

- ( ) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- (●) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
MR/DD Waiver Licensed Group Home	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Policy requires providers operating MR/DD Waiver Group Homes to furnish and maintain the homes in a manner that is homelike, personalized and comfortable for the residents and provide full access to typical facilities in a home such as a kitchen with cooking facilities and small dining areas. These facilities must also provide privacy for the participants and allow visitors at times convenient to the individual. The homes must have easy access to resources and activities in the community. Participants living Group Homes have input in the decoration of their own bedrooms and may purchase their own furnishings and other items. All Group Homes are located in communities that include privately owned homes, apartment buildings, businesses, etc.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

MR/DD Waiver Licensed Group Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Goods and Services - Participant - Directed	☑
Electronic Monitoring/Surveillance System and On-Site Response	☑
Physical Therapy	☑
Financial Management Services - Participant-Directed (Agency-with-Choice)	☐
Dietary Therapy	☑
Enviromental Accessibility Adaptations - Home	☐
Crisis Services	☑
Environmental Accessiblity Adaptation - Vehicle	☐
Skilled Nursing - Nursing Services by a Licensed Practical Nurse	☑
Occupational Therapy	☑
Speech Therapy	☑
Supported Employment	☐
Skilled Nursing - Nursing Services by a Licensed Registered Nurse	☑
Respite	☐
Positive Behavior Support Professional	☑
Therapeutic Consultant	☑
Service Coordination	☑
Facility Based Day Habilitation	☐
Transportation	☐
Participant -Centered Support	☑

Facility Capacity Limit:

10

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑

Standard	Topic Addressed
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

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

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

- ○ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ◉ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

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 annually reevaluation of eligibility by the ASO. A representative cannot serve in the dual role as the representative and a paid service provider except in extraordinary circumstances when it is the only appropriate and available option. Identification of these incidences will be incorporated into the IPP which is approved through the IDT process. The most prevalent example of this would be a single parent without natural supports. The rural nature of the state of West Virginia also makes it problematic for behavioral health agencies to recruit appropriate staff. For participants eligible to receive public education services/home schooling/other education alternatives, participant -centered support services cannot exceed an average of 8 hours per day. The legal guardian of an participant who is not eligible for public education services/home schooling/other educational alternatives, is limited to an average of 12 hours per day of participant-centered support services. A spouse is not allowed to provide participant-centered support services. The IDT must approve all services which are monitored by the Service Coordinator through at least monthly home visits. If a Therapeutic Consultant is providing services, then the TC would also be monitoring any training or support services provided by the legally responsible adult. Additionally, all services are prior authorized through the ASO.

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

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

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

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

  Any qualified relative/legal guardian living in the participant's home except for a participant's spouse may provide Traditional - Family participant-centered support services. Any qualified relative/legal guardian except for a participant's spouse may provide respite and/or transportation provided they meet qualifications including acceptable Criminal Investigation Background (CIB) check, current CPR & First Aid certification, and participant-specific training. To ensure that only services rendered are in the best interests of the individual are paid, the type and quantity of services must be identified on the IPP. Respite cannot exceed 1,728 hours annually, transportation cannot exceed 800 miles per month and participant-directed supports cannot exceed 2,920 hours annually for participants eligible to receive public education services/home schooling/other educational alternatives living in natural family/Specialized Family Care settings and 4,380 hours annually for participants not eligible to receive public education services/home schooling/other educational alternatives living in natural family/Specialized Family Care settings or 8,760 hours annually for adults living in Individualized Staffed Settings (ISS). Regardless of residential setting or service limits, the amount of service is limited by the individualized budget.
- **Other policy.**

  Specify:

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

In order to participate in the WV MR/DD Home and Community Based Waiver program, provider agencies must meet the following requirements:
(1) Receive Certificate of Need approval from the WV Health Care Authority and/or Certificate of Need Summary Review Committee designated in WV Code § 9-5-19. The CON Summary process was put into place to expedite applications for providers that are only providing services through the MR/DD Waiver so as not to limit participant's access and choice of service providers. A committe comprised of the BMS MR/DD Waiver Program Manager, the BHHF DD Director and the ASO Waiver management staff.

(2) Meet and maintain all applicable licensing requirements
(3) Obtain a behavioral health license through the Office of Health Facilities and Licensure and Certification (OHFLAC)
(4) Meet and maintain all Bureau for Medical Services requirements including a valid provider agreement on file that is signed by the provider and the Bureau for Medical Services.
(5) Workers and vendors providing services under the participant-directed options, must meet established provider qualificiations as specified in the service description section. The FMS (Agency with Choice and the Government Fiscal/Employer Agent) verifies that qualifications are met.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of MR/DD providers who have an active behavioral health license.
Numerator = # of MR/DD providers who have an active behavioral health license.
Denominator = # of MR/DD providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Office of Health Facilities Licensure Accreditation and Certification (OHFLAC)

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
Number of licensed MR/DD providers who have been monitored/reviewed by OHFLAC and the ASO. Numerator = # of licensed MR/DD providers who have been monitored/reviewed by OHFLAC and the ASO. Denominator = # of licensed MR/DD providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OHFLAC-WV's Behavioral health licensing entity, ASO performance monitoring

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

		Confidence Interval =
☑ **Other** Specify: ASO, Division of Rehabilitation Services	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
Number and percent of agency staff whose Abuse/Neglect training is current. Numerator = # of agency staff whose Abuse/Neglect training is current. Denominator = # of agency staff files reviewed.

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

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

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

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

	☑ **Continuously and Ongoing**	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☑ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: ASO, F/EA vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of agency staff whose First Aid training is current. Numerator = # of agency staff whose First Aid training is current. Denominator = # of agency staff files reviewed.

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

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

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
ASO and F/EA vendor	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of agency staff whose cardiopulmonary resuscitation (CPR) training is current. Numerator = # of agency staff whose cardiopulmonary resuscitation (CPR) training is current. Denominator = # of agency staff files reviewed.

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

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

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

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

☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: ASO and F/EA vendor performance monitoring	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☑ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: ASO and F/EA vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of agency staff files whose Consumer Rights training is current.
Numerator = # of agency staff files whose Consumer Rights training is current.
Denominator = # of agency staff files reviewed.

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
	☐ **Weekly**	☐ **100% Review**

☐ **State Medicaid Agency**		
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: ASO performance monitoring	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☑ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: ASO and F/EA vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of agency staff files whose Infectious Disease Control training is current. Numerator = # of agency staff files whose Infectious Disease Control training is current. Denominator = # of agency staff files reviewed.

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

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

	Specify:	

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☑ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: ASO, F/EA vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measure:
Number and percent of agency staff files whose background check is conducted and returned as satisfactory prior to providing MR/DD services. Numerator = # of agency staff files whose background check is conducted and returned as satisfactory prior to providing MR/DD services. Denominator = # of agency staff files reviewed

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

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

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

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

		☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: ASO and F/EA performance monitoring	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

identifies the means by which they will monitor and track required staff training.

Additionally, OHFLAC verifies provider training requirements. Data collected from their reviews will be shared with the ASO for follow-up, as indicated above.

All evidence relating to this assurance is collected through the review of provider qualifications (Detailed in Appendix H) and reviewed by the Bureau for Medical Services (BMS) and the operating agency. Individual provider qualification issues related to these specific indicators are addressed immediately upon identification by the operating agency. Providers are required to submit corrective action plans addressing identified issues that must be approved by the operating agency.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

○ **No**

◉ **Yes**

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

Sub-assurance B: All currently non-licensed MR/DD Waiver providers will submit application for a Certificate of Need by July 1, 2010. All providers have been seen notice by BMS that they must obtain a Behavioral Health License. BMS, OHFLAC, and the ASO will be monitoring to ensure this occurs. During the mean time, the ASO will conduct Quality and Utilization reviews of all MR/DD agencies, including those that are non-licensed. Non-licensed providers will be held to the same standards of those providers that are currently licensed.

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

○ **Applicable** - The State imposes additional limits on the amount of waiver services.

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Individualized Program Plan

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

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  Specify qualifications:

- ☐ **Social Worker**

  Specify qualifications:

- ☐ **Other**

  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

Participants are informed of Service Coordination (Case Management) providers and have free choice of providers. This information is made available to each participant initially by the independent psychologist contracted by the Medicaical Eligibility Conracted Ageent (MECA) and annually thereafter by an ASO independent assessor. The ASO independent assessor provides the paticipant and/or legal/non-legal representative with the list of all service coordination providers in their catchment area. Participants may choose to receive Service Coordination from a different agency or from the same agency that provides other waiver services to the participant. Participants may change Service Coordination providers at any time.

The Administrative Service Organization (ASO) (1) conducts an independent assessment in collaboration with the participant and/or their legal/non-legal representative that is necessary to complete the participant's individualized waiver budget prior to their Annual Service Plan which will be referred to as the Individual Program Plan (IPP). (2) The ASO at the time of the annual assessment provides the participant and/or their legal/non-legal representative education on the Interdisciplinary Team membership and process, the available services under the waiver program, available provider agencies in the area and general information on the program and the Individualized Waiver Budget. (3) The Individualized Waiver Budget based upon on an objective assessment is developed by the ASO. (4) The ASO makes available the Individualized Waiver Budget to the Service Coordinator (with the results of the individualized assessments of the participant) (5) The Service Coordinator reviews the budget with the IDT team and the team outlines the amount and frequency of the services, goals, and objectives in the IPP. (6) The Service Coordinator notifies the ASO of the specific services(s) and units of service(s) for registration with the claims agent. (7) Once the ASO has registered with claims agent, the ASO will continue to register all services with the claims agent or respond to emergency requests for service changes that require registration with the claims agent (8) The ASO will monitor health and safety as it relates to request for service authorizations (Example: Participant who lives in an Individual Support Setting {1 to 3 person home} and cannot administer his/her own medication yet the IDT does not request nursing nor does the Service Coordinator identify if

the home is provided with certified staff to assist the member with his/her medications).

Service Coordinators may provide direct care services in an emergency situation provided they meet the qualifications and are chosen by the participant's Interdisciplinary Team to provide this service on the participant's IPP. Emergency back-up plans are part of the IPP and must be approved by the IDT. The Service Coordinator may not bill the service coordinator code when they are providing direct service of another type. The ASO and OHFLAC will conduct retrospective reviews of representative samples of participants charts in alternating years to determine correct codes have been billed.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

(a) The supports and information that are made available to the participant and/or their legal/non-legal representative to direct and be actively engaged in the service plan development process is provided by the ASO at the time of the annual assessment that is completed prior to the IPP provides the participant and/or their legal/non-legal representative education on Person Centered Planning, the Interdisciplinary Team (IDT) membership and the team's role in the development of the IPP. At minimum, the composition of the IDT must consist of the participant and/or their legal/non-legal representative, service coordinator and representatives of all agencies/providers who provide services to the individual. The IDT team meeting is a process by which the service coordination works in collaboration with the participant and/or their legal/non-legal representative to develop the person centered Individualized Program Plan (IPP).

(b) The participant and/or their legal/non-legal representative has the authority to determine who is included in the process. The participant and/or their legal/non-legal representative has the authority to determine the membership of his/her IDT beyond the required membership. It is recognized that any individual who is part of the team is very important, therefore, attendance at the IDT meeting is extremely important. The IDT meeting attendance is a responsibility of each of the team members.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

a. 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 persons with developmental disabilities. The IDT process is designed to ensure accessibility, accountability, and continuity of support and services. The IDT process also ensures that persons with mental retardation/developmental disabilities have 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. The development of the IPP is the process by which the participant and/or their legal/non-legal represenative, with the assistance of his/her Interdisciplinary Team (IDT), develops a plan based on a person centered philosophy. The IDT is comprised of the participant and his or her "Circle of Support". The circle of support may include the Service Coordinator, professionals, direct care providers, family members, legal/non-legal representatives, and significant individuals in the member's life with a vested interest in the member. At minimum, the IDT consist of the participant, their legal/non legal representative as applicable, service coordinator and representative of all agencies/providers who provide services to the participant. Other members must be included, as necessary, to develop a comprehensive plan and to assist the participant. Such members of the team may include Physician, Registered Nurse, Physical Therapist, Occupational Therapist, Speech Therapist, Registered Dietitian, Social Worker and natural supports.

The content of the IPP must be guided by the participant's needs, wishes, desires, and goals. The team, which includes the

participant, 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, outlines of service options and training goals, and preparation of interventions or strategies necessary to implement a person centered plan. The Service Coordinator assumes the role of Facilitator and Coordinator for the meeting; however, the team is directed by the participant utilizing a person centered approach to planning. IPP development occurs when the participant is present. 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).

Three professionals (Therapeutic Consultant, Positive Behavior Support Professional and Registered Nurse) may bill IPP Planning Codes for participating in the IPP. This code is used for face-to-face participation in IPP meetings. The service does not include reviews of data or information prior to the meeting, notification of team meetings, drafts of strategies or interventions, or distribution of the IPP outside the team meeting. In order to bill this code, the TC, RN, PBSP and service Coordinator must attend the entire meeting. The meeting attendance sheet is a component of the IPP and all team members must sign and indicate start and stop times. This document is reviewed as part of the provider review process in order to verify attendance and appropriateness of billing. All other members who attend the IPP must bill their regular codes for IPP Meeting participation.

b. The Service Coordinator will coordinate evaluations annually 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, Nutritional, Nursing Evaluations in addition to an Independently completed Annual Functional Assessment.

c. The ASO at the time of the annual assessment provides the participant and/or their legal/non-legal representative education on the available services under the waiver program and available provider agencies in their geographic area, which would include completion of the Freedom of Choice documention. A manual is also made available to each participant that contains the services offered under the waiver program.

d. The IDT must be based upon person centered philosophy. The development of the IPP by the IDT must be guided by the participant'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 participant, his/her legal/non-legal representative, professional, direct care providers, and if desired by the participant significant other individuals in with a vested interest in the participant's life. The Service Coordinator has the responsibility for ensuring that the participant'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 ASO will monitor health and safety as it relates to request for service authorizations and assure that service needs are addressed through individual service requests.

The Service Coordinator must have a Bachelors Degree in a human services field with one or more years experience in the MR/DD field.

e. The IPP specifies services needed by the participant 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 days. The Service Coordinator is responsible for ensuring that service providers implement the content of the IPP.

f. The IPP format specifically addresses the service, frequency of the service, and the responsible party for delivering the services. The Service Coordinator is required to meet the participant at a minimum of monthly at his/her residence to personally meet the individual and service providers to verify that services are being delivered in accordance with the IPP in a safe environment. Visits with the individual, his/her family and/or legal/non-legal representative will be used by the Service Coordinator to update progress towards obtaining services and resources and discuss progress towards achieving objectives contained in the IPP. The Service Coordinator will also elicit information from the member, his/her family and/or legal/non-legal representative on their assessment of services, achievements, and/or unmet needs.

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 as warranted). The IPP is to be developed on an annual basis. Minimally, the annual IPP must be reviewed at a six month interval. IPP reviews may occur more often if needed. The IDT is also required to convene (1) an initial seven (7) Day IDT. This meeting is a mandatory meeting when a member first receives agency or Medicaid Services through the waiver program. (2) Thirty (30) Day IDT Meeting must be finalized within thirty days (30) days of being admitted to the waiver program. (3) Transitional IDT Meeting is a mandatory meeting when a participant is having a change among services or service providers. (Example: a change in where the participant lives, when a new service is being added or deleted or a change is being requested for a service provider). (4) The IPP must also be reviewed at critical junctures. A critical juncture occurs when a participant is experiencing a crisis (example: behavioral, medical, housing and service provision). 5) Crisis IDT meeting occurs when a participant is experiencing a crisis (example: behavioral, medical, housing and service

provision).

h. The IPP outlines who will be responsible for each lan activity (both paid and natural supports). The SC is responsible for monitoring service delivery to ensure these individuals are carrying out that role as planned. The IPP is an all inclusive plan and identifies services provided to the participant through other state and Federal programs as well as community-based natural supports.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Risks are assessed at the time of the IPP development utilizing annual functional assessments conducted by the ASO. The IPP requires a detailed description of the contingency plans that are to be implemented in case of an emergency. Per WV waiver policy, each IPP must have a contingency plan for emergencies (i.e. primary caretaker in the family becomes incapacitated, power outages, inclement weather, natural disasters and healthcare epidemics such as the flu). Each provider will have a crisis plan to address the failure of staff to appear when scheduled to provide necessary services when the absence of the service would present a risk to the participant's health and welfare. The crisis plans are developed by the service coordinator or the therapeutic consultant which must incorporate recommendations from other professionals on the team. Staff issues are the most common need for crisis planning and natural supports are the first consideration. If these are not available, then the crisis plan must address alternative paid supports. Crisis plans must address alternative housing when needed due to floods, power outages, severe weather, etc.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

At the time of the intital medical eligibility determination, the independent psychologist contracted by the MECA will provide a list of available waiver providers in the participant's geographic area. At the time of the annual assessment, the ASO provides the participant and/or their legal/non-legal representative education on Person Centered Planning, the Interdisciplinary Team membership and process, the available services under the waiver program, available provider agencies in the area and general information on the program and the Individualized Waiver Budget. The Service Coordinator will be able to provide a listing of available qualified providers to the participant and their IDT members. The MECA, the ASO and the Service Coordinator inform the member/legal guardians of thei right to choose provider agency/agencies. Many members currently receive services from multiple provider agencies. Selection of a provider or providers is a significant component of the IPP process. For example, a participant may choose to receive Service Coordination from Agency A, Participant-Centered Supports from Agency B and Facility-Based Day Habilitation from Agency C. At this time, all available providers are invited to send a representative to the IPP to describe the services they have available so that the individual/legal guardians can make an informed choice of providers.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

There are specific requirements of who must participate in the IDT which is the designated entity for formulating the IPP. The IPP must include the signature of all participants of the IPP meeting, date of the meeting and the total time spent in the meeting for each team member. A copy of the IPP will be maintained in all participating provider agency records and distributed to all team members. A copy of the IPP will be distributed by the Service Coordinator to all team members within fourteen days. The Service Coordinator has the responsibility for ensuring the implementation of services as indicated on the IPP. As a part of the Quality Improvement System, staff of the ASO will review a representative sample of IPPs.

Retroactive reviews are conducted by the ASO as well as OHFLAC in alternate years. These reviews include comprehensive evaluation of IPP's to ensure the individual's needs are addrssed and meet all policy requirements. By year 2 of the waiver, the IPP document will be incorporated into the ASO's web-based software application. It will be mandatory that service coordinators submit the electronic IPP document within established timelines. The electronic document will ensure that all required data is included in the IPP and will allow the ASO to monitor compliance with 100% sample.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

- ○ **Every three months or more frequently when necessary**
- ◉ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

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

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☑ **Other**

Specify:

Each licensed entity that provides services are required to maintain a copy of the service plan for a minimum of three years. For those individuals participating in the self directed option, the participant will also be required to maintain a copy in the home for a minimum of three years.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The Service Coordinator is required to meet the participant at his/her home at least monthly regardless of the service delivery options chosen by the participant. The primary purpose of this face-to-face meeting is to verify that services are being delivered in accordance with the IPP in a safe environment. Information obtained through these visits with the individual, his/her family and/or legal/non-legal representative will be used by the Service Coordinator to update progress towards obtaining services and resources and discuss progress towards achieving objectives outlined in the IPP. The Service Coordinator will also elicit information from the participant, his/her family and/or their legal/non-legal representative on their assessment of services, achievements, and/or unmet needs. The Service Coordinator will also evaluate the effectiveness of back-up plans for staffing needs and emergency circumstances.

Any concern related to member health and safety must be reported through the WV Incident Management System (IMS). The ASO will review a representative sample of service plans at a minimum biennially to monitor compliance and identify systemic problems/trends.

During the yearly assessment conducted by the ASO, each participant is informed of his/her right to choose service providers as well as services and service delivery options. The participant's choices are documented on the Freedom of Choice form which is made available to the participant's Interdisciplinary Team. It is the responsibility of the service coordinator to evaluate at the

time of monthly home visit that services being delivered are meeting the participant's needs, including their health and welfare. IPP's are to indicate non-waiver service that meet the participant's identified needs.

During the retroactive reviews, the ASO and OHFLAC also evaluate the IPP and its implementation to ensure the participant is exercising their choice of services, providers and that needs are being met. Identified problems are addressed in the written retroactive report. The service provider must provide a plan of correction and demonstrate implementation of not only the specific issue, but also the systemic issue and a means to prevent reoccurrence.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The Service Coordinator 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, Agency with Choice and Government F/EA). These responsibilities allow the Service Coordinator to monitor the health and welfare of the participant. There is an additional health and welfare safeguard through the ASO which conducts provider reviews at a minimum biennially.

The ASO 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 ASO will monitor health and welfare as it relates to requests for service authorizations.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Number and percent of participant records reviewed whose IPP reflects identified health and safety needs. Numerator = # of participant records reviewed whose IPP reflects identified health and safety needs. Denominator = # of participant records reviewed.

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participant records reviewed whose IPP reflects identified personal goals. Numerator = # of participant records reviewed whose IPP reflects identified personal goals. Denominator = # of participant records reviewed.

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

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

	☐ **Other** Specify:	

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

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

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

Performance Measure:
Number and percent of participant records reviewed whose Individual Program Plan is current. Numerator = # of participant records reviewed whose Individual Program Plan is current. Denominator = # of participant records reviewed.

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participant records reviewed whose IPP was signed by the participant and/or the legal representative. Numerator = # of participant records reviewed

whose IPP was signed by the participant and/or the legal representative. Denominator = # of participant records reviewed.

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

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

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

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

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

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

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

Performance Measure:
Number and percent of participant records reviewed whose IPP was updated at least every six months. Numerator = # of participant records reviewed whose IPP was updated at least every six months. Denominator = # of participant records reviewed.

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants who utilized 80% to 120% of services indicated on the IPP. Numerator = # of participants who utilized 80% to 120% of services indicated on the IPP. Denominator = # of MR/DD program participants.

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: ASO and claims vendor performance monitoring	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants with a current/signed Freedom of Choice form. Numerator - # of participants with a current/signed Freedom of Choice form. Denominator = # of MR/DD program participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ASO performance monitoring

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

☑ **Other** Specify: ASO performance monitoring	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

All information relating to this assurance is collected by the operating agency through the review of member 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.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: ASO	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

- ◉ **No**
- ○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability*(from Application Section 3, Components of the Waiver Request)*:

- ◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Please see section Main 8 B for the Description of Participant Direction in its entirety.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☑ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

1. All Waiver enrollees will receive information about participant direction and afforded a number of opportunities to receive information about the new option. Avenues to obtain this information include: The initial eligibility determination by the MECA, the education component of the annual reassessment by the ASO, and the Service Coordinator's routine home visits.

2. Participants and legal/non-legal representatives will receive information about both traditional and participant-directed service opportunities during their Educational component conducted by the ASO during their Annual Budgetary Assessment's educational component. The educational component will provide participants and their legal/non-legal representatives with information on participant-directed services; FMS options; the roles, responsibilities of and potential liabilities for each of the key stakeholders related to the delivery and receipt of participant-directed services (i.e., participant, legal/non-legal representative, Government F/EA FMS and subagent, ASO, SC, BMS); and traditional service options available to them in order to inform their decision-making concerning the election of participant-directed services. It also will provide information on all service providers, including those entities that provide the two types of FMS (Government F/EA and AwC FMS), and contact information.

3. Participants and legal/non-legal representatives will have the opportunity to receive Information and Assistance (I&A) services, similar to those provided during the educational component in their Annual Budgetary Assessment. These educational sessions will be offered to participants/legal/non-legal representatives statewide on a biannual basis. The information provided will be identical to that provided during the educational component so that participants and legal/non-legal representatives who are considering using participant-directed services after his/her Annual Budgetary Assessment is completed can get the information necessary to make an informed decision about electing to use participant-directed and FMS services.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

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

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A participant may select a non-legal representative to assist with directing the participant's services including being either the common law employer or managing employer of the participant's qualified support workers depending on the FMS model used. If a non-legal representative is selected, that individual may not be paid for providing participant-directed services or be an agency employee who may be providing any MR/DD waiver service to the participant unless it is an immediate family member which would be a biological or adoptive parent; biological, half-, step- or adoptive sibling; biological or adoptive grandparent; biological or adoptive aunt/uncle; or specialized family care provider. The selected non-legal representative is:

• restricted to acting on the participant's behalf and in a manner that reflects the participant's wishes to the extent possible;
• must attend and participate in scheduled Interdisciplinary Team meetings for the participant;
• must complete and sign a Non-legal Representative Designation Form; and
• must complete the agreed upon non-legal representative's tasks.

The participant's Interdisciplinary Team must ensure that the non-legal representative is acting in the best interest of the participant. A Service Coordinator or Government F/EA FMS provider staff person may submit a complaint with the ASO office to review the non-legal representative's ability to act in the best interest of the participant. They also must report to the ASO any exploitation of the participant-directed option for the legal or non-legal representative's benefit rather than the participant's.

The Interdisciplinary Team and/or the ASO staff have the right to terminate the assistance and support provided to the

participant by a non-legal representative in directing their services at any time with documented evidence of abuse, neglect and exploitation of the participant.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Goods and Services - Participant - Directed	☐	☑
Respite	☑	☑
Transportation	☑	☑
Participant -Centered Support	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

☑ **Governmental entities**
☐ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

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

The waiver service entitled:

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

Provide the following information

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

The Government F/EA FMS used is the WV Bureau for Medical Services and the subagent it delegates agent tasks to is procured through a Request for Proposal process and the execution of a contractual agreement with BMS. The Government F/EA FMS and subagent operates under §3504 of the IRS code, Revenue Procedure 80-4 and Proposed Notice 2003-70, applicable state and local labor, employment tax and workers' compensation insurance and Medicaid program rules, as required. Agency with Choice (AwC) FMS will be provided by Behavioral Health providers procured

through a state Medicaid provider agreement with an AwC FMS addendum and through the successful completion of an AwC FMS Provider Self Assessment. See Appendix E-1(a) for more details on the AwC FMS option.

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

The Government Fiscal/Employer Agent (F/EA) is compensated through an administrative fee established by a competitive procurement (RFP) on a per participant/per month basis. The Agency with Choice (AwC) is a compensated service on a per participant/per month basis established by the Bureau for Medical Services.

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

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

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [ ] **Other**

Specify:

Supports furnished when the participant exercises budget authority:

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

Specify:

Additional functions/activities:

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

Specify:

Provide Information and Assistance (I&A) services related to participant/legal/non-legal representative orientation and skills training.

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

BMS has executed a contractual agreement with the Government F/EA FMS' subagent that was selected through a Request for Proposal process. The contractual agreement identifies the role and responsibilities of the Government F/EA FMS' sub agent and tasks to be performed. The contractual agreement outlined the specific requirements for the entity to successfully complete a Readiness Review prior to being approved by BMS to perform as the subagent to the

Government F/EA FMS provider. The contract stipulates the oversight methodologies to be implemented by BMS to ensure fiscal responsibility and accountability is achieved by the Government F/EA FMS' subagent. These methods include, but are not limited to, the collection and processing of timesheets, the disbursement of payments, completing proper withholdings from pay, reporting withholdings as required by federal and state laws, generating statements for each participant's budget authorization, distributing annual participant satisfaction surveys and completing end of year tax processing. BMS will complete an annual review of the fiscal integrity of the government F/EA FMS and review the satisfaction survey results which will be collected by the ASO.
If BMS finds that the Government F/EA FMS provider is not meeting the requirements agreed upon, it may recommend the following options:
• Provide a letter of recommendation to the Government F/EA FMS for passing their review and permit the contract to continue;
• Provide a letter of completion to the Government F/EA FMS for completing their review with technical assistance being provided;
• Require a POC be completed while continuing to provide Government F/EA FMS services;
• Require a POC be completed, as well as, disallowances of noted FMS administrative reimbursements due to review findings;
• Require a POC to be completed with all FMS administrative reimbursements being suspended until all identified deficits have been corrected;
• Generate notice to discontinue contract initiate transfer support to participants using the government F/EA FMS provider.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

See section Main 8 B for Case Management Activity in its entirety.

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Goods and Services - Participant - Directed	☐
Electronic Monitoring/Surveillance System and On-Site Response	☐
Physical Therapy	☐
Financial Management Services - Participant-Directed (Agency-with-Choice)	☐
Dietary Therapy	☐
Enviromental Accessibility Adaptations - Home	☐
Crisis Services	☐
Environmental Accessiblity Adaptation - Vehicle	☐
Skilled Nursing - Nursing Services by a Licensed Practical Nurse	☐
Occupational Therapy	☐
Speech Therapy	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
	☐
Supported Employment	☐
Skilled Nursing - Nursing Services by a Licensed Registered Nurse	☐
Respite	☐
Positive Behavior Support Professional	☐
Therapeutic Consultant	☐
Service Coordination	☑
Facility Based Day Habilitation	☐
Transportation	☐
Participant -Centered Support	☐

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

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

The Government F/EA FMS' subagent will provide I&A supports to participants/legal/non-legal representatives. The educational presentations will provide interested participants and legal/non-legal representatives with information on the role and responsibilities of the Government F/EA FMS, its subagent and each of the other key stakeholders (i.e., participant, legal/non legal representative, qualified support worker, direct service providers and vendors of individual-directed goods and services and BM) and what it is required of the participant and./or legal/nonlegal representative to be the common law employer of his or her qualified support worker(s). These presentations also will provide the venue through which an MR/DD Waiver participant may enroll in the participant-directed option. The Government F/EA FMS' subagent will make available I&A supports to participants and legal/non-legal representatives, to implement and support their use of participant-directed services and performing as the common law employer.

If the Government F/EA FMS option is selected by the participant/legal/non-legal representative, the Government F/EA FMS' subagent, rather than the SC will provide I&A service that will include:

1. Providing or linking individuals with program materials in a format that they can use and understand.
2. Providing and assisting with the completion of enrollment packets for participants and/or legal/non-legal representatives.
3. Providing and assisting the participant/legal/non-legal representative with employment packets.
4. Discussing and/or helping determine the participant-directed budget with the participant/representative.
5. Presenting the participant/legal/non-legal representative with their role in regards to payment for services, goods, etc.
6. Assisting individual to determine participant-directed budget expenditures (hiring, or purchasing participant directed goods and services).
7. Providing participants and legal/non-legal representatives with list of approved purchases or criteria for selection of participant directed goods and services.
8. Assisting with the development of the participant-directed budget and any related purchasing/spending plan.
9. Providing a list of complaints or concerns to ASO to review related to non-legal representative's ability to perform the required tasks to participant in the Participant-directed service option or acting in best interest of the participant.
10. Providing additional oversight to legal or non-legal representative as requested or needed.
11. Monitoring and reporting information about over/under expenditures identified by the Government F/EA FMS'subagent to the SC and the ASO.

I&A support costs incurred by the ASO and Government F/EA FMS' subagent will be reimbursed as administrative costs included in their contractual agreements. BMS will evaluate the processes of the ASO and the Government F/EA FMS' subagent annually through the Participant/Legal/Non legal Representative Survey process.

The AwC FMS providers will provide I&A supports and bill Medicaid using their administrative service code. The I&A

supports will be provided by the AwC FMS provider's designated contact person. The participant/legal/non-legal representative will be provided I&A supports in order to make an informed choice to use the AwC FMS option and outline the participant's/ legal/nonlegal representative's roles and responsibilities as the managing employer, and information on their option to choose the level of participation they are able and willing to engage in. Additional I&A will be provided once the participant enrolls with the AwC FMS provider to assist him or her with the selection and referral of qualified support workers and their training, supervision and discharge from the work site.

BMS will evaluate the satisfaction of participants/representatives with theI&A provided by the AwC FMS provider(s) through the Participant/Legal/Non-legal Representative Survey process. The survey will be conducted 90 days after enrollment and annually thereafter.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Voluntary termination may be completed at any regularly scheduled Interdisciplinary Team meeting or a critical juncture meeting. This transition plan will identify the supports required by the participant, how the supports will be delivered and who will become responsible for the delivery of supports. The participant or representative will develop the transition plan with their Team (whose composition varies due to the participant's choice and needs). The transition plan, with timelines identifying all services, must be approved by the participant's Team members. The Service Coordinator (SC) will be responsible for the submission of authorizations in completing the transition. All voluntary terminations will require notification to the ASO for monitoring and reporting requirements. The reporting of terminations by the SC to the ASO, must include the dates of implementation and completion of transition for the individual. This process is the same for participants using either the Government F/EA FMS or AwC model.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

The Service Coordinator (SC), Government F/EA FMS' subagent or AwC FMS provider staff must develop a report to the ASO outlining concerns regarding the participant's continuance in the participant-directed option. Issues such as the verification of Medicaid fraud, inability to maintain safe staffing supports, inability to keep the spending plan within the budget would require the SC and/or Government F/EA FMS or AwC FMS staff to notify the ASO to review any participant for involuntary removal from the participant-directed option. An additional concern that may be reported is the exploitation of the participant-directed option for the legal or non-legal representative's benefit rather than the participant's benefit. This would be reported to the ASO and any involved advocacy program's representative, as well as, any other agency that requires mandatory reporting of suspected abuse and/or neglect.

An immediate notification of the lack of health and safety oversight must be reported to the ASO if the following is not identified in the participant's Individual Program Plan (IPP). Each individual in participant-direction must have emergency and contingency plans developed within their IPP. These plans must address the issues of weather related staffing and transportation issues, natural disaster effects to their support system, illness/epidemic/pandemic effects to supports and the back-ups for each situation. All paid and natural supports must be outlined in each participant's IPP. The service coordinator provider is responsible for the oversight of program implementation, health, safety and welfare of each participant.

The SCs/Government F/EA FMS' subagent or AwC FMS staff will report to the ASO any concerns regarding unreported abuse or neglect by staff..

The Service Coordinator will ensure that no break in vital services will occur and that a timely revision of the IPP occurs.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		2990
Year 2		2990
Year 3		2990
Year 4		2990
Year 5		2990

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

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

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☑ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

AwC providers reflected as outlined in E-1-a.

Agencies that will be functioning as the co-employer (Agency with Choice - AwC) will be provider agencies who are Licensed Behavioral Health Agencies. These agencies are certified by the Office of Health Facility and Licensure through the Certificate of Need (CON) process and successfully passing a self assessment submitted to the Bureau of Medical Services. Supports are available from the AwC in conducting employer-related functions.

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- [x] **Recruit staff**
- [x] **Refer staff to agency for hiring (co-employer)**
- [ ] **Select staff from worker registry**
- [x] **Hire staff common law employer**
- [x] **Verify staff qualifications**
- [x] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

These costs will be incurred by the Government F/EA sub-agent or the AwC agency provider as a portion of their reimbursement to perform the specified tasks.

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [ ] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

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

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

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

The Participant-Directed Budget is based on the standardized assessment of the individual electing the participant-directed option. Only participant-directed services (participant-centered support, respite, transportation and participant-directed Goods and Services) will be considered in the participant directed budget and will not include the costs of the Traditional Services. Participant-Directed services will be monetized based on the amount, duration and frequency established in the standardized assessment process to meet the specific need ONCE THE COST OF TRADITIONAL SERVICES HAVE BEEN DEDUCTED .

FMS is a waiver service through Agency with Choice.

FMS through Government Fiscal Employer Agent is a flat fee for an administrative service.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The Service Coordinator reviews with participant and/or their legal/non-legal representative, the budget that is calculated for the services during the initial phase of the assessment for services and thereafter with the participant and/or their legal/non-legal representative on a monthly basis. These monthly meetings will review the participant's budget and will inform and familiarize the participant and/or their legal/non-legal representative with the services considered in the budget, expenditures to support these services and projected services and expenditures for the future. At any time, a participant may contact the service coordinator to request modification of the asssessment if a change in need is indicated.

If the request to adjust the budget is denied or if a budget is reduced, the participant and/or their legal/non-legal representative may request a review of the assessment data that was used to determine the individualized budget by the ASO. If this review results in no adjustments to the data and therefore, no adjustments to the budget, then the IDT will convene to develop the plan and request services necessary to carry out the plan. These services and their cost(s) will be submitted to the ASO and identify the gap between the budget amount and the cost for needed services. Services are evaluated by the ASO for necessity and if determined appropriate, the budget will be negotiated accordingly. If it is determined by the ASO that the requested service(s) are not necessary, the service (s) will be denied and the participant will be afforded the opportunity for a Medicaid Fair Hearing to appeal the denial.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility.*Select one*:

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

The Participant-Directed Budget may be changed if the changes are consistent with the participant's IPP and do not exceed the specified dollar value of the Participant-Directed Budget. If the changes are not consistent with the IPP, the participants may request a modification to the IPP. The participant will then work with their service coordinator to develop a modified IPP that is mutually agreed upon and approved. The FMS is notified of such changes by the service coordinator.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The FMS, both the AwC and the Government F/EA, may not make payment on invoices or payment for staff timesheets unless the Participant-Directed Budget has adequate funds to cover the cost and the requested reimbursements have been included in the Participant-Directed Budget. The FMS will notify the service coordinator in instances where over use or under use is identified. The service coordinator will contact the participant and/or their legal/non-legal representative to determine reasons for over use or under use and take appropriate action. Such action may include modifying the Participant-Directed Budget, recommending the appointment of an legal or non-legal representative, providing additional participant training or increasing the level of oversight.

The FMS will generate a monthly state of expenditures and balances to the participant and/or their legal/non-legal representative and the service coordinator.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

MR/DD Waiver participants and their legal representatives and their chosen Service Coordinators are notified in writing by the ASO of their fair hearing rights when:
1) they do not meet financial and/or medical eligibility requirements for ICF/MR level of care on initial assessment and/or reevaluation assessment, or
2) they have been denied a service or the requested amount of the service has not been approved.
3) reduction of service(s)

Participants/legal representatives choosing to implement their Fair Hearing options may complete the "Request for Fair Hearing" form. This form is made available to the participant/legal representative by the ASO at the time of the denial of eligibility or service authorization or by the Service Coordinator upon disagreement with an Individual Program Plan.

Upon application, the participant is provided with information regarding Medicaid Fair Hearings by the service coordination agency. Once a participant is determined eligible and are enrolled in the MR/DD Waiver Program, the ASO will schedule and conduct a

functional assessment during which education is provided about the Fair Hearing Process.

If a participant files a request for a Medicaid Fair Hearing, the ASO's Consumer and Family Educator contacts the participant/legal/non-legal representative to notify them that services can continue throughout the appeal process.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.***Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

The ASO is responsible for the operation of the grievance/complaint system. Newly enrolled participants are oriented to the program by the ASO. This orientation includes information regarding the participant's rights including the Fair Hearing process. As per policy if the participant requests a Fair Hearing within an established time frame, the services or the existing IPP may continue until the date of the hearing outcome. This same information is reviewed with each participant annually by the ASO at the time of the individualized assessment. This information is also shared with any participant for whom eligibility has been denied or a service or a specific amount of service has been denied.

The participant is informed that filing a grievance or making a complaint is not a pre-requisite or substitute for a Fair Hearing.

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

Participants/legal representatives may register complaints/grievances and/or appeals regarding (1) Individual Program Plan (IPP); (2) the authorization of services; and (3) eligibility decisions.

Participants are educated by MECA at the time of the initial medical eligibility assessment regarding their rights to file a grievance and appeal and the opportunity for a Medicaid Fair Hearing. This education is performed for active participants annually by the ASO at the time of the functional reassessment. Additionally, each provider agency is required to have a grievance policy per OHFLAC regulations. It is the Service Coordinator's responsibility to educate the participant and/or legal representative on the agency's grievance policy and procedures. The education provided to the participants/legal guardians by both the ASO and the Service Coordinators address the right to Medicaid Fair Hearing and that it is not necessary to first file a

complaint/grievance before requesting a Medicaid Fair Hearing. The participant is informed that filing a grievance or making a complaint is not a pre-requisite or substitute for a Fair Hearing.The education provided to the participants/legal guardians by both the ASO and the Service Coordinators address the right to Medicaid Fair Hearing and that it is not necessary to first file a complaint/grievance before requesting a Medicaid Fair Hearing.

Individual Program Plan Complaints/Grievances/Appeals:
Each MR/DD Waiver provider must have a policy that allows participants/legal representatives the opportunity to file a formal grievance/complaint. This policy must also indicate that participants/legal representatives have the right to by-pass the typical complaint/grievance process and directly file a request for a Medicaid Fair Hearing. Participants/legal representatives who are not satisfied with the outcome of the provider agency's follow-up to the grievance/complaint may further appeal in writing to the ASO within 5 working days of written notification of the decision from the provider agency. The ASO will review the grievance/complaint, the relevant documentation and the written decision from the provider agency to determine whether the grievance/complaint was fully researched and addressed. The ASO issues a response within 10 calendar days of receipt of the grievance request. The response is provided in writing to the participant/legal representative and the provider agency. At this time the participant/legal representative will be provided a "Request for Fair Hearing" form and will be contacted by the ASO's Participant & Family Liaison who will offer assistance in filing an appeal for a fair hearing.

Service Appeals:
Service(s) requested by the Service Coordinator on behalf of the participant/legal representative and IDT must be reviewed and prior authorized by the ASO. If the type or amount of service requested does not appear to be appropriate, the ASO issues a response to the Service Coordinator indicating the need for further documentation to process the request. If this requested information is not submitted or if the information does not justify the request, the request for service will be closed. This marks the end of 1st level negotiation.

The Service Coordinator on behalf of the participant/legal representative and IDT may make a second request for the service(s) and may submit additional documentation to justify the request. This request will be reviewed by a second ASO manager/specialist/medical professional who will determine the appropriateness of the ASO's level 1 decision. If the original decision is upheld, the request is denied and this marks the end of the 2nd level negotiation. A notice of decision letter is mailed to the participant/legal representative and the service provider. The participant/legal representative will be provided a "Request for Fair Hearing" form and will be contacted by the ASO's Participant & Family Liaison who will offer assistance in filing an appeal for a fair hearing.

Eligibility/Re-eligibility Determination Appeals:

If a participant is determined not to be medically eligible by the MECA a Notice of Decision and a Request for Hearing form will be issued to the participant/legal representative. The ASO will be notified, and the Participant & Family Liaison will contact the participant/legal representative to offer assistance in completing the Fair Hearing forms.

The participant/legal representative has ninety (90) days to request a hearing after a Notice of Decision regarding eligibility has been received. Any participant or authorized legal representative may request a hearing and must do so either by a written request or by using the “Request for Hearing” form. When the participant requests a hearing, the participant has 13 days to submit a request to the ASO to continue services. If services are terminated by the MECA and a hearing is requested, services will continue until a hearing decision is rendered. If a participant wishes to appeal a decision they must submit the request for a hearing or pre-hearing conference within 13 days of receipt of the “Notice of Decision” to continue to receive services in the interim. When a participant chooses to petition the appellate court following the final appeal decision on an MR/DD Waiver hearing, services are not continued while petitioning the appellate court. Upon notice of denial, the Service Coordinator must arrange for an emergency IDT meeting to develop a “back-up” plan for transition. If the decision regarding eligibility for the program is upheld by the hearing officer, on the date of the hearing decision, services under the MR/DD Waiver Program will cease.

For existing participants whose eligibility was denied during re-evaluation, the Service Coordinator must arrange for an emergency IDT meeting to develop a “back-up” plan for transition. If the participant is eligible financially for Medicaid services without the MR/DD Waiver program, other services may be available for the participant.

Any participant who requests a fair hearing shall be entitled to a final administrative action within ninety (90) days of the date of the request for hearing, unless the applicant waives his or her request for a final administrative action within ninety (90) days. If the participant was denied MR/DD Waiver Program services, the participant shall have the right to a second medical eligibility determination at the expense of the WV DHHR. Any additional documents pertinent to the condition affecting eligibility must be submitted 10 working days prior to the hearing. The participant shall have the right to access their waiver application file and copies shall be provided free of charge by MECA.

If the decision regarding eligibility for the program is reversed by the hearing officer, the person is eligible for enrollment into the program on the date/time of the written hearing provided a slot is available.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

• Allegation of abuse, neglect, or exploitation - must be reported to Adult Protective Services (APS) for participants over the age of 18 or Child Protective Services (CPS) for participants under the age of 18.
• Critical incident - a high likelihood of producing real or potential harm to the health and welfare of the member.
• Simple incident - unusual events occurring to a member that cannot be characterized as a critical incident and does not meet the level of abuse or neglect.

The Provider Director or designated staff will immediately review each Incident Report and determine whether the incident warrants a thorough investigation. Investigations must be initiated within twenty-four (24) hours of learning of the incident. An Incident Report must be entered into the WV IMS within fourteen (14) calendar days of the incident.
At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the provider shall immediately notify Adult Protective Services or Child Protective Services as mandated by state code.
A provider is responsible to investigate all incidents, including those reported to APS and CPS.

Providers are required to regularly review and analyze incident reports to identify health and safety trends. Identified health and safety concerns and remediation strategies must be incorporated into the provider's quality management plan.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

A brochure that defines abuse, neglect and exploitation and how to notify the appropriate authorities is provided by the Medical Eligibility Contracted Agent (MECA) to all applicants (or legal representative) at their initial assessment and by the Administrative Services Organization (ASO) to all active participants (or legal representative) at their annual reassessment.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

MR/DD Waiver Provider Directors (or designated staff) must immediately review each Incident Report and determine whether the incident warrants an investigation. Investigations are required to be initiated within twenty-four (24) hours of the provider learning of the incident. An Incident Report must be entered into the WV Incident Management System (IMS) within fourteen (14) calendar days of the incident.

At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the provider shall immediately notify Adult or Child Protective Services (APS/CPS) as mandated by State Code. Members/legal representatives may request to review APS/CPS investigation findings at any time. MR/DD Waiver providers are responsible for investigating all incidents, including those reported to APS. Per policy, when there has been an allegation of abuse, neglect or exploitation, providers must 1) Take immediate necessary steps to ensure the health and safety of the participant while investigating the incident 2) Revise the participant's Individual Program Plan (IPP) if necessary to implement additional supports, and 3) Implement necessary system's changes including additional staff training as a proactive means of preventing future incidents.

Service Coordinators are required to meet with participants at least monthly. At this meeting, the Service Coordinator is required to summarize incidents that have occurred since the previous monthly visit. Upon request, the participant/legal representative may request a printout of his/her incidents reported via IMS.
Providers are required to review periodically their incident data to identify and address systemic issues and concerns.

The ASO monitors provider incidents in real time via the WV IMS and generates a monthly summary of incident data. This summary is reviewed by the Bureau for Medical Services (BMS) the regular MR/DD Waiver Contract Management meetings. Quarterly reports are also developed to be reviewed by the MR/DD Waiver QA/QI Advisory Council.

The provider agencies' compliance with incident reporting requirements is also evaluated retrospectively during the ASO's and OHFLAC's on-site provider reviews. Providers failing to meet these requirements will be subject to sanctions ranging from a citation requiring a written Plan of Correction to suspension of their Behavioral Health License.

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

BMS is responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants. The ASO is responsible for monitoring the operation of the WV IMS follows-up as necessary regarding provider incident investigations. Incidents must be entered into the WV IMS or on a tracking spread sheet and submitted to the ASO. These incidents are tracked and summarized by the ASO. The ASO makes available a monthly incident summary report which is reviewed by the BMS and contracted entities at regular contract meetings to identify and address issues or concerns. Quarterly incident summary reports are also reviewed by the Quality Improvement Advisory Council for input on processes to identify trends and prevent reoccurrence.

Appendix G: Participant Safeguards

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

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

○ **The State does not permit or prohibits the use of restraints**

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

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

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

WV only permits the use of personal restraints in conjunction with a Positive Behavior Support Plan or in an emergency situation only to prevent harm to the participant or others. Positive Behavior Support plans employ non-aversive methods to replace maladaptive behaviors with functional and useful behaviors. Any Positive Behavior Support plan is considered part of the participant's Individual Program Plan. Participant/legal representative consent is required prior to developing and implementing any Positive Behavior Support plan. If a plan utilizes any restrictive measures, the provider agency's Human Rights Committee must review and approve the restrictive measures.

Additionally, Nonviolent Crisis Intervention training is required for any individual providing paid supports to the participant. This method focuses on proactive methods to de-escalate and prevent maladaptive behaviors, with physical restraint emphasized as a last resort.

Behavioral Health providers must adhere to Behavioral Health Licensure 64CRS11 in regards to using physical restraints, mechanical restraints or psychotropic medications. According to this policy, seclusion is not allowed in WV for the treatment of mentally retarded or developmentally disabled consumers. Also according to this policy, each Behavioral Health provider must develop and implement policies and procedures for interventions in working with behaviors that are interfering with the consumer's ability to function socially or personally. All behavior intervention plans shall be based on a functional analysis of the behavior, include positive programming to teach a participant adaptive, more effective behavior, ensure that a participant does not discipline another participant and ensure that physical restraints are used only as a last resort and used only as long as necessary to manage the behavior.

Unauthorized use of restraints would be detected during retroactive reviews in alternating years by the ASO and OHFLAC in addition to reviews of incidences reported through the Incident Management System and Adult and Child Protective Service reports. By Year 2, all IPP's will be entered electronically into the ASO's computer system so reviews will be more readily available.

Aversive procedures are only used with the written consent of the participant and/or his/her legal representative. A participant shall not be placed in a mechanical device used as a physical restraint until he or she is either: examined by an attending physician or other licensed professional, and a discussion is held between a member of the professional staff and available interdisciplinary team members; or a physician or other licensed professional has ordered by telephone these interventions after a member of the professional staff has discussed the situation with the available interdisciplinary team members. No restraint order shall be valid for more than three (3) hours; but if ordered for longer, the interdisciplinary team shall review a consumer's status and develop a written plan for responding to the participant's needs. When emergency control measures are used, a detailed report shall be written, describing the incident and the rationale for the emergency measures.

Psychotropic drugs are ordered only as part of the treatment plan and with documentation of the diagnosis and the specific behaviors that indicate a need for the medication and the rationale for its choice. All medications are administered in compliance with the physician's order and State law and all medication errors and adverse drug reactions are reported immediately in accordance with written procedures, including properly recording it in a participant's record and notifying the physician who prescribed the drug.

All individuals who provide direct service in the Waiver program must meet OHFLAC's standards which are also contained in 64CSR11 to include staff orientation, training in emergency care, first aid, infection disease control, cardiopulmonary resuscitation, Heimlich maneuver, care of the participant to whom they will be providing services, training in behavior management, including methods of de-escalating volatile situations and of using nonphysical techniques in such situations, to deal appropriately with aggressive or out of control behavior. In addition, agency staff who administer medications shall be Approved Medication Assistive Personnel (AMAP).

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

OHFLAC is the state agency responsible for overseeing the use of restraints and ensuring that the state's safeguards are followed. In Behavioral Health Centers Licensure, 64CSR11, OHFLAC requires each provider agency to establish a Human Rights Committee. This committee's primary function is to assist the provider agency in the promotion and protection of a participant's rights, and to review, approve and monitor individual programs designed to manage inappropriate behaviors and other programs that are intrusive or involve risks to a participant's protection and rights. During the site reviews and interviews conducted biennially by the ASO and OHFLAC, any noted

docoumentation or observation of unauhorized use of restraints will be reported to the proper authorities (Child Protective Services or Adult Protective Services). OHFLAC attends monthly Wavier Contract meetings with BMS and communicates their information and findings. Addition meetings are called if necessary.
Unauthorized use of restraints would be detected during retroactive reviews in alternating years by the ASO and OHFLAC in addition to reviews of incidences reported through the Incident Management System and Adult and Child Protective Service reports. By Year 2, all IPP's will be entered electronically into the ASO's computer system so reviews will be more readily available.

Appendix G: Participant Safeguards

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

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

○ **The State does not permit or prohibits the use of restrictive interventions**

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

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The State allows the use of restrictive interventions when used in conjunction with a written Positive Behavior Support Plan, or in an emergency situation only to prevent harm to the participant or others. Behavior support standards require that behavior plans employ non-aversive methods to replace maladaptive behaviors with functional and useful behaviors. Behavior Support Plans must be approved in advance of implementation by the IDT and the provider agency's Human Rights Committee as required by OHFLAC.

The use of seclusion is probhibited by Behavioral Health Centeres Licensure 64CSR11, however mechanical and physical restraints are allowed. Use of these prohibited techniques or the use of unauthorized restrictive interventions are evaluated and any violations are reported to the proper entities by the service coordinator during the monthly face to face home visit. OHFLAC and the ASO also evaluate unauthorized use of restrictive measures during periodic reviews and report to BMS during monthly contract meetings. Additional reports to Child or Adult Protective Services that detect the use of unauthorized restraints are reported to OHFLAC which in turns reports to BMS during monthly contract meetings or more often, if needed. Each behavioral health provider must have a Human Rights Committee whose primary function is to assist the behavioral health provider in the promotion and protection of a participant's rights, and to review, approve and monitor individual programs designed to manage inappropriate behavior and other programs that are intrusive or involve risks to a participant's protection and rights.

Per OHFLAC regulations, beginning on the first day of employment, professional and direct care staff shall begin orientation and training on treatment policies and procedures, consumer rights and the use of emergency procedures, such as crisis intervention and restraints. Staff assigned to work with a participant are required to be trained in advance on support and training programs which would include Positive Behavior Support plans and emergency procedures. Ongoing oversight of Positive Behavior Support Plans and implementation is provided by the Therapeutic Consultant and/or the Positive Behavior Support Professional.

MR/DD Waiver providers must comply with the OHFLAC regulation that states When emergency control measures are used, a detailed report shall be written, describing the incident and the rationale for the emergency measures. In addition, the use of restrictive interventions must be reported to the agency’s Human Rights Committee.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

OHFLAC is responsible for overseeing the use of restrictive interventions and ensuring that State safeguards concerning their use are followed. Oversight of the use of restrictive interventions at the participant level occurs through the IDT and the provider agency's Human Rights Committee. The IDT must approve these at least every six months. The Human Rights Committee reviews and approves all new restrictive interventions prior to implementation and annually thereafter. The plans and implementation of the plans are reviewed biennially in alternating years by the ASO and OHFLAC and the findings of these reviews are shared wtih BMS during monthly contract meetings.

Unauthorized use of restrictive intervention and violations of rights is monitored through the incident reporting process, the grievance process and the Service Coordination function--specifically through the review of the IPP and behavior support plan. In addition, on-site service provider reviews conducted in alternating years by the ASO and OHFLAC address behavior support services to assure that appropriate plans are in place and appropriately implemented.

The data obtained through agency self-reviews and on-site reviews conducted by the ASO is reported by the provider an in aggregate form to BMS. This allows the identification of specific and/or systematic deficits as well as trends and patterns. This data is used to support improvement strategies.

The IMS system is an additional means of monitoring program quality and participant safety. The ASO monitors critical incidents via the web on a daily basis as well as all incident types on a monthly basis and reports findings to BMS as outlined above in monthly contract meetings.

Appendix G: Participant Safeguards

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

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- **The State does not permit or prohibits the use of seclusion**

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

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

  i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

MR/DD Waiver providers are required to report via the Incident Management System (IMS) all general/minor and critical incidents involving medication errors. A reportable medication error involves one or more of the following: (1) medication administered to the wrong person; (2) incorrect mediation administered; (3) incorrect dosage administered; (4) medication administered by incorrect route; (5) medication administered at incorrect time and (6) the administration of the medication not properly documented.
The ASO is responsible for ongoing monitoring of IMS data to ensure medication errors and other types of incidents are reported and adequate follow-up activities are performed by the provider. A significant medication error involving a single case can prompt the ASO to request additional information or conduct an on-site investigation. Systemic problems pertaining to medication errors at a particular provider location or on a state-wide level are also monitored by the ASO and aggregate data is reported to BMS on a monthly basis and to the QA/QI Council on a quarterly basis. Findings may result in the collection of additional data, on-site review(s) and/or QA/QI strategies.
In addition to the IMS, medication errors that could potentially or actually result in a negative outcome must be reported to The Office of Health Facility Licensure and Certification (OHFLAC). OHFLAC's regulations also require the provider to complete and document an internal investigation of these and other critical incidents. Depending on the case-specific or systemic impact of the error, OHFLAC may follow-up by requesting the results of the provider's internal investigation and/or conducting an on-site investigation.

Service Coordinators are required to meet with the program participants at their homes at least once a month. This meeting includes a review of incidents that have occurred—including those related to medication errors. The Service Coordinator is required to summarize these incidents and their outcomes in a note that documents the home visit.

WV State Code 16-50 and Legislative Rule 64CSR60 require non-licensed employees of Licensed Behavioral Health Providers who are responsible for medication administration to Waiver participants to be certified Approved Medication Assistive Personnel (AMAPs). This employee must meet the eligibility requirements to become an AMAP, must have successfully completed the required training and competency testing and has been deemed competent by the supervising RN to administer medications to program participants.

AMAPs are required to have monitoring and retraining quarterly by a Registered Nurse. Methods of oversight/retraining include observation and assessment of the AMAP passing medication. All medications administered by an AMAP must be documented on a Medication Administration Record (MAR) which is reviewed and signed by the supervising RN each month. This documentation system provides communication among all providers that administer medication and the monitoring of medication side effects and/or medication errors. The MAR and ongoing RN oversight serve a means to detect potentially harmful practices. Additionally, an RN must be available (on call) for AMAPs at all times.

The system for medication administration must include a storage and accountability of all medication, that includes provisions for a medication administration record procedure and is in compliance with state and federal requirements. The process for prescribing and administering medications shall ensure:

*That all orders for medications are reviewed at least every ninety (90) days by the physician;
*That psychotropic drugs are ordered only as part of the treatment plan and with documentation of the diagnosis and the specific behaviors that indicate a need for the medication and the rationale for its choice;
*That all medications are administered in compliance with the physician's order and State law; and
*That medication errors, as defined by this rule, and adverse drug reactions are reported immediately in accordance with written procedures, including properly recording it in a participant's record and notifying the physician who prescribed the drug.
*The provider agency must note changes in a participant's condition, including adverse reactions, as a result of receiving

a medication.
*A participant to the extent capable shall administer his or her own medication.
*The provider agency shall provide locked storage for the medication that is not administered by participants.
*The provider agency shall inform a participant, or his or her legal representative, about the medication prescribed: the dosage, purpose, possible side effects, effects of not taking the medication; and about alternate treatments and their effects.

The ASO and OHFLAC conduct provider reviews in alternating years during which participant charts will be retrospectively reviewed. All medication errors that result in serious consequences are considered to be Critical Incidents according to Behavioral Health Centers Licensure 64CSR11. Each provider agency must maintain a system for critical incident reporting and demonstrate that it uses the system to improve treatment planning and services. Personnel shall immediately notify a supervisor of any critical incident and clear other participants from the area. Each provider agency must have policies and procedures for handling medical and psychiatric emergencies that ensures communication with the nearest medical emergency services, hospital and police; a twenty-four (24) hour telephone response system, toll-free to a consumer; and an investigation of any incident that results in serious injury or death, a reporting by the provider agency to appropriate authorities and a written report on it.

The ASO and OHFLAC perform routine periodic on-site reviews of providers to ensure compliance with all policies & procedures including those pertaining to the handling and administration of medications and tracking/reporting medication errors. These on-site reviews are conducted on an annual basis alternatively by OHFLAC and the ASO staff. Any identified deficiencies are cited in a written exit report to which the provider must respond with a written plan of correction. Citations that indicate a serious and immediate threat to program members' health and safety may result in suspension of the provider's ability to administer medications, temporary or permanent revocation of the provider's license, etc.
BMS, OHFLAC and the ASO meet at least monthly to review program performance including data related to medication administration. The ASO and OHFLAC are each responsible for providing BMS with the findings of ad hoc and routine monitoring and evaluation activities.

The data from the IMS which includes critical incidents related to medication errors is reported by the ASO to BMS at regular monthly contract meetings.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The provider agency Registered Nurse oversees AMAP medication administration. This oversight allows for ensuring medications are managed appropriately and identifying harmful practices (e.g. medication errors). All medications are recorded and communicated on a central document, the Medication Administration Record (MAR). The RN follows up if any medication errors are indicated, and can take action to ensure the health and welfare of the participant, up to and including revocation of the staff person's AMAP status.

Any medication error that results in serious consequence must be reported as a Critical Incident via the Incident Management System and possibly to Adult or Child Protective Services or to OHFLAC for follow-up. The ASO and OHFLAC report to BMS on a monthly basis or more frequently if necessary. At least quarterly a report is presented to BMS and the MR/DD Waiver QAI Council during which trends are discussed and actions are recommended.

On a state level, OHFLAC is responsible for policy implementation and ongoing monitoring of the AMAP program. Ongoing monitoring activities include:
* Biennial on-site provider reviews which include review of AMAP policies/procedures and their implementation
* Providers are required to submit all medication/treatment errors into the WV Incident Management System which is monitored by the ASO. Medication errors that result in serious outcome must be further reported to Adult Protective Services, Child Protective Services and OHFLAC as neglect
* AMAPS failing to meet requirements and/or responsibilities are reported by the supervising RN and no longer certified as AMAP's through OHFLAC.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

CHAPTER 16 of the WEST VIRGINIA STATE CODE SUB-SECTION 5O specifies that:

Administration of medication shall be performed only by:

1. Registered professional nurses;

2. Other licensed health care professionals; or

3. Facility staff members who have been trained and retrained every two years and who are subject to the supervision of and approval by a registered professional nurse.

Subsequent to assessing the health status of an individual resident, a registered professional nurse, in collaboration with the resident's attending physician and the facility staff member, may recommend that the facility authorize a facility staff member to administer medication if the staff member:

1. Has been trained pursuant to the requirements of this article;

2. Is considered by the registered professional nurse to be competent;

3. Consults with the registered professional nurse or attending physician on a regular basis; and

4. Is monitored or supervised by the registered professional nurse

The program developed by the department shall require that any person who applies to act as a facility staff member authorized to administer medications pursuant to the provisions of this article shall:

1. Hold a high school diploma or general education diploma;

2. Be trained or certified in cardiopulmonary resuscitation and first aid;

3. Participate in the initial training program developed by the department;

4. Pass a competency evaluation developed by the department; and

5. Subsequent to initial training and evaluation, participate in a retraining program every two years.

A registered nurse who is authorized to train facility staff members to administer medications in facilities shall:

1. Possess a current active West Virginia license in good standing to practice as a registered nurse;

2. Have practiced as a registered professional nurse in a position or capacity requiring knowledge of medications for the immediate two years prior to being authorized to train facility staff members; and

3. Be familiar with the nursing care needs of residents of facilities as described in this article.

Oversight of medication administration by unlicensed personnel.

a. Each facility in which medication is administered by unlicensed personnel shall establish in policy an administrative monitoring system. The specific requirements of the administrative policy shall be established by the department through rules proposed pursuant to section eleven of this article.

b. Monitoring of facility staff members authorized pursuant to this article shall be performed by a registered professional nurse employed or contracted by the facility.

Withdrawal of authorization.

The registered professional nurse who monitors or supervises the facility staff members authorized to administer medication pursuant to this article may withdraw authorization for a facility staff member if the nurse determines that the facility staff member is not performing medication administration in accordance with the training and written instructions. The withdrawal of the authorization shall be documented and shall be relayed to the facility and the department in order to remove the facility staff member from the list of authorized individuals.

Limitations on medication administration:

The following limitations apply to the administration of medication by facility staff members:

a. Injections or any parenteral medications may not be administered;

b. Irrigations or debriding agents used in the treatment of a skin condition or minor abrasions may not be administered;

c. No verbal medication orders may be accepted, no new medication orders shall be transcribed and no drug dosages may be converted and calculated; and

d. No medications ordered by the physician or a health care professional with legal prescriptive authority to be given "as needed" may be administered unless the order is written with specific parameters which preclude independent judgment.

Self-administration of medication:

Supervision of self-administration of medication by facility staff members who are not licensed health care professionals may be permitted in certain circumstances, when the substantial purpose of the setting is other than the provision of health care.

iii. Medication Error Reporting.*Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

Medication errors are reported to BMS through the Incident Management System. The ASO is responsible for ongoing monitoring of the IMS and preparing summary reports to BMS and other contracted entities.

Medication errors resulting in negative outcomes (medical follow-up, hospitalization, etc.) for the participant must be reported as neglect to OHFLAC, Adult Protective Services and/or Child Protective Services.

(b) Specify the types of medication errors that providers are required to *record:*

All medication errors are required to be recorded. Medication errors are defined as: (1) incorrect route of administration; (2) incorrect time of administration; (3) incorrect dosage; (4) incorrect drug; (5) medication administered to the incorrect person; and (6) incorrect or failure to document administration of medication.

(c) Specify the types of medication errors that providers must *report* to the State:

All medication administration errors that result in critical incidents or abuse, neglect or exploitation must be reported to BMS through the IMS. Additionally, medication errors that result in abuse, neglect, exploitation or negative outcomes for the participant must be reported to APS or CPS as well as OHFLAC.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.

Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.**Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

BMS monitors program performance utilizing data that is obtained through a variety of sources including the ASO; OHFLAC; the Medical Eligibility Contract Agent (MECA); the state's claims payer and Adult & Child Protective Services agencies. The type of data and frequency at which it is collected and reported is driven by the MR/DD Waiver Quality Plan which includes performance indicators pertaining to CMS Quality Assurances as well as performance indicators identified by BMS and the QA/QI Advisory Council.

Examples of the types of data collected include: Incident data reported by providers through the Incident Management System (IMS); Data pertaining to program policies and procedures collected during routine on-site reviews of provider agencies; data regarding the volume and types of grievances and complaints filed by program participants; claims data; etc.

The ASO is responsible for coordinating the collection of data and using it to prepare monthly reports that are submitted to BMS and reviewed during the MR/DD Waiver Contract Management meetings. These meetings are held at least monthly and include representatives from BMS, the ASO, OHFLAC and MECA. Others are invited to attend as needed. Based upon a review of the performance indicators and all corresponding data the group may determine (1) the findings are satisfactory and do not require further action at this time; (2) a more detailed evaluation of the findings is needed and additional information/data may be requested; or or (3) the findings are not satisfactory or indicate there is an opportunity for improvement. Further action will be taken which may include formation of a QI workgroup through the QA/QI Council.

On a quarterly basis, data pertaining to performance indicators and other program activities are presented to the QA/QI Council. Performance Indicator data failing to achieve desired outcomes are addressed through various methods including the formation of QI workgroups with members chosen from the Council, program participants & family members, and other stakeholders.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which

each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of IMS reports completed within required time frames. Numerator = # IMS reports completed within required time frames. Denominator = # of participant charts reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
WV IMS

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

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

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

		Confidence Interval = 95%
☑ **Other** Specify: ASO performance monitoring	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of reported IMS critical incidents followed up on by the MR/DD provider with 14 days. Numerator = # of reported IMS critical incidents followed up on by the MR/DD provider with 14 days. Denominator = # of reported critical IMS incidents.

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

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

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants who receive monthly home visit by a Service Coordinator. Numerator = # of participants who receive monthly home visit by a Service Coordinator. Denominator = # of MR/DD participant records reviewed.

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

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

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
All information relating to this assurance is collected and monitored through the WV Incident Management System (IMS)which is monitored by the operating agency. Individual issues/concerns such as failure to meet reporting and/or follow-up requirements are addressed immediately upon identification by the operating agency. Providers may be required to submit Corrective Action Plans addressing identified issues that must be approved by the operating agency.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Administrative Services Organization (ASO) is responsible for monitoring the quality of West Virginia's MR/DD Waiver services and ensuring that quality improvement strategies are implemented and evaluated. The MR/DD Waiver Quality Improvement System (QIS) is evidence-driven and incorporates a broad base of stakeholders in active roles in the process.

Discovery and remediation activities focus on the collection of data necessary to monitor the quality indicators established to provide evidence relating to the six CMS assurances and sub-assurances. Specific data sources include provider monitoring, claims data, incident management reports, contract oversight meetings and reports, participant/family focus groups/interview, and other stakeholder feedback and input.

The primary mechanism for involving stakeholders in the Waiver's quality improvement initiative is the MR/DD Waiver Quality Improvement Advisory (QIA) Council. The Council has a minimum of fifteen (15) members comprised of at least five (5) current or former program participants (or family/legal representatives), Waiver providers, advocates and other interested stakeholders. The Council serves as a forum for participants and the public to raise and address program issues and concerns affecting the quality of Waiver services.

The Council:
1. Reviews findings from discovery activities.
2. Recommends program priorities and quality initiatives.
3. Recommends policy changes.
4. Monitors and evaluates the implementation of Waiver priorities and quality initiatives.
5. Monitors and evaluates policy changes.
6. Serves as a liaison between the Waiver and its stakeholders.
7. Establishes committees and work groups consistent with its purpose and guidelines.

The Quality Management Report, which incorporates data from discovery and remediation activities, is reviewed and analyzed by Bureau for Medical Services (BMS) Management staff through regular meetings with contractors. The report is also reviewed quarterly with the QIA Council in order to identify trends and to monitor the effectiveness of quality improvement activities.

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

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☑ **Other** Specify: ASO	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The MR/DD Quality Improvement System (QIS) is designed to: 1) Collect the data necessary to provide evidence that the six (6) CMS assurances are consistently being met and 2) ensure the active involvement of stakeholders in the quality

improvement process. The primary sources of discovery include provider reviews, incident management reports and member complaints/grievances, administrative reports, oversight of delegated administrative functions, and stakeholder input.

Provider Reviews:

The primary means of monitoring the quality of MR/DD Waiver services is through provider reviews conducted biennially by the Office of Health Facility Licensing and Certification (OHFLAC) and the ASO.

To become an MR/DD Waiver provider, an agency must apply and be approved for a Certificate of Need (CON) through the Bureau of Behavioral Health and Health Facilities (BHHF) and then obtain a Behavioral Health License through the Office of Health Facility Licensing and Certification (OHFLAC). Licensure of a new agency involves an initial on-site OHFLAC review followed by a six month comprehensive on-site review (if necessary) to ensure all certification standards are substantially met.

OHFLAC licenses are issued as follows:

An initial six (6) month license shall be issued to provider agencies establishing a new program or service for which there is insufficient consumer participation to demonstrate substantial compliance with certification standards;

A provisional license shall be issued when a provider agency seeks a renewal license, and is not in substantial compliance with certification standards, but does not pose a significant risk to the rights, health and safety of a program participant. It shall expire not more than six (6) months from date of issuance, and not be consecutively reissued, unless the provisional recommendation is that of the state fire marshal.

A renewal license shall be issued when a provider agency is in substantial compliance with certification standards, and shall expire not more than two (2) years from date of issuance.

Providers are required to submit evidence to the ASO semi-annually to document continuing compliance with all certification requirements as specified in the MR/DD Waiver Policy Manual. This evidence report must be signed by an appropriate official of the provider agency (e.g., Executive Director, Board Chair, etc.). The ASO performs on-site provider reviews on a 24 month cycle alternating with OHFLAC on-site reviews to validate certification documentation. Targeted on-site provider reviews and/or desk audits may be conducted by OHFLAC and/or the ASO based on Incident Management Reports and complaint data.

A statewide representative sample of MR/DD Waiver participant charts are reviewed every 12-24 months. Charts are reviewed by the ASO using the Quality and Utilization Review Tool. This tool has been developed to ensure that the critical data necessary to monitor CMS assurances are collected. A proportionate random sample, ensuring that at least two member charts from each provider agency are reviewed, will be identified with the guidance of CMS technical assistance contractors.

West Virginia Incident Management System (WVIMS):

Another key source for monitoring the quality of MR/DD Waiver services is the online West Virginia Incident Management System (WVIMS). Per policy, MR/DD Waiver providers are required to utilize the WVIMS to report and track all incidents including 1) Simple Incidents, 2) Critical Incidents, and 3) Abuse, Neglect, and Exploitation. The online system gives providers the ability to generate agency specific reports to identify and monitor trends. The WVIMS also allows monitoring of reported incidents to ensure that timely, appropriate steps are taken by providers. The ASO generates periodic reports to identify & monitor statewide trends.

The ASO also employs a Participant & Family Liaison to whom program participants, their families and their legal/non-legal representatives may report concerns with their services. The Liaison is responsible for providing education and assistance to participants/families and periodically compiles aggregate reports regarding concerns/complaints which are analyzed for trends.

Reports:

BMS management staff will receive and review the following contract reports:
(1) ASO Monthly Dashboard Report, Quality Management Report and ad hoc reports as requested.
(2) Participant-Directed Financial Management Services Vendor Monthly Report and ad hoc reports as requested.

(3) Bureau for Behavioral Health and Health Facilities (BHHF) Monthly Activity Report and ad hoc reports as requested.
(4) Claims Vendor routine reports on claims data and ad hoc reports as requested.
(5) Eligibility Vendor Monthly Report and ad hoc reports as requested.

Contract Oversight Meetings:

BMS management staff conduct semi-monthly meetings with its contractors to monitor performance and address identified issues/concerns.

The quality management data collected through discovery methods is compiled using the Quality Management Report Template and reviewed at least monthly by BMS at its contract meetings. The Quality Management Report is also compiled and reviewed quarterly by the MR/DD QIA Council. A comprehensive report summarizing the findings of provider reviews is compiled at the end of each review cycle, reviewed and analyzed by Waiver staff and presented to the QIA Council for its review and analysis.

The Quality Improvement Advisory Council:

The QIA Council is the focal point of stakeholder input for the MR/DD Waiver and plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies. The Council is comprised of 15 members with at least 5 being current or former waiver recipients (or their legal representatives).

The Council provides Waiver staff feedback and guidance regarding quality improvement initiatives. In partnership with Waiver staff, the Council reviews and analyzes data, identifies trends and priorities, and develops the annual Quality Management Plan in which specific quality improvement goals and objectives are established.

The Council establishes work groups consisting of Council members and others wishing to participate in the process to address specific improvement goals and objectives.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The goals and objectives outlined in the Quality Management Plan are continuously monitored by the MR/DD Waiver Quality Improvement Advisory Council, with updates being provided at each quarterly meeting. An annual planning meeting is held to review progress toward the goals and objectives of the plan and to update the plan as indicated by quality management data.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

A statewide representative sample of member charts are reviewed every 12 months to verify documentation of services billed. Provider reviews are conducted by staff of the operating agency to ensure the integrity of payments that have been made for waiver services.
When provider documentation does not support services billed, providers are required to submit Corrective Action Plans which must be approved by the operating agency. Providers are required to reimburse the Bureau for Medical Services for any services billed without supporting documentation. The Medicaid Program (which would include the Mental Retardation/Developmental Disability Waiver) is audited annually under the West Virginia Statewide Single Audit. The State of West Virginia Statewide Single Audit is conducted by Ernst & Young, LLP.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of processed claims for services reviewed and prior authorized by the ASO. Numerator = # of processed claims for services reviewed and prior authorized by the ASO. Denominator = # of processed claims.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of claims paid against current IPPs reviewed. Numerator = # of claims paid against current IPPs reviewed. Denominator = # of claims paid against all IPPs reviewed.

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

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver claims that were submitted using the correct rate as specified in the approved Waiver. Numerator = # of waiver claims that were submitted using the correct rate as specified in the approved Waiver. Denominator = # of waiver claims submitted.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Evidence relating to this assurance is collected through the ASO's prior authorization system and through the ASO's Quality and Utilization Review process. All providers must initially submit request for and receive prior authorization through the ASO prior to billing for any Waiver service. Any issues identified at the prior authorization stage are identified and resolved immediately (prior to services being authorized). This sometimes lead to request by the ASO for

the provider to submit additional information/documentation to support the request for service authorization.

All information relating to this assurance is collected through the review of member charts by the ASO and the review and analysis of claims data provided by the claims processing entity. Individual issues/concerns related to appropriate documentation of services billed identified during the review of member charts are addressed immediately by the operating agency with providers during an exit interview. Providers may be required to submit Corrective Action Plans addressing identified issues that must be approved by the operating agency. Evidence collected via claims data is reviewed and analyzed by BMS and the claims processing entity in order to identify any system issues.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The current rate structure has been developed to reflect service definitions, provider requirements, operational service delivery and administrative considerations. The following components were used to determine the current MR/DD rates: Bureau for Labor Statistics wage information; employee related expenses; productivity adjustment factor; and administrative overhead. This methodology was applied to all HCPCS Level II codes and were last updated in November 2006; for HCPCS Level I codes RBRVS reimbursement rates were applied (RBRVS rates are updated on January 1 of each year). Mileage reimbursement is based on the approved mileage rate as published by the West Virginia Division of Purchasing, Travel Management Office. The described rate methodology is consistently applied to all waiver services. The current rate methodology provides consistency with the provisions of section 1902(a)30(A) and 42 CFR section 447.200-205. The state of West Virginia does not use a formula to base increase for inflation, and at this time does not anticipate rate increases.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billing flow directly from waiver providers to the State's claims payment system.

Appendix I: Financial Accountability

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

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

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

***Select at least one*:**

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

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

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

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

Appendix I: Financial Accountability

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

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

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

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

  Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- **No. The State does not make supplemental or enhanced payments for waiver services.**
- **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services**

through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☐ **Appropriation of State Tax Revenues to the State Medicaid agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

☑ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

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

Appendix I: Financial Accountability

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

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

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

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

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

☐ **Other Local Government Level Source(s) of Funds.**

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

Appendix I: Financial Accountability

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

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

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

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

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings.*Select one:*

○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

For participants living in group home settings (four or more beds), the participants are responsible for the cost associated with room and board.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.*Select one:*

◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver**

participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	60767.93	8476.94	69244.87	115751.00	6495.00	122246.00	53001.13
2	64399.19	9400.65	73799.84	118886.00	6671.00	125557.00	51757.16
3	68280.87	10420.93	78701.80	122107.00	6858.00	128965.00	50263.20
4	72390.70	11535.11	83925.81	125414.00	7037.00	132451.00	48525.19
5	77088.03	12959.62	90047.65	128811.00	7228.00	136039.00	45991.35

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	4484	4484
Year 2	4534	4534
Year 3	4534	4534
Year 4	4534	4534
Year 5	4634	4634

Appendix J: Cost Neutrality Demonstration

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

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Estimate for average length of stay is derived from historical claims experience.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimates for Factor D are derived from historical trends of actual claims experience adjusted for anticipated increases in utilization and definition of service.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for Factor D' are derived from historical trends of actual claims experience used in preparing the CMS-372 reports adjusted for inflationary increases based on the most recent five year reporting periods. There are no wrap-around benefits provided to Medicare/Medicaid dual eligibles therefore the only prescription costs included would be for those drugs excluded from the Medicare formulary.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for Factor G are derived from historical trends of actual claims experience adjusted for anticipated increases in utilization.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for Factor G' are derived from historical trends of actual claims experience adjusted for anticipated increases in utilization.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Facility Based Day Habilitation	

Waiver Services	
Participant -Centered Support	
Respite	
Service Coordination	
Supported Employment	
Financial Management Services - Participant-Directed (Agency-with-Choice)	
Crisis Services	
Dietary Therapy	
Electronic Monitoring/Surveillance System and On-Site Response	
Enviromental Accessibility Adaptations - Home	
Environmental Accessiblity Adaptation - Vehicle	
Goods and Services - Participant - Directed	
Occupational Therapy	
Physical Therapy	
Positive Behavior Support Professional	
Skilled Nursing - Nursing Services by a Licensed Practical Nurse	
Skilled Nursing - Nursing Services by a Licensed Registered Nurse	
Speech Therapy	
Therapeutic Consultant	
Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

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

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Facility Based Day Habilitation Total:						**15434624.70**
Facility Based Day Habilitation	15 minute	2817	1870.00	2.93	**15434624.70**	
Participant -Centered Support Total:						**147767212.88**
Participant-Centered Support - Participant Directed	15 minute	2990	6332.00	2.27	**42977183.60**	
Participant-Centered Support - Traditional	15 minute	1494	20243.00	2.84	**85890239.28**	
Participant-Centered Support - Family - Traditional	15 minute	1978	4900.00	1.95	**18899790.00**	
Respite Total:						**30687757.18**

GRAND TOTAL:	**272483384.91**
Total Estimated Unduplicated Participants:	**4484**
Factor D (Divide total by number of participants):	**60767.93**
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite - Traditional	15 minute	1209	1822.00	3.38	7445457.24	
Respite - Participant - Directed	15 minute	2162	3881.00	2.77	23242299.94	
Service Coordination Total:						13368776.96
Service Coordination	15 minute	4484	352.00	8.47	13368776.96	
Supported Employment Total:						1980587.52
Supported Employment	15 minute	558	944.00	3.76	1980587.52	
Financial Management Services - Participant-Directed (Agency-with-Choice) Total:						1614600.00
Financial Management Services - Participant-Directed (Agency-with-Choice)	month	1495	12.00	90.00	1614600.00	
Crisis Services Total:						76272.24
Crisis Services	hour	11	173.00	40.08	76272.24	
Dietary Therapy Total:						92103.48
Dietary Therapy	15 minute	393	12.00	19.53	92103.48	
Electronic Monitoring/Surveillance System and On-Site Response Total:						1742656.30
Electronic Monitoring/Surveillance System and On-Site Response	hour	77	4985.00	4.54	1742656.30	
Enviromental Accessibility Adaptations - Home Total:						141000.00
Enviromental Accessibility Adaptations - Home	each	141	1000.00	1.00	141000.00	
Environmental Accessiblity Adaptation - Vehicle Total:						24000.00
Environmental Accessiblity Adaptation - Vehicle	each	24	1000.00	1.00	24000.00	
Goods and Services - Participant - Directed Total:						2990000.00
Goods and Services - Participant - Directed	each	2990	1000.00	1.00	2990000.00	
Occupational Therapy Total:						526944.00
Occupational Therapy	15 minute	330	80.00	19.96	526944.00	
Physical Therapy Total:						612556.80
Physical Therapy	15 minute	320	96.00	19.94	612556.80	

GRAND TOTAL:	272483384.91
Total Estimated Unduplicated Participants:	4484
Factor D (Divide total by number of participants):	60767.93
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Positive Behavior Support Professional Total:						**3379072.50**
Positive Behavior Support Professional	15 minute	758	378.00	11.25	**3223395.00**	
IPP Planning-Positive Behavior Support Professional	15 minute	629	22.00	11.25	**155677.50**	
Skilled Nursing - Nursing Services by a Licensed Practical Nurse Total:						**13129785.76**
Skilled Nursing - Nursing Services by a Licensed Practical Nurse	15 minute	1954	994.00	6.76	**13129785.76**	
Skilled Nursing - Nursing Services by a Licensed Registered Nurse Total:						**4658096.52**
Skilled Nursing - Nursing Services by a Licensed Registered Nurse	15 minute	4071	77.00	11.82	**3705179.94**	
IPP Planning-Licensed Registered Nurse	15 minute	3839	21.00	11.82	**952916.58**	
Speech Therapy Total:						**534588.34**
Speech Therapy	event	517	26.00	39.77	**534588.34**	
Therapeutic Consultant Total:						**11632345.04**
Therapeutic Consultant	15 minute	4134	312.00	8.38	**10808591.04**	
IPP Planning-Therapeutic Consultant	15 minute	3932	25.00	8.38	**823754.00**	
Transportation Total:						**22090404.69**
Transportation - Miles - Participant-Directed	mile	3093	5982.00	0.47	**8696093.22**	
Transportation - Miles - Traditional	mile	3838	5982.00	0.47	**10790690.52**	
Transportation - Trip - Traditioinal	trip	1435	307.00	5.91	**2603620.95**	
				GRAND TOTAL:		**272483384.91**
				Total Estimated Unduplicated Participants:		**4484**
				Factor D (Divide total by number of participants):		**60767.93**
				Average Length of Stay on the Waiver:		352

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

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

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Facility Based Day Habilitation Total:						**16555765.76**
Facility Based Day Habilitation	15 minute	2848	1984.00	2.93	**16555765.76**	
Participant -Centered Support Total:						**158437604.12**
Participant-Centered Support - Participant Directed	15 minute	3023	6718.00	2.27	**46100326.78**	
Participant-Centered Support - Traditional	15 minute	1511	21466.00	2.84	**92115757.84**	
Participant-Centered Support - Family - Traditional	15 minute	1995	5198.00	1.95	**20221519.50**	
Respite Total:						**32919381.84**
Respite - Traditional	15 minute	1222	1933.00	3.38	**7983985.88**	
Respite - Participant - Directed	15 minute	2186	4118.00	2.77	**24935395.96**	
Service Coordination Total:						**14362714.52**
Service Coordination	15 minute	4534	374.00	8.47	**14362714.52**	
Supported Employment Total:						**2122760.64**
Supported Employment	15 minute	564	1001.00	3.76	**2122760.64**	
Financial Management Services - Participant-Directed (Agency-with-Choice) Total:						**1681948.80**
Financial Management Services - Participant-Directed (Agency-with-Choice)	month	1512	12.00	92.70	**1681948.80**	
Crisis Services Total:						**80681.04**
Crisis Services	hour	11	183.00	40.08	**80681.04**	
Dietary Therapy Total:						**93040.92**
Dietary Therapy	15 minute	397	12.00	19.53	**93040.92**	
Electronic Monitoring/Surveillance System and On-Site Response Total:						**1872940.68**
Electronic Monitoring/Surveillance System and On-Site Response	hour	78	5289.00	4.54	**1872940.68**	
Enviromental Accessibility Adaptations - Home Total:						**143000.00**
Enviromental Accessibility Adaptations - Home	each	143	1000.00	1.00	**143000.00**	
Environmental Accessiblity Adaptation - Vehicle Total:						**24000.00**

GRAND TOTAL:	**291985908.40**
Total Estimated Unduplicated Participants:	**4534**
Factor D (Divide total by number of participants):	**64399.19**
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessiblity Adaptation - Vehicle	each	24	1000.00	1.00	24000.00	
Goods and Services - Participant - Directed Total:						3023000.00
Goods and Services - Participant - Directed	each	3023	1000.00	1.00	3023000.00	
Occupational Therapy Total:						559997.76
Occupational Therapy	15 minute	334	84.00	19.96	559997.76	
Physical Therapy Total:						658977.12
Physical Therapy	15 minute	324	102.00	19.94	658977.12	
Positive Behavior Support Professional Total:						3627337.50
Positive Behavior Support Professional	15 minute	766	401.00	11.25	3455617.50	
IPP Planning-Positive Behavior Support Professional	15 minute	636	24.00	11.25	171720.00	
Skilled Nursing - Nursing Services by a Licensed Practical Nurse Total:						14079079.04
Skilled Nursing - Nursing Services by a Licensed Practical Nurse	15 minute	1976	1054.00	6.76	14079079.04	
Skilled Nursing - Nursing Services by a Licensed Registered Nurse Total:						4998867.12
Skilled Nursing - Nursing Services by a Licensed Registered Nurse	15 minute	4116	82.00	11.82	3989391.84	
IPP Planning-Licensed Registered Nurse	15 minute	3882	22.00	11.82	1009475.28	
Speech Therapy Total:						561592.17
Speech Therapy	event	523	27.00	39.77	561592.17	
Therapeutic Consultant Total:						12494010.16
Therapeutic Consultant	15 minute	4180	331.00	8.38	11594400.40	
IPP Planning-Therapeutic Consultant	15 minute	3976	27.00	8.38	899609.76	
Transportation Total:						23689209.21
Transportation - Miles - Participant-Directed	mile	3127	6346.00	0.47	9326652.74	
Transportation - Miles - Traditional	mile	3881	6346.00	0.47	11575548.22	
Transportation - Trip - Traditioinal	trip	1451	325.00	5.91	2787008.25	

GRAND TOTAL:	**291985908.40**
Total Estimated Unduplicated Participants:	**4534**
Factor D (Divide total by number of participants):	**64399.19**
Average Length of Stay on the Waiver:	352

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

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

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Facility Based Day Habilitation Total:						**17565467.20**
Facility Based Day Habilitation	15 minute	2848	2105.00	2.93	**17565467.20**	
Participant -Centered Support Total:						**168094690.42**
Participant-Centered Support - Participant Directed	15 minute	3023	7127.00	2.27	**48906970.67**	
Participant-Centered Support - Traditional	15 minute	1511	22775.00	2.84	**97732991.00**	
Participant-Centered Support - Family - Traditional	15 minute	1995	5515.00	1.95	**21454728.75**	
Respite Total:						**34926624.54**
Respite - Traditional	15 minute	1222	2051.00	3.38	**8471368.36**	
Respite - Participant - Directed	15 minute	2186	4369.00	2.77	**26455256.18**	
Service Coordination Total:						**15245983.06**
Service Coordination	15 minute	4534	397.00	8.47	**15245983.06**	
Supported Employment Total:						**2254240.32**
Supported Employment	15 minute	564	1063.00	3.76	**2254240.32**	
Financial Management Services - Participant-Directed (Agency-with-Choice) Total:						**1714245.12**
Financial Management Services - Participant-Directed (Agency-with-Choice)	month	1512	12.00	94.48	**1714245.12**	
Crisis Services Total:						**85530.72**
Crisis Services	hour	11	194.00	40.08	**85530.72**	
Dietary Therapy Total:						**100794.33**
Dietary Therapy					**100794.33**	

GRAND TOTAL:	**309585473.54**
Total Estimated Unduplicated Participants:	**4534**
Factor D (Divide total by number of participants):	**68280.87**
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 minute	397	13.00	19.53		
Electronic Monitoring/Surveillance System and On-Site Response Total:						**1987321.44**
Electronic Monitoring/Surveillance System and On-Site Response	hour	78	5612.00	4.54	**1987321.44**	
Enviromental Accessibility Adaptations - Home Total:						**143000.00**
Enviromental Accessibility Adaptations - Home	each	143	1000.00	1.00	**143000.00**	
Environmental Accessiblity Adaptation - Vehicle Total:						**24000.00**
Environmental Accessiblity Adaptation - Vehicle	each	24	1000.00	1.00	**24000.00**	
Goods and Services - Participant - Directed Total:						**3023000.00**
Goods and Services - Participant - Directed	each	3023	1000.00	1.00	**3023000.00**	
Occupational Therapy Total:						**593330.96**
Occupational Therapy	15 minute	334	89.00	19.96	**593330.96**	
Physical Therapy Total:						**697740.48**
Physical Therapy	15 minute	324	108.00	19.94	**697740.48**	
Positive Behavior Support Professional Total:						**3857085.00**
Positive Behavior Support Professional	15 minute	766	426.00	11.25	**3671055.00**	
IPP Planning-Positive Behavior Support Professional	15 minute	636	26.00	11.25	**186030.00**	
Skilled Nursing - Nursing Services by a Licensed Practical Nurse Total:						**14947333.44**
Skilled Nursing - Nursing Services by a Licensed Practical Nurse	15 minute	1976	1119.00	6.76	**14947333.44**	
Skilled Nursing - Nursing Services by a Licensed Registered Nurse Total:						**5288007.96**
Skilled Nursing - Nursing Services by a Licensed Registered Nurse	15 minute	4116	87.00	11.82	**4232647.44**	
IPP Planning-Licensed Registered Nurse	15 minute	3882	23.00	11.82	**1055360.52**	
Speech Therapy Total:						**623991.30**
Speech Therapy	event	523	30.00	39.77	**623991.30**	
Therapeutic Consultant Total:						**13261215.92**
Therapeutic Consultant	15 minute	4180	351.00	8.38	**12294968.40**	

GRAND TOTAL:	**309585473.54**
Total Estimated Unduplicated Participants:	**4534**
Factor D (Divide total by number of participants):	**68280.87**
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
IPP Planning-Therapeutic Consultant	15 minute	3976	29.00	8.38	966247.52	
Transportation Total:						25151871.33
Transportation - Miles - Participant-Directed	mile	3127	6738.00	0.47	9902771.22	
Transportation - Miles - Traditional	mile	3881	6738.00	0.47	12290583.66	
Transportation - Trip - Traditioinal	trip	1451	345.00	5.91	2958516.45	
				GRAND TOTAL:		309585473.54
				Total Estimated Unduplicated Participants:		4534
				Factor D (Divide total by number of participants):		68280.87
				Average Length of Stay on the Waiver:		352

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

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

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Facility Based Day Habilitation Total:						18641925.76
Facility Based Day Habilitation	15 minute	2848	2234.00	2.93	18641925.76	
Participant -Centered Support Total:						178351699.37
Participant-Centered Support - Participant Directed	15 minute	3023	7562.00	2.27	51892032.02	
Participant-Centered Support - Traditional	15 minute	1511	24165.00	2.84	103697814.60	
Participant-Centered Support - Family - Traditional	15 minute	1995	5851.00	1.95	22761852.75	
Respite Total:						37059663.28
Respite - Traditional	15 minute	1222	2176.00	3.38	8987663.36	
Respite - Participant - Directed	15 minute	2186	4636.00	2.77	28071999.92	
Service Coordination Total:						16167654.58
				GRAND TOTAL:		328219450.22
				Total Estimated Unduplicated Participants:		4534
				Factor D (Divide total by number of participants):		72390.70
				Average Length of Stay on the Waiver:		352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service Coordination	15 minute	4534	421.00	8.47	16167654.58	
Supported Employment Total:						2392081.92
Supported Employment	15 minute	564	1128.00	3.76	2392081.92	
Financial Management Services - Participant-Directed (Agency-with-Choice) Total:						1784280.96
Financial Management Services - Participant-Directed (Agency-with-Choice)	month	1512	12.00	98.34	1784280.96	
Crisis Services Total:						91262.16
Crisis Services	hour	11	207.00	40.08	91262.16	
Dietary Therapy Total:						108547.74
Dietary Therapy	15 minute	397	14.00	19.53	108547.74	
Electronic Monitoring/Surveillance System and On-Site Response Total:						2108430.48
Electronic Monitoring/Surveillance System and On-Site Response	hour	78	5954.00	4.54	2108430.48	
Enviromental Accessibility Adaptations - Home Total:						143000.00
Enviromental Accessibility Adaptations - Home	each	143	1000.00	1.00	143000.00	
Environmental Accessiblity Adaptation - Vehicle Total:						24000.00
Environmental Accessiblity Adaptation - Vehicle	each	24	1000.00	1.00	24000.00	
Goods and Services - Participant - Directed Total:						3023000.00
Goods and Services - Participant - Directed	each	3023	1000.00	1.00	3023000.00	
Occupational Therapy Total:						633330.80
Occupational Therapy	15 minute	334	95.00	19.96	633330.80	
Physical Therapy Total:						742964.40
Physical Therapy	15 minute	324	115.00	19.94	742964.40	
Positive Behavior Support Professional Total:						4079677.50
Positive Behavior Support Professional	15 minute	766	451.00	11.25	3886492.50	
IPP Planning-Positive Behavior Support Professional	15 minute	636	27.00	11.25	193185.00	

GRAND TOTAL:	328219450.22
Total Estimated Unduplicated Participants:	4534
Factor D (Divide total by number of participants):	72390.70
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skilled Nursing - Nursing Services by a Licensed Practical Nurse Total:						**15869018.88**
Skilled Nursing - Nursing Services by a Licensed Practical Nurse	15 minute	1976	1188.00	6.76	**15869018.88**	
Skilled Nursing - Nursing Services by a Licensed Registered Nurse Total:						**5623034.04**
Skilled Nursing - Nursing Services by a Licensed Registered Nurse	15 minute	4116	92.00	11.82	**4475903.04**	
IPP Planning-Licensed Registered Nurse	15 minute	3882	25.00	11.82	**1147131.00**	
Speech Therapy Total:						**644791.01**
Speech Therapy	event	523	31.00	39.77	**644791.01**	
Therapeutic Consultant Total:						**14065159.60**
Therapeutic Consultant	15 minute	4180	373.00	8.38	**13065593.20**	
IPP Planning-Therapeutic Consultant	15 minute	3976	30.00	8.38	**999566.40**	
Transportation Total:						**26665927.74**
Transportation - Miles - Participant-Directed	mile	3127	7143.00	0.47	**10497995.67**	
Transportation - Miles - Traditional	mile	3881	7143.00	0.47	**13029332.01**	
Transportation - Trip - Traditioinal	trip	1451	366.00	5.91	**3138600.06**	
				GRAND TOTAL:		**328219450.22**
				Total Estimated Unduplicated Participants:		**4534**
				Factor D (Divide total by number of participants):		**72390.70**
				Average Length of Stay on the Waiver:		352

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Facility Based Day Habilitation Total:						**20444564.31**
Facility Based Day Habilitation					**20444564.31**	
				GRAND TOTAL:		**357225912.32**
				Total Estimated Unduplicated Participants:		**4634**
				Factor D (Divide total by number of participants):		**77088.03**
				Average Length of Stay on the Waiver:		352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 minute	2911	2397.00	2.93		
Participant -Centered Support Total:						**193190779.44**
Participant-Centered Support - Participant Directed	15 minute	3090	8112.00	2.27	**56900001.60**	
Participant-Centered Support - Traditional	15 minute	1544	25434.00	2.84	**111527072.64**	
Participant-Centered Support - Family - Traditional	15 minute	2028	6262.00	1.95	**24763705.20**	
Respite Total:						**40627080.22**
Respite - Traditional	15 minute	1249	2334.00	3.38	**9853261.08**	
Respite - Participant - Directed	15 minute	2234	4973.00	2.77	**30773819.14**	
Service Coordination Total:						**17740990.96**
Service Coordination	15 minute	4634	452.00	8.47	**17740990.96**	
Supported Employment Total:						**2620569.60**
Supported Employment	15 minute	576	1210.00	3.76	**2620569.60**	
Financial Management Services - Participant-Directed (Agency-with-Choice) Total:						**1878102.00**
Financial Management Services - Participant-Directed (Agency-with-Choice)	month	1545	12.00	101.30	**1878102.00**	
Crisis Services Total:						**96552.72**
Crisis Services	hour	11	219.00	40.08	**96552.72**	
Dietary Therapy Total:						**118937.70**
Dietary Therapy	15 minute	406	15.00	19.53	**118937.70**	
Electronic Monitoring/Surveillance System and On-Site Response Total:						**2324116.80**
Electronic Monitoring/Surveillance System and On-Site Response	hour	80	6399.00	4.54	**2324116.80**	
Enviromental Accessibility Adaptations - Home Total:						**146000.00**
Enviromental Accessibility Adaptations - Home	each	146	1000.00	1.00	**146000.00**	
Environmental Accessiblity Adaptation - Vehicle Total:						**25000.00**
Environmental Accessiblity Adaptation - Vehicle	each	25	1000.00	1.00	**25000.00**	

GRAND TOTAL:	**357225912.32**
Total Estimated Unduplicated Participants:	**4634**
Factor D (Divide total by number of participants):	**77088.03**
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Goods and Services - Participant - Directed Total:						**3090000.00**
Goods and Services - Participant - Directed	each	3090	1000.00	1.00	**3090000.00**	
Occupational Therapy Total:						**694248.72**
Occupational Therapy	15 minute	341	102.00	19.96	**694248.72**	
Physical Therapy Total:						**811817.22**
Physical Therapy	15 minute	331	123.00	19.94	**811817.22**	
Positive Behavior Support Professional Total:						**4475497.50**
Positive Behavior Support Professional	15 minute	783	484.00	11.25	**4263435.00**	
IPP Planning-Positive Behavior Support Professional	15 minute	650	29.00	11.25	**212062.50**	
Skilled Nursing - Nursing Services by a Licensed Practical Nurse Total:						**17396724.80**
Skilled Nursing - Nursing Services by a Licensed Practical Nurse	15 minute	2020	1274.00	6.76	**17396724.80**	
Skilled Nursing - Nursing Services by a Licensed Registered Nurse Total:						**6189294.78**
Skilled Nursing - Nursing Services by a Licensed Registered Nurse	15 minute	4207	99.00	11.82	**4922947.26**	
IPP Planning-Licensed Registered Nurse	15 minute	3968	27.00	11.82	**1266347.52**	
Speech Therapy Total:						**723598.20**
Speech Therapy	event	535	34.00	39.78	**723598.20**	
Therapeutic Consultant Total:						**15373746.88**
Therapeutic Consultant	15 minute	4272	399.00	8.38	**14283944.64**	
IPP Planning-Therapeutic Consultant	15 minute	4064	32.00	8.38	**1089802.24**	
Transportation Total:						**29258290.47**
Transportation - Miles - Participant-Directed	mile	3196	7665.00	0.47	**11513749.80**	
Transportation - Miles - Traditional	mile	3967	7665.00	0.47	**14291315.85**	
Transportation - Trip - Traditioinal	trip	1483	394.00	5.91	**3453224.82**	

GRAND TOTAL:	**357225912.32**
Total Estimated Unduplicated Participants:	**4634**
Factor D (Divide total by number of participants):	**77088.03**
Average Length of Stay on the Waiver:	352