WEST VIRGINIA Department of Health & Human Resources BUREAU FOR MEDICAL SERVICES

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

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BACKGROUND

The West Virginia Medicaid Program is administered in agreement with Title XIX of the Social Security Act and Chapter 9 of the West Virginia Code. The Bureau for Medical Services (BMS) is the single State agency responsible for administering the Medicaid Program. This program, therefore, must also function within federally defined parameters. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical and behavioral health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible, and completed documentation to justify medical necessity of services provided to each member receiving Medicaid and made available to the BMS or its designee upon request.

This chapter sets forth the BMS requirements for the Traumatic Brain Injury Waiver (TBIW) program provided to eligible West Virginia Medicaid members. The policies and procedures set forth herein are promulgated as regulations governing the provision of TBIW services by TBIW providers in the Medicaid Program. Requirements and details for other West Virginia Medicaid covered services can be found in other chapters of the BMS Provider Manual.

All forms for this program can be found on the TBIW website.

Federal regulations governing Medicaid coverage of home and community-based services under an approved waiver specify that services provided under waiver authority must be targeted to individuals who would otherwise be eligible for placement in a long-term care facility.

PROGRAM DESCRIPTION

The TBIW Program is a long-term care alternative which provides services that enable individuals to live at home rather than receiving nursing facility care. The program provides home and community-based services to West Virginia residents who are financially and medically eligible to participate in the program and who can provide a safe working environment for TBIW program staff and agency staff. Applicants must be at least three years of age and have a documented traumatic brain injury, defined as a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment or an injury caused by anoxia due to near drowning. The goals and objectives of this program are focused on providing services that are person-centered, that promote choice, independence, respect, dignity, and community integration. All members are offered and have a right to freedom of choice of providers for services. The BMS contracts with a Utilization Management Contractor (UMC) to implement the administrative functions of the program.

TBIW services include case management, personal attendant, non-medical transportation, personal emergency response systems (PERS) and Environmental Accessibility Adaptations (EAA) home and/or vehicle.

TBIW services are to be provided exclusively to the members eligible for services and only for necessary activities as listed in their Person-Centered Service Plan (PSCP). Enrollment on the TBIW is contingent on a person requiring two or more of the services offered in the TBIW in order to avoid institutionalization. One service, which must be utilized monthly, is Personal Attendant services unless in a nursing home, hospital, or other inpatient medical facility. This may include hands on assistance or supervision of Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (IADL). Personal Attendant services must be used monthly either through a Traditional provider or Self-Direction. The other service required is case management. Individuals may not be enrolled in the TBIW for the sole purpose of obtaining Medicaid eligibility. Services may not solely involve ancillary tasks such as housekeeping, assistance with chores, essential errands, non-emergency transportation and/or community activities.

Within the TBIW program, members may choose from either the Traditional (Agency) Model or the Self-Directed Model known as *Personal Options* for service delivery. In the Traditional Model, members receive their services from employees of a certified provider agency. In *Personal Options*, members can hire, supervise, and terminate their own employees. The BMS cannot mandate an agency to accept a member that has chosen them for services.

TBIW services do not replace the age-appropriate care that any minor child would need from a parent or legal guardian. ADLs provided for children must be for assistance beyond the age-appropriate care that is typically proved by a parent or legal guardian and must be medically necessary.

TBIW services are not intended to replace support services that a minor child would receive from the school system during a school day/year or educational hours provided during home schooling.

West Virginia does not allow restrictive interventions including restraints and seclusions of its members. Any unauthorized utilization of restrictive interventions must be reported in the West Virginian Incident Management System (WV IMS).

TAKE ME HOME (TMH) TRANSITION PROGRAM

Individuals wishing to transition from long-term care facilities to the community often face obstacles including lack of basic household items (i.e., furniture, bedding, etc.), limited community supports and no one to help develop comprehensive plans to transition home. Transition services help address many of these barriers by providing a variety of services and supports to program members to promote a successful and safe transition to the community. Take Me Home applicants are not subject to the same Managed Enrollment List (MEL) requirements which requires a TBIW funded slot be available. They may access a slot immediately if a slot, designated for TMH, is available in Waiver Years one, two, three, four and five.

Transition coordination is an essential part of transition services. Transition coordinators, provided through a contract, work one-on-one with members and their transition teams to:

- Accept and follow up with referrals;
- Conduct intake interviews to share information about options for returning to the community, including the availability of waiver transition services;
- Assess residents' transition support needs, including risk factors that may jeopardize a safe and successful transition to the community;
- Assess and verify residents' readiness to begin transition assessment and planning;

- Facilitate the development of a transition team consisting of the resident, the transition coordinator, the waiver case manager, the facility social worker and other appropriate staff, and anyone else the resident chooses to include in the transition process;
- Work with the TMH participant and their transition team to develop a written transition plan which incorporates specific services and supports to meet identified transition needs;
- Conduct a Risk Analysis and develop a written Risk Mitigation Plan to address and monitor all identified risks that may jeopardize the TMH participant's successful transition, and;
- Arrange and facilitate the procurement and delivery of needed transition services and supports, including waiver transition services prior to transition.

Transition Services Available

In addition to Money Follows the Person demonstration services, there are two services available to assist individuals in transitioning back to the community:

1. Case Management (Section 512.36): To develop a Waiver members Service Plan and ensure that the needed community services and supports are in place on the first day of the members return to the community; and
2. Community Transition Services (Section 512.37): One-time expenses that address identified barriers to a safe and successful transition from facility-based living to the community.

512.1 HOME AND COMMUNITY BASED SETTINGS REQUIREMENTS

In January 2014, the Centers for Medicare & Medicaid Services promulgated a final federal rule (2014 Home and Community Based Services Final Rule. CMS-2249-F and CMS 2296-F) to ensure that individuals receiving long term services and supports (LTSS) through home and community-based services (HCBS) programs under 1915(c) and 1915(i) have full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal finances and receive services in the community to the same degree as individuals not receiving Medicaid HCBS.

The West Virginia HCBS Statewide Settings Transition Plan (STP) is a document that is several years in the making and is West Virginia's response to how West Virginia will meet the standards in the final federal rule. Over the past eight years, West Virginia has put this document out for public comment seven times, adding to the plan each time and making revisions. This final plan is divided into four sections – Phase I is Planning, Phase II is Initial Research and Discovery, Phase III is Analysis of Research and Phase IV is Steps Going Forward. In an effort to make the document less voluminous much of the research, analysis and public comments have been moved to the West Virginia STP webpage.

West Virginia underwent the process of developing a transition plan pursuant to 42 CFR 441.301(c)(6) that contained the actions the State took to bring all West Virginia waivers into compliance with requirements set forth in 42 CFR 441.301(c)(4-5). The TBIW is affected by this Rule. All members and settings for the TBIW program will be reviewed annually using the following protocols.

The case manager must complete mandatory training on the STP prior to completing the member-controlled assessments. The case manager training is available on the WV Learning Management System. Direct-support professional staff must also receive mandatory training on the STP. This training can be the same training available to case managers or can be in the form of the educational brochure available to members.

The provider agency must document how the paid caregiver was trained and if using the brochure, the agency must ensure the paid caregiver passes with 80% competency. Members will receive educational information on the STP from their case manager in the form of the brochure and documented on the member's person-centered plan.

Member-Controlled Settings

Member-controlled settings are defined as a home or apartment, owned or leased by a HCBS member or by one of their family members. 92% of the members on the Waiver programs own or lease their own individual, privately-owned homes. These settings are presumed to follow the regulatory criteria of a home or community-based setting. The state includes private residences as part of the overall quality assurance framework when implementing monitoring processes for ongoing compliance with the settings criteria, as well as any oversight provisions in the approved HCBS waivers or State Plan Amendments.

The member's case manager must assess the setting annually, up to 90 days prior to the member's anchor date, to ascertain that the member continues to reside in a setting with the characteristics of a member-controlled setting and that the setting continues to meet the standards as described below:

- The setting is integrated in and supports full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. 42 CFR 441.301(c)(4)(i)/441.710(a)(1)(i)/441.530(a)(1)(i)
- The setting is selected by the member from among setting options including non-disability specific settings. The settings options are identified and documented in the person-centered plan and are based on the member's needs, preferences 42 CFR 441.301(c)(4)(ii)/ 441.710(a)(1)(ii)/441.530(a)(1)(ii)
- The setting ensures a member's rights of privacy, dignity, and respect, and freedom from coercion and restraint. 42 CFR 441.301(c)(4)(iii)/ 441.710(a)(1)(iii)/441.530(a)(1)(iii)
- The setting optimizes, but does not regiment, member initiative, autonomy, and independence in making life choices including but not limited to daily activities, physical environment, and with whom to interact. 42 CFR 441.301(c)(4)(iv)/ 441.710(a)(1)(iv)/441.530(a)(1)(iv)
- The setting facilitates member choice regarding services and supports, and who provides them. 42 CFR 441.301(c)(4)(v) 441.710(a)(1)(v)/441.530(a)(1)(v)

If the setting cannot be remediated to meet the standard, then the setting will be disenrolled from the waiver program and the member will be referred to transition to an approved setting. If the member refused to move to an approved setting, then the member will be disenrolled from the waiver program. If all transition efforts are refused by the member, then the member will be disenrolled from the program. Assistance from BMS or its designee (the Utilization Management Contractor (UMC) or the Operating Agency (OA)) is available upon request.

The member-controlled setting assessment may be found under the Resource section of the STP webpage.

Provider-Controlled Settings

Provider-controlled settings are settings where a member resides with a paid unrelated caregiver or with

an agency provider who provides HCBS services the majority of the day.

All provider-controlled settings and members who receive services in these settings will be evaluated at least annually by BMS or its designee (the Utilization Management Contractor) at least 90 days prior to their annual anchor date to ascertain that the setting continues to exhibit the characteristics of a provider-controlled setting and that the setting meets the standards as described below:

- The setting was selected by the member from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the member's needs, preferences, and, for residential settings, resources available for room and board.
- The member participates in unscheduled and scheduled community activities in the same manner as individuals not receiving Medicaid HCBS services.
- Members have opportunities to seek employment and work in competitively integrated settings and engage in community life.
- The members have their own bedroom or shares a room with a roommate of choice.
- The member chooses and controls a schedule that meets their wishes in accordance with a person-centered plan.
- The members control their personal resources.
- The members choose when and what to eat and may have access to food at any time.
- The members choose with whom to eat or to eat alone.
- Member choices are incorporated into the services and supports received.
- The members choose from whom they receive services and supports.
- The member has access to make private telephone calls/text/email at the member's preference and convenience.
- Members are free from coercion and restraint.
- The member, or a person chosen by the individual, has an active role in the development and update of the member's person-centered plan.
- The setting does not isolate members from individuals not receiving Medicaid HCBS in the broader community.
- State laws, regulations, licensing requirements, facility protocols or practices do not limit members' choices.
- The setting is an environment that supports members' comfort, independence and preferences.
- The member has unrestricted access in the setting.
- The physical environment meets the needs of those members who require support.
- Members have full access to the community.
- The members' right to dignity and privacy is respected.
- Members who need assistance to dress are dressed in their own clothes appropriate to the time of day and individual preferences.
- Staff communicate with members in a dignified manner.
- The member can have visitors of their choosing at any time.
- The member's unit has an entrance door that is lockable by the member, with only appropriate staff having keys to doors.

Any provider-controlled setting that does not meet these standards will be referred to BMS or its designee for assistance with remediation to attempt to attain compliance. If the setting cannot be remediated to

meet all these standards, then the setting will be removed from approved provider listing and the member(s) will be referred to transition to an approved setting. If this transition is not successful, then, as a last resort, the member will be discharged from the program.

The provider-controlled setting assessment may be found under the Resource tab of the STP webpage.

In addition, all waiver agencies will be contacted annually to verify the settings owned, leased, or operated by the provider agency. It is the responsibility of the agency to notify BMS within 15 days of any change in status, i.e., sites are added or removed. When a new setting is added, BMS or its designee must review the site to ascertain the site is in compliance before any HCBS services may be billed.

All HCBS Settings

All home and community-based settings must have all the following qualities, and such other qualities based on the needs of the individual as indicated on their person-centered plan:

- The setting is integrated in and supported full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitively integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- The setting is selected by the member from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered plan and are based on the member's needs, preferences, and, for residential settings, resources available for room and board.
- The setting ensures the member's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact.
- The setting facilitates member choice regarding services and supports, and who provides them.

Heightened Scrutiny Overview

As the State reviewed each distinct setting/address, settings were sorted into one of five categories:

1. The setting meets the HCBS characteristics and is compliant.
2. The setting does not currently meet HCBS characteristics but intends to become compliant.
3. The setting cannot meet the HCBS characteristics.
4. The setting is presumptively institutional and is determined incompatible with HCBS.
5. Settings that are Intermediate Care Facilities for Individual with Intellectual Disabilities (ICF/IID), Institutions for Mental Disease (IMD), nursing facility, or hospitals do not provide HCBS and were not subject to transition.

The State of West Virginia works with Waiver providers to monitor their plans to come into compliance. If a setting is unable or unwilling to become compliant with remediation, as determined by on-site review of the setting, then the state will initiate the process for resolution of beneficiary concerns when in a setting that will not be compliant.

Some settings may be presumptively non-HCBS settings that isolate as described below:

- Settings that are in a building that is also a publicly or privately-operated facility that provides inpatient institutional support treatment;
- Settings that are in a building on the grounds of, or immediately adjacent to, a public institution; or
- Any other settings that have the effect of isolating members receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS, including:
    - Where members have limited, if any, opportunities for interaction in and with the broader community, including with individuals not receiving Medicaid funded HCBS
    - Where the setting restricts member choice to receive services or to engage in activities outside of the setting
    - Where the setting is physically located separate and apart from the broader community and does not facilitate member opportunity to access the broader community and participate in community services, consistent with the member's person-centered service plan

These settings will be subject to a heightened scrutiny process. These are settings that the state has determined to be presumed institutional and that the state has determined have or will overcome the institutional presumption and comply with the settings criteria by the end of the transition period. In such cases, the setting would be submitted to CMS for a heightened scrutiny review. Evidence compiled by the State will accompany this submission. This evidence will include review documents, stakeholder interviews and comments and other evidence as necessary.

At present there are no such determined settings. West Virginia does not have any Waiver settings that are in a building that provides inpatient institutional treatment. West Virginia does not have any Waiver settings on the grounds of, or adjacent to, a public institution. All settings where Waiver services are provided have been evaluated through the Setting Review Process for each respective Waiver and all provide integration into the broader community. Data analysis from these evaluations can be found on the West Virginia STP webpage.

West Virginia is adding all settings that provide services to more than 4 members to their heightened scrutiny process.

Transition of Members Overview

When a case manager or BMS designee discovers a setting that no longer meets the standards of the Integrated Settings Rule, the case manager will work with the provider to develop a remediation plan within 30 days of this discovery. This plan may include transfer to another setting that complies. The provider will have 30 additional days to complete the remediation plan and the case manager will have an additional 30 days to make a visit to the setting to ensure the plan is completed. If, after this 90-day total period, the setting is not in compliance, then it shall be determined that the setting does not meet the characteristics necessary for HCBS and remediation efforts have been unsuccessful. At this point, the member will be dis-enrolled from the Medicaid program and the setting will be removed from the HCBS program. Notification to the provider will be by certified mail as well as electronically. The provider is responsible for notification of members, with all correspondence or contacts copied to the Bureau for Medical Services.

BMS will also notify the individual members five working days after the provider notification, to assure that all stakeholders are notified of the dis-enrollment. This information will include material on transition

assistance and extensions and will be provided through:

1. the specific time frame indicated in the letter sent to each member; and
2. the general informational meetings for members as noted below.

While the transitions of members to other providers or settings will begin as soon as the provider is notified, the provider will have 90 calendar days from the date of the notification to assist individuals to transition to other services and/or settings that do comply with the Rule. The Provider will have 10 calendar days from the date of its notification of disenrollment to notify all participants of the disenrollment and actions the provider will take to ensure person centered planning. BMS will be copied on all provider to member correspondence. The Utilization Management Contractor (UMC) will also notify the member within 10 calendar days of the date of notification.

Members may remain at the setting, but HCBS services may not be billed for that member. Member team meetings will be held, and the member and their legal representative (if applicable) will make the final choice of available settings/sites. Provider disenrollment will occur at the end of the 45 days or when all members are successfully transitioned.

Within 30 working days of the date of the notification, the provider will submit to BMS an Agency Transition Plan. This Plan will list:

1. Setting location which is non-compliant;
2. The member(s) by name and Medicaid number;
3. The service(s) provided to each listed member;
4. The date for the transition meeting for each listed member;
5. The result of the meeting including setting/location of services that do comply with the rule;
6. The date of the change of provider/setting.

The provider will submit updates to the Agency's Transition Plan weekly to BMS, completing items 4-6 as these events occur. This plan update will be provided to BMS until all member transitions are complete.

BMS shall be copied on all correspondence with members and/or families. Members will also be encouraged to call BMS should they have any questions. BMS contact information will be made available to all affected members at a Service Plan Addendum meeting and on the BMS website.

Should a member request assistance beyond that given by the provider, BMS will assist the member in the timely transition to another provider and/or setting. Requests should be made by phone, email or letter. In isolated instances, BMS may extend the 90-day transition period for a member to assure that there is no interruption of services to the member. It is anticipated that approximately 10% of members in an affected setting would have need of some mode of direct intervention from BMS.

This procedure would also apply to a provider which concurs with the setting review that the site is not HCBS compliant. Thus far, no sites have been disenrolled from any of the Waiver programs and no members have been transitioned to other providers or discharged from the program.

PROVIDER PARTICIPATION REQUIREMENTS

512.2 BUREAU FOR MEDICAL SERVICES CONTRACTUAL RELATIONSHIPS

The BMS contracts with a UMC. The UMC is responsible for day-to-day operations and oversight of the TBIW program including conducting medical eligibility evaluations, determining medical eligibility for applicants and members enrolled in the program, initial and ongoing certification of provider agencies and providing prior authorization for services provided to members enrolled in the TBIW, conducts education for TBIW providers, advocacy groups, and members receiving TBIW services.

The UMC, in collaboration with the BMS, will provide answers to policy questions which will serve as policy clarifications. These policy clarifications will be posted on the TBIW website.

The BMS contracts with a Fiscal/Employer Agent (F/EA) to administer the *Personal Options* Financial Management Services (FMS) program and resource consultant Services. The F/EA is a subagent of the BMS for the purpose of performing employer and payroll functions for members wishing to self-direct their services through the *Personal Options* FMS.

The BMS contracts with TBIW providers for the provision of services for members receiving TBIW services. All TBIW providers must be certified by the UMC and enrolled as a Medicaid provider.

Please refer to the TBIW website for UMC and FMS- *Personal Options* contact information.

512.3 PROVIDER AGENCY CERTIFICATION

TBIW provider agencies must be certified by the UMC. A certification application must be completed and submitted to the UMC. Please refer to the TBIW Program website for program contact information.

An agency may provide case management and/or personal attendant services, but not to the same member. They are required to maintain:

- A separate certification and National Provider Identifier (NPI) for each service;
- Separate staffing; and,
- Separate files for case management and personal attendant services.

Conflict free case management services must be separate from personal attendant services. A provider Agency may offer other services (case management and personal attendant) but not to the same member. Exceptions will be submitted to the UMC when necessary if there is only one willing and qualified provider in a county. BMS will make the final determination.

Case management agencies cannot serve the same member who is receiving direct-care worker services through the Medicaid State Plan Personal Care Services program. However, it may be necessary for an exceptions determination to be made for the case management agency if they are the only willing and qualified Case management agency provider in a county.

Case management agencies must have a policy to ensure there will not be a conflict of interest if an exception has been made. A conflict of interest is when the case manager who represents the TBIW member, also provides personal attendant agency services through the same provider agency. Failure to abide by conflict-of-interest policy will result in the loss of provider certification for a period of one year

and all current members being served will be transferred to another case management agency. Any case manager working for a case management agency that will also be providing Personal Attendant Agency services will need to sign the case management Conflict of Interest Exception Application for home and community-based waiver services. The completed and approved Application must be placed in the member's file at the case management agency. Failure to have the approved Application in the file when reviewed could result in sanctions. If it is determined that a case manager has violated conflict of interest assurances, they may be subject to sanctions including being prohibited from billing for services.

If there is a lack of willing and qualified providers to accommodate the waiver member's need for services within 25 miles from the members home, or who speak the waiver member or family's language, the State can waive the conflict-free requirements. A Conflict-of-Interest Exception Application for Home and Community Based Waiver Services will be initialed by the UMC on behalf of the member and submitted on behalf of the case management agency. The UMC will review the request and submit the request to the BMS program manager for authorization. An approved Conflict of Interest Exception Application for Home and Community Based Waiver Services is valid for one year during the annual Service Plan development meeting. The exception will be reviewed by the UMC and approved by BMS annually thereafter.

For providers granted an exception to the conflict-free requirements, the provider has ensured conflict of interest protections, certifying that case managers employed by that provider remain neutral during the development of the person-centered service plan and including the requirement that the provider separate direct care services and case management into distinct functions, with separate oversight.

If an exception has been granted by BMS the following must be ensured by the case management agency:

- Case management agencies must have a policy to ensure there will not be a conflict of interest if an exception has been made.
    - Include a basic description of the duties of the home and community-based services supervisor(s) and the case management supervisor(s).
    - Explain how members are provided a case manager.
    - Explain how members are given a choice of home and community-based services and other natural supports or services offered in the community.
    - Explain how the agency ensures that the case manager is free from the influence of direct service providers regarding member service plans.
    - Evidence of administrative separation on organizational chart that includes position titles and names of staff.
    - The agency has administrative separation of supervision of case management and home and community-based services.
    - The attached organization chart shows two separate supervisors, one for case management and one for home and community-based services.
    - Case management members are offered a choice for home and community-based services between and among available service providers.
    - Case management members are not limited to home and community-based services provided only by this agency.
    - Case management members are provided with a case manager within the agency.
    - Disputes between case management and home and community-based services units are resolved.

- Members are free to choose or deny home and community-based services without influence from the internal agency case manager and home and community-based service staff.
- Members choose how, when, and where to receive their approved home and community-based services.
- Members are free to communicate grievance(s) regarding case management and/or home and community-based services delivered by the agency.
- The grievance/complaint procedure is clear and understood by members and legal representatives.
- Grievances/complaints are resolved in a timely manner.

To be certified as a TBIW case management and/or personal attendant service provider agencies, applicants must meet and maintain the following requirements:

- A business license issued by the State of West Virginia.
- A federal tax identification number (FEIN).
- Insurance: The provider shall have the following:
  - A minimum of one million dollars in commercial liability insurance, which includes coverage for individuals' losses due to theft or property damage.
- Written instructions a member would use to obtain payment for loss due to theft or property damage caused by the provider's employee.
- Providers cannot require personal attendants or case managers to sign any type of agreement that limits employment opportunities that would affect member choice of provider agency.
- A competency-based curriculum for required training areas for personal attendant staff.
- An organizational chart.
- A list of the Board of Directors (if applicable).
- A list of all agency staff, which includes their qualifications.
- A Quality Management Plan for the agency.
- Written policies and procedures for processing complaints and grievances from staff or members receiving TBIW services that:
  - Addresses the process for submitting a complaint.
  - Provides steps for remediation of the complaint including who will be involved in the process.
  - Steps include the process for notifying the member of the findings and recommendations.
  - Provides steps for advancing the complaint if the member/staff does not feel the complaint has been resolved.
  - Ensures that a member receiving TBIW services or agency staff are not discharged, discriminated, or retaliated against in any way if they have been a complainant, on whose behalf a compliant has been submitted or who has participated in an investigation process that involves a TBIW provider.
- Written policies and procedures for the use of personally and agency owned electronic devices which includes, but is not limited to:
  - Prohibits using personally identifiable information in texts and subject lines of emails;
  - Prohibits the use of personally identifiable information in the body of emails unless the email is sent securely through a Health Insurance Portability and Accountability Act (HIPAA) compliant connection;
  - Prohibits personally identifiable information be posted on social media sites;

  - Prohibits using public Wi-Fi connections without use of a secure Virtual Private Network (VPN) connection;
  - Informs agency employees that during an investigation, information related on their personal cell phone is discoverable; and
  - Requires all electronic devices be encrypted.
- Written policies and procedures for members to transfer.
- Written policies and procedures for the discontinuation of member's services.
- Written policies and procedures to avoid conflict of interest (if the agency is providing both case management and personal attendant services) must be included at a minimum.
- Education of case managers on general conflict of interest/professional ethics with verification;
- Annual signed Conflict of Interest Statements for all case managers and the agency director;
- Process for investigating reports on conflict-of-interest complaints;
- Policy and procedure for reporting Medicaid Fraud to the BMS (Office of Program Integrity and program manager);
- Process for complaints to professional licensing boards for ethics violations.
- Office space that allows for confidentiality of the members receiving TBIW services.
- An Agency Emergency Plan (for members receiving TBIW services and office operations). This plan must include:
  - Office Emergency Back-Up Plan ensuring office staffing and facilities are in place during emergencies such as floods, fires, etc. However, the new temporary facilities must meet all requirements. The provider must notify the UMC within 48 hours.
- Providers must inform members receiving TBIW services of their Emergency Back-Up Plan.
- The agency must accept referrals within five business days or forfeit the referral.
- All providers are required to have and implement policies and procedures for members with limited English proficiency and/or accessible format needs that are culturally and linguistically appropriate to ensure meaningful access to services.
- Computer(s) for staff with HIPAA secure email accounts, UMC web portal software, internet access, and current (within last five years) software for spreadsheets.
- Hires and retains a qualified workforce.
- Ensure that a member receiving TBIW services is not discharged unless a viable discharge/transfer plan is in place that effectively transfers all services that the members need to another provider(s) and is agreed upon by the member and the receiving provider(s).
- Ensures that services are delivered, and documentation meets regulatory and professional standards before the claim is submitted.
- Participate in all BMS mandatory training sessions.
- Written policy and procedures regarding Personal Attendant staff not being allowed to sub-contract their work responsibilities to another person.
- Provider must have written policy and procedures for reporting and documenting incidents if/when a program member presents an unsafe work environment for staff.
- Written policies and procedures to ensure that service provider staff that fail to report incidents and delays in incident reporting, will result in appropriate employee discipline up to and including employee suspension or termination.
- Written policies and procedures to ensure that individuals including the member, staff and family members are free from retaliation or adverse consequences because they reported incidents or allegations of abuse, neglect, exploitation or other staff misconduct.

- Written policies and procedures to ensure that guardians are informed of reported incidents as soon as possible after learning of an incident and in all cases within 72 hours of learning of an incident.
- Written policy and procedures outlining agency personal attendant staff actions when the member is not home/doesn't respond to calls and the personal attendant has arrived to provide scheduled services.
- Written policy and procedures outlining case manager's actions when the member is not responding to a home visit and/or calls.
- Provider must comply with the CMS settings rule.
- Have written policy regarding member's right to request their records.
- All TBIW providers must provide any services, when they are needed, that are listed on the member's Service Plan. This includes services on weekdays and weekends.
- Have written Policy and Procedure for documentation training for case managers and personal attendants that at the minimum must include current program forms and proper documentation correction procedures.

Provider agencies will be reviewed by the UMC within six months of initial agency certification, and annually thereafter (Refer to Section 512.10 Initial/Continuing Certification of Provider Agencies).

More information regarding provider participation requirements in Medicaid services can be found in *Chapter 300, Provider Participation Requirements*. Providers will be held accountable for information contained in all Medicaid common chapters.

Providers are encouraged to contact the UMC for training needs and technical assistance at any time. The hourly wage of agency staff employed by an TBIW provider is determined solely by the agency that employs the staff person. Agency providers must always comply with all local, state, and federal wage and hour employment laws and regulations, including, but not limited to, the West Virginia Wage and Hour Act, Fair Labor Standards Act (FLSA) and Internal Revenue Service (IRS) laws and regulations. TBIW providers are solely responsible for making their own determination as to whether an individual performing work for the agency is an employee or independent contractor under applicable state and federal laws and regulations. Provider agencies should not interpret this as an opportunity to misclassify workers as independent contractors. Provider agencies are solely responsible for any liability resulting from misclassification of workers. The BMS reserves the right to disenroll any TBIW provider which is found to have misclassified employees by the U.S. Department of Labor, IRS, or any other applicable state or federal agency. All agency staff hired by an TBIW provider must meet the requirements listed Section 512.16, Staff Qualifications and Training Requirements.

In the event a provider sells their business, the members do not automatically transfer with the sale. Members must be provided freedom to choose from available TBIW providers in their catchment area. Any effort to coerce a member to transfer to the purchasing TBIW provider will be considered a conflict of interest and will result in the purchasing TBIW provider being removed from the TBIW provider selection list for one calendar year. (See Section 512.44 Voluntary Agency Closure). If a provider sells their business, they must notify BMS and the UMC in writing at least 30 days prior. The UMC will facilitate member transfers.

512.4 ELECTRONIC VISIT VERIFICATION (EVV)

As required by the Cures Act, the BMS implemented an EVV system to verify home visits. The EVV system verifies:

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

For services requiring EVV, personal attendant staff will use the system to check-in at the beginning of the visit. After the visit, the member or authorized representative will use the system to verify the correct visit has been provided. BMS will ensure the EVV solution is secure, minimally burdensome, and does not constrain member selection of a caregiver or the manner of care delivery. BMS will provide training and an EVV guide. Personal attendants that live in the members' home will not be required to use EVV.

512.5 CRIMINAL BACKGROUND CHECKS

Refer to *Chapter 700, West Virginia Clearance for Access: Registry & Employment Screening (WV CARES)* for Criminal Background Check information.

The current length of time for Crime Identification Bureau (CIB) checks is every five years.

512.6 OFFICE CRITERIA

TBIW case management and personal attendant service provider agencies must designate and staff at least one physical office within West Virginia. **The office cannot be in or part of a private residence**. A post office box or commercial mailbox will not suffice. Each designated office must meet the following criteria:

- Physically located in West Virginia.
- An agency office site can serve the counties in West Virginia as designated in their application. TBIW providers wishing to make changes in the approved counties they serve **must** make the request in writing 30 days prior to providing services to the UMC.
- Changes can only be made annually unless it is a request for a provider to expand their service area by the BMS.
- Be readily identifiable to the public through signage that includes hours of operation.
- Meet Americans With Disabilities Act (ADA) requirements for physical accessibility (refer to 28 CFR 36, as amended). These include but are not limited to:
    - Maintains an unobstructed pedestrian passage in the hallways, offices, lobbies, bathrooms, entrance and exits.
    - The entrance and exit have accessible handicapped curbs, sidewalks and/or ramps.
    - The restrooms have grab bars for convenience.
- A telephone is accessible.
- Drinking fountains and/or water made available as needed.
- Maintain a primary telephone number that is listed with the name and local address of the business. (Note: Exclusive use of a pager, answering service, a telephone line shared with

another business/individual, facsimile machine, cell phone, or answering machine does not constitute a primary business telephone.)

- Maintain an agency secure HIPAA compliant e-mail address for communication with the BMS and the UMC for all staff.
- At a minimum, must have access to a computer, fax, email address, scanner, and internet.
- Utilize any database system, software, etc., compatible with/approved and/or mandated by BMS.
- Be open to the public at least 40 hours per week. Observation of state and federal holidays is at the provider's discretion.
- Contain space for securely maintaining program and personnel records (refer to *Chapter 100, General Information*, and *Chapter 300, Provider Participation Requirements*, for more information on maintenance of records).
- Maintain a 24-hour contact method.
- Change in agency location due to emergencies such as flood or fire for over 30 days requires a site review of the agency by the UMC.
- Any authentication method for electronic and stamped signatures must meet the following basic requirements:
    - Unique to the person
    - Capable of verification
    - Under the sole control of the person, and
    - Linked to the data in such a manner that if the data is changed, the signature is invalidated.
    - Agencies that provide electronic devices to their staff must ensure all personally identifiable information is secure.
- Certified TBIW providers cannot subcontract any services they are approved to provide to another agency.
- TBIW provider agencies cannot obtain certification for the benefit of serving individuals receiving services from another program such as Veteran Administration (VA) clients. BMS is not responsible for certifying other in-home service programs or its workers.

512.7 QUALITY IMPROVEMENT SYSTEM (QIS)

The Quality Improvement System (QIS) is designed to:

- Collect data necessary to provide evidence to CMS that Quality Assurances are being met; and
- Ensure the active involvement of interested parties in the quality improvement process; and
- Ensure remediation and/or systemic quality improvement within the program.

512.8 CENTERS FOR MEDICARE AND MEDICAID (CMS) SERVICES QUALITY ASSURANCES

- TBIW Administration and Oversight: 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.
- Level of Care Evaluation/Re-evaluation: The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an

applicant's/waiver member's level of care consistent with level of care provided in a hospital, nursing facility, or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

- 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.
- Person Centered Service Plan: The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of person-centered service plans for waiver members.
- Health and Welfare: The State demonstrates it has designed and implemented an effective system for assuring waiver members health and welfare.
- Financial Accountability: The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

Data is collected and analyzed for all quality assurances and sub-assurances based on West Virginia's Quality Performance Indicators, as approved by CMS. The primary sources of discovery include TBIW provider reviews, West Virginia Incident Management System (IMS), complaints/grievances, abuse, neglect and exploitation reports, administrative reports, the Home and Community Based Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey, oversight of delegated administrative functions, and the Quality Improvement Advisory (QIA) Council.

512.9 QUALITY IMPROVEMENT ADVISORY (QIA) COUNCIL

The QIA Council is the focal point of stakeholder input for the TBIW program and plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies. The role of the QIA Council is to advise and assist the BMS and the UMC staff in program planning, development and evaluation consistent with its stated purpose. In this role, the QIA Council uses the TBIW performance measures as a guide to:

- Review findings from evidence-based discovery activities.
- Recommend policy changes to the BMS.
- Recommend program priorities and quality initiatives.
- Monitor and evaluate the implementation of TBIW priorities and quality initiatives.
- Monitor and evaluation of policy changes.
- Serve as a liaison between the TBIW program and interested parties; and
- Establish committees and workgroups consistent with their purpose and guidelines.

The Council membership is comprised of former and/or current members receiving TBIW services (or their legal representatives), service providers, advocates, and other allies of the population served.

512.10 INITIAL/CONTINUING CERTIFICATION OF PROVIDER AGENCIES

Following the receipt of a completed Certification Application, the UMC will conduct an onsite review, if required, to verify that the prospective provider meets certification requirements. This requirement may be waived if the prospective provider is a current Licensed Behavioral Health Center (LBHC) or is enrolled as an Aged and Disabled Waiver (ADW), Personal Care (PC) Services program, or Intellectual/Developmental Disabilities Waiver (IDDW) provider at the time of application.

The UMC will notify the BMS fiscal agent, upon satisfactory completion of the onsite review or verification of LBHC, ADW, PC Services, or IDDW status. The BMS fiscal agent will provide the provider applicant with an enrollment packet which includes the TBIW Provider Agreement. Once this process has been completed, the fiscal agent will assign a provider number. A letter informing the provider agency that it may begin providing and billing for TBIW services will be sent to the provider agency and to the UMC by the fiscal agent.

When a case management or personal attendant service provider agency is physically moving to a new location or open a satellite office, they must notify the UMC 45 days prior to the move. The UMC will schedule an on-site review of the new location to verify the site meets certification requirements. Medicaid services cannot be provided from an office location that has not been certified by the UMC prior to becoming an enrolled Medicaid provider.

In addition, all providers of TBIW services are subject to and bound by Medicaid rules and regulations found in *Chapter 100, General Information* of the BMS Provider Manual.

Once certified and enrolled as a Medicaid provider, TBIW case management and personal attendant service provider agencies must continue to meet the requirements listed in this chapter as well as the following:

- Employ adequate, qualified, and appropriately trained personnel who meet minimum standards for providers of the TBIW program.
- Provide services based on each member's individual assessed needs, including evenings and weekends.
- Maintain records that fully document and support the services provided.
- Furnish information to the BMS, or its designee, as requested. (Refer to *Chapter 100, General Information* and *Chapter 300, Provider Participation Requirements*, for more information on maintenance of records).
- Maintain a current list of members receiving TBIW services.
- Comply with WV IMS

512.11 QUALITY REVIEWS

TBIW provider agencies are required to submit designated evidence to the UMC every 12 months to document continuing compliance with all certification requirements as specified in this Chapter. This evidence must be attested to by an appropriate official of the provider agency (e.g., Director or Board Chair). If appropriate documentation is not provided within 30 calendar days of expiration of current certification, a Provisional Certification may apply. Provider agencies who receive a Provisional Certification will be required to have a review by the UMC prior to full recertification.

If deficiencies are found by the UMC during document review, the provider must submit a Plan of Correction within 30 calendar days of notice of deficiency. If the Plan of Correction, submitted by the provider to the UMC, requires additional information and/or technical assistance, the additional information must be submitted within 10 business days. If an approved Plan of Correction and required documentation is not submitted within the required time frame, the BMS may hold provider reimbursement and remove the provider from Freedom of Choice Selection forms until an approved Plan of Correction is in place.

A Plan of Correction must include:

- How the deficient practice cited in the deficiency will be corrected. What system will be put into place to prevent recurrences of the deficient practice.
- How the provider will monitor to assure future compliance and who will be responsible for the monitoring.
- The date each item on the Plan of Correction will be completed; and
- Any provider-specific training requests related to the deficiencies.

If an agency requires a Plan of Correction, the UMC will conduct a six month follow up to see if the Approved Plan of Correction has been implemented as stated.

If the six-month follow up reveals that the correction(s) have not been implemented, the BMS may request a pay hold and/or remove the agency from the provider list until such time that all the corrections have been implemented.

TBIW providers will be required to participate in an on-site or desk review every year at the discretion of the UMC. Any provider who enrolls at least one program member during a calendar year will be queued for on-site retrospective review the subsequent year and each year thereafter.

Targeted onsite certification reviews may be conducted based on Incident Management Reports and complaint data. In some instances, when a member's health and safety are in question, a full review of all records will be conducted.

Certification Reviews

The UMC staff will validate the information from the most recent completed certification with a review of the agency policy and procedures, the agency Quality Management Plan, personal attendant staff competency-based training curriculum, and a walk through of the agency office setting to monitor office criteria compliance. The walk through will include digital verification (digital photos) that the physical office meets policy requirements.

Within 10 business days of the conclusion of the exit interview, the UMC will email a Provider Review Report and draft Plan of Correction, if needed, to the provider and to the BMS. If a draft Plan of Correction is required by a provider, they must complete and submit it to the UMC within 30 days of notice of the deficiency. If the UMC returns the draft Plan of Correction to the provider requesting additional information the provider must complete and re-submit the draft Plan of Correction within 10 business days. If the draft Plan of Correction and required documentation is not submitted within the time frame, the BMS may hold provider reimbursement and remove the provider from the Freedom of Choice Selection forms until an approved Plan of Correction is in place.

Quality Reviews

The Quality Review Tools monitoring tools used by the UMC to review charts are available on the TBIW program website. Due to the member size of the TBIW program, CMS requires a 100% review of member records.

Upon completion of each provider Quality Review, the UMC conducts an exit summation with the agency director or their designated staff. Following the exit summation, the UMC will make available to the provider a draft Review Report and if necessary, a draft Plan of Correction to be completed by the TBIW provider. If potential disallowances are identified, the TBIW provider will have 30 days from receipt of the draft Review Report to send comments back to the UMC. After the 30-day comment period has ended, the BMS will review the draft Review Report and any comments submitted by the TBIW provider and issue a Final Review Report to the TBIW provider's director.

Note: If a lapse occurs for any checks within the WV CARES, the BMS will request reimbursement for paid claims should any disqualifying offenses be found during the lapse time frame.

The final report reflects the provider's overall performance, details of each area reviewed and any TBIW disallowance, if applicable, for any inappropriate or undocumented billing of TBIW services. A letter to the TBIW provider's director will outline the following options to effectuate repayment:

- Payment to the BMS Office of Program Integrity (OPI) within 60 days after the BMS notifies the provider of the overpayment: or
- Placement of a lien by the BMS OPI against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment: or
- A recovery schedule of up to a 12-month period, through monthly payments or the placement of a lien against future payments.

Failure to provide written comments to the draft report will result in forfeiture of being able to request a document/desk review.

If the TBIW provider disagrees with the final disallowance report, the TBIW provider may request a document/desk review within 30 days of receipt of the final report pursuant to the procedures in *Chapter 100, General Information* of the BMS Provider Manual. The TBIW provider must still complete the written repayment arrangement within 30 days of receipt of the Final Disallowance Report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document/desk review must be in writing, signed, and set forth in detail the items in contention. The letter must be addressed to:

Bureau for Medical Services
Legal Department – Document Desk Review
350 Capitol Street, Room 251
Charleston, WV 25301-3706

If no potential disallowances are identified during the UMC review, then the TBIW provider will receive a final letter and a Final Review Report from the BMS.

For information concerning other audits relevant to services provided under this chapter please see *Chapter 800, Program Integrity*.

512.12 TRAINING AND TECHNICAL ASSISTANCE

The UMC develops and conducts training for TBIW providers and other interested parties as necessary to

improve systemic and provider-specific quality of care and regulatory compliance. Training is available through both face-to-face and web-based venues.

All TBIW providers must send at least one representative to the BMS mandatory quarterly provider meetings. That representative is responsible for dissemination of the information learned at the quarterly provider meetings to all other pertinent agency personnel.

512.13 SELF-AUDIT

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

- The provider becomes aware there was a noncompliance issue, and/or
- A self-audit is assigned by the BMS.

TBIW providers must use the approved format for submitting self-audits to the Office of Program Integrity (OPI). Failure to submit an assigned self-audit may result in the BMS withholding Medicaid payments until the self-audit is submitted. TBIW providers are required to send all completed forms in an electronic format to the OPI along with the original Excel spreadsheet and repayment forms.
The self-audit form can be found on the BMS TBIW website.

For more information on sanctions available to the BMS, see *Chapter 800, Program Integrity*.

512.14 RECORD REQUIREMENTS

Providers must fully complete all required TBIW forms and follow published forms instructions. Forms with corrective fluid/tape or removeable labels used on them will not be accepted. Documentation must be member-specific, legible and errors in documentation cannot be completely covered over but should be indicated with a line through the error and noted/initialed by the person making the correction. Forms and instructions can be found on the TBIW website.

TBIW providers must meet the following program record requirements:

- The provider must keep a file on each member utilizing the TBIW.
- The files must contain all original documentation for services provided to the member by the provider responsible for development of the document (for example the case management agency should have the original Person-Centered Service Plan, the complete service assessment, contact notes, enrollment confirmation, etc.).
- Original documentation on each member and employee must be kept by the Medicaid provider for five years, with all exceptions having been declared resolved by the BMS, in the designated office that represents the county where services were provided. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years, whichever is greater.
- The provider must upload the following documentation into the UMC web portal within seven business days from the date of the Service Plan meeting:

- Person Centered Service Plan (initial/annual including Responsibility Agreements if applicable)
- Person Centered Assessment and Discovery Tools
- Any legal documents pertaining to power of attorney, legal guardianship, conservatorship, etc. and
- The member-controlled settings assessment

Provider Personnel Records

Legible original copies of personnel documentation including training records, licensure, confidentiality agreements, fingerprint-based background checks etc. must be maintained on file by the provider.

- Minimum credentials for professional staff (case manager) must be verified upon hire and thereafter based upon their individual professional license requirements.
- All documentation on each staff member must be kept by the provider in a designated location office that represents the county where services were provided.
- Verification that the Office of Inspector General (OIG) Exclusion List was checked as appropriate for the position.

TBIW providers must agree to abide by all applicable federal and state laws, policy manuals, and other documents that govern the waiver program. Providers must also agree to make themselves, Board Members (if applicable), their staff, and all records pertaining to TBIW services available to any audit, desk review, or other service evaluation that ensures compliance with billing regulations and program goals.

Providers must ensure that all required documentation is maintained at the agency as required by state and federal regulations and is accessible for state and federal audits.

512.15 LEGAL REPRESENTATIVES

When reference is made to “applicant/member” in this manual, it also includes any person who may, under State law, act on the person’s behalf when the person is unable to act for himself or herself. That person is referred to as the person’s legal representative. There are various types of legal representatives, including but not limited to: guardians, conservators, power of attorney representatives, health care surrogates and representative payees. Each type of legal representative has a different scope of decision-making authority. For example, a court-appointed conservator might have the power to make financial decisions, but not health care decisions. The case manager must verify that a representative has the necessary authority and obtain copies of supporting documentation, e.g., court orders or power of attorney documents, for the member’s file.

Legal representatives must always be consulted for decisions within their scope of authority. However, contact with or input from the legal representative should not replace contact and communication with the member. If the member can understand the situation and express a preference, the member should be kept informed, and their wishes respected to the degree practicable.

A court appointed legal guardian authorized by the court to make healthcare decisions for the applicant/member is required to:

- Attend in person and sign the initial and annual medical eligibility assessment,
- Sign the initial and annual Medical Necessity Evaluation Request (MNER), and
- Attend, in person, the initial and annual Person-Centered Service Plan meetings and sign the initial and annual Person-Centered Service Plan.

Attendance at the six-month Person-Centered Service Plan meeting can be in person or by phone. If the guardian attends by phone, the guardian must still sign the service plan. The signature may be obtained electronically.*****

*****All faxed/emailed signed documents must be obtained by the UMC within three business days for Bureau for Social Services (BSS) guardians and within 10 business days for non-BSS guardians or services will cease until such time that documents are obtained.

Note: West Virginia BSS Adult Protective Services/Child Protective Services (APS/CPS) as the appointed guardian is responsible for attending meetings concerning the protected individual. As the guardian they must approve and sign off on all decisions, except financial, relating to the protected person. By attending and participating in the scheduled meetings fulfilling their fiduciary obligation that all services are in the client's best interest (WV APS Policy, Section 5.19.1)

512.16 STAFF QUALIFICATIONS AND TRAINING REQUIREMENTS

All staff must be trained to provide TBIW services in a culturally and linguistically appropriate manner. All training materials must be approved by the UMC.

Prior to using an internet provider for training purposes, TBIW providers must submit the name, web address, and course name(s) to the UMC for review. The UMC will respond in writing whether this internet training meets the training criteria.

Members who select to self-direct their services through *Personal Options* may access their resource consultant through *Personal Options* for UMC approved training materials and assistance.

All training must use a competency-based training curriculum defined as a training program which is designed to give staff the skills they need to perform certain tasks and/or activities. The curriculum should have goals, objectives and an evaluation system to demonstrate competency in training areas. Competency is defined as passing a graded posttest at no less than 70% except for Case Management Certification and STP training which requires 80%. If a member of staff fails to meet competency requirements, the case manager or personal attendant agency must conduct additional training and retest the staff before the staff can work with members.

EVV requires personal attendants that do not live in the member's home to have an NPI number to link the worker to the member for whom they are providing services. Personal attendants living in the member's home are not required to obtain an NPI for billing for the member they live with. If the personal attendant provides services to another TBIW member they do not live with, then they will be required to obtain an NPI number for billing with those members.

512.16.1 Case Manager Qualifications

A case manager must be fully licensed in West Virginia as a social worker, counselor, or registered nurse (RN), or have a four-year degree in an approved Human Service Field. Those without a licensure credentials are required to complete the online case management training developed by the BMS and be employed by a TBIW case management agency enrolled with Medicaid. If you are unclear if a degree falls within the approved Human Services Field, submit transcripts of the specific degree being considered to the UMC. The BMS will make a final decision of eligibility. Licensure documentation or a certificate of completion of the online Case Management training must be maintained in the employee's file. Documentation that covers all the employee's employment period must be present (Example - if an employee has been with your agency for three years – documentation of licensure must be present for all three years). All documented evidence of staff qualifications such as licenses, certificates, signed confidentiality agreements (Refer to *Chapter 100, General Information*), and references shall be maintained on file by the provider. The provider shall have an internal review process to ensure that employees providing TBIW services meet the minimum qualifications.

Resource consultants under the *Personal Options* Model for the F/EA are not case managers.

The TBIW program does not allow interns to operate independently as these "paraprofessionals are not qualified yet to provide the service(s). Providers will not be reimbursed for services provided by unqualified professionals as outlined in the TBIW program.

A case manager with a four-year human service field degree cannot begin to provide and bill for services until they receive their case management certification from the BMS approved online trainings.

Case managers are not required to obtain an NPI number for billing purposes.

512.16.2 Case Manager Initial and Annual Training Requirements

Initial:

- Conflict-free case management training for case managers with an approved four-year Human Service Degree without license. This training is found on the BMS Learning Management System.
- Training on the *Personal* Options Service Delivery Model
- Recognizing and reporting abuse, neglect and exploitation training
- HIPAA training
- Person-centered planning and Service Plan development
- Traumatic Brain Injury training (Introduction to Brain Injury)
- Recognizing Medicaid Fraud and how to report
- Statewide Transition Plan Rules and Member Controlled Assessment training found on the BMS Learning Management System.
- Training regarding proper documentation correction requirements and forms.

Licensed Professionals must maintain their professional licensure training requirements.

Annual:

- Recognizing and reporting abuse, neglect and exploitation training
- HIPAA training
- Training related to Person Centered Planning Approach-

- Training related to TBI
- Recognizing Medicaid fraud and how to report licensed professionals must maintain their professional licensure training requirements.

512.16.3 Personal Attendant Professional Qualifications

A personal attendant professional is an individual paid to provide the day-to-day care to a member utilizing the TBIW including both the Traditional and *Personal Option* models.

Medicaid prohibits legally responsible individuals such as the spouse, a parent of a minor child (under the age of 18) or court appointed Legal Guardian(s) of a member utilizing the TBIW from providing waiver services for purposes of reimbursement. A Medical Power of Attorney (MPOA), Power of Attorney (POA), Health Care Surrogate or any other legal representative may provide services. However, if an MPOA, POA, Health Care Surrogate, or another legal representative is providing services they must:

- Work for an TBIW provider agency, or
- If the member self-directs, the personal attendant cannot be the program representative.
- A personal attendant professional must be at least 18 years of age and must have completed the required initial and/or annual competency-based training before providing services to a member utilizing the TBIW.
- A certified nursing assistant (CNA) able to provide documentation of current Certification, can be hired with their CNA credentials once they have completed First Aid/CPR training, member specific needs, Member Handbook, required TBI training and specific agency policies trainings. After the initial hire the CNA would be required to provide documentation of continued certification and then would only be required to take the remaining annual TBIW related personal attendant trainings

For Self-direction, all documented evidence of staff qualifications such as licenses, certificates, signed confidentiality statements, and references shall be maintained on file by the resource consultant.

A TBIW member receiving TBIW services cannot be a paid personal attendant/direct care worker through another Home and Community Based Services program.

512.16.4 Personal Attendant Initial Training Requirements

Competency-based training curriculum is defined as a training program which is designed to give staff the skills they need to perform certain tasks and/or activities. The curriculum should have goals, objectives, and an evaluation system to demonstrate competency in training areas. Competency is defined as passing a graded posttest at no less than 70%. If a member of staff fails to meet competency requirements, the agency must conduct additional training and retest the staff (must score at least 70%) before the staff can work with members.

- Cardiopulmonary Resuscitation (CPR) Training – Provided only by certified trainers of UMC approved courses. (Refer to BMS website for current list of approved CPR vendors). Additional CPR courses may be approved by the UMC. All CPR courses must include a return skills-based demonstration. Documentation that each trainee successfully completed the course and is

certified must be maintained by the agency and made available upon demand. If training is conducted by agency staff, documentation that each trainer has successfully completed and been certified by the certified entity must be maintained by the agency and made available upon demand. Documentation of proof of CPR certification for Personal Attendants must be the card issued by the certifying body.

- First Aid Training – Provided only by certified trainers of UMC approved courses. Documentation that each trainee successfully completed the course and is certified by the agency. If training is conducted by agency staff, documentation that each trainer has successfully completed and been certified by the certified entity must be maintained by the agency and made available upon demand. Online First Aid courses are allowed, but it must be a UMC approved course. An agency RN's education and skill set are sufficient to provide the First Aid Training.
- Universal Precautions Training – Must use the most current training material.
- Personal Attendant Skills – Training focused on assisting individuals with TBI with Activities of Daily Living (ADLs)/Instrumental Activities of Daily Living (IADL) – must be provided by an RN, social worker/counselor, a documented specialist in this content area or an approved internet training provider.
- If applicable, one-hour training specific to children/adolescents with TBI.
- Abuse/Neglect/Exploitation Identification Training – Must be provided by an RN, social worker/counselor, a documented specialist in this content area, or an approved internet training provider.
- HIPAA Training – Must include agency staff responsibilities regarding securing protected health information must be provided by an RN, social worker/counselor, a documented specialist in this content area or an approved internet training provider.
- Personal Attendant Professional Ethics training on ethics such as promoting physical and emotional well- being, respect, integrity, responsibility, justice, fairness, equity and Medicaid Fraud, Waste and Abuse. Training must include developing and maintaining working relationships and boundaries with the member (i.e. cannot take member to their own home and bill hours, discouraging after work hours interaction to maintain a professional relationship. These trainings must be provided by an RN, social worker/counselor, a documented specialist in this content area, or an approved internet training provider.
- Member Health and Welfare Training – Must include emergency plan response, fall prevention, home safety, seizure response and risk management must be provided by an RN, social worker/counselor, a documented specialist in this content area or an approved internet training provider.
- Member Rights and Responsibilities Training – Must include a review of the section of the West Virginia TBIW Handbook for Members and other relevant provider specific policies and must be provided by a social worker/counselor/RN.
- Delivering Person-Centered Care Training (can use the training developed by the UMC) and must be provided by a social worker/counselor/RN, a documented specialist in this content area, or an approved internet training provider.
- Personal attendant safety training (how to keep safe in the workplace) and must be provided by an RN, social worker/counselor, a documented specialist in this content area or an approved internet training provider. Statewide Transition Plan Rules training found on the BMS Learning Management System.
- Training regarding proper documentation correction requirements and forms.

- STP training Rules and Member/Provider controlled assessment training. Staff can take the training found on the BMS LMS or the provider agency can develop competency-based training and test of their own (80% competency required).

Note: Personal Attendants are not required to have training in the administration of Narcan, however it is encouraged.

512.16.5 Personal Attendant Annual Training Requirements

CPR, First Aid, universal precautions, abuse, neglect, exploitation identification, Medicaid Fraud, Waste, Abuse and how to report, and HIPAA trainings must be kept current.

- CPR is current as defined by the terms of the approved certifying agency (i.e., American Red Cross, American Heart Association. A list of approved agencies can be found on the BMS website). CPR must include an in-person demonstration.
- First Aid is current as defined by the terms of the approved certifying agency (i.e., American Red Cross, American Heart Association. A list of approved agencies can be found on the BMS's website.).
- Training will be considered current as defined by the time period on the card.
- Universal Precautions Training, Abuse, Neglect and Exploitation, Medicaid Fraud, Waste, Abuse and how to report, and HIPAA training must be renewed every 12 months or less. Training will be determined current in the month it initially occurred.

In addition, two hours of approved training focused on enhancing personal attendant service delivery knowledge, skills and person-centeredness must be provided annually. Member specific on-the-job training can be counted toward this requirement. It is recommended that the same training not be repeated from year to year. It is suggested that providers evaluate and identify trends at their agencies when identifying potential training topics. Approved training courses can be found on the BMS website. If there is a training not listed, the agency may submit a request to the UMC for approval prior to use.

512.16.6 Training Documentation

Documentation for training conducted by an agency RN, social worker/counselor, or a documented specialist in the content area must include the training topic, date of the training, and the signature of the instructor and the trainee or for *Personal Options*, the member/program representative. Training documentation for the UMC approved internet-based training must include the employee's name, the name of the internet provider/trainer and either a certificate or other documentation proving successful completion of the training. Providers may use the approved TBIW Form to document training. It can be found on the BMS website or they may provide the certificates for all required trainings.

CPR/First Aid Documentation

TBIW Provider Agencies: Personal attendants must have a CPR/First Aid card. While an agency is waiting for the card, if the agency staff, a certified trainer from a UMC approved certifying agency, provided the training, then the BMS will accept the training log in each personal attendant's personnel file as evidence, if the log has the information listed in policy-documentation of training. The sign in sheet documentation is valid for 30 days from the date of the class, the card must be secured and copied into the staff record after 30 days.

Self-Direction: Personal attendants must have a CPR/First Aid card. The BMS will accept a letter-on-letter head from the certifying agency that it meets the policy requirements for documentation of training. The letter is valid for 30 days from the date of the class, the card must be secured and copied into the staff record after 30 days.

512.16.7 Non-Medical Transportation Services Qualifications

In addition to meeting all requirements for TBIW personal attendant professionals, individuals providing non-medical transportation services must have a valid driver's license, proof of current vehicle insurance and registration. Copies of all required documentation will be kept by the provider or if applicable F/EA.

The TBIW personal attendant professional must also abide by local, state, and federal laws regarding vehicle licensing, registration and inspections upon hire and checked annually thereafter.

512.17 INCIDENT CLASSIFICATION AND MANAGEMENT

TBIW shall 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 people they serve. Agencies should conduct trend analysis to assist in determining any implementation recommendations for any corrective actions. Investigations must be conducted by a professional who is licensed or registered in the State of West Virginia (licensed social worker or counselor or an RN). All incident details must be objectively and factually documented (what, when, where, and how). All inconsistencies must be explored. The provider must ensure the safety of all involved (the members and/or the staff) during the investigation. In addition, all required entities must be notified as applicable (APS/CPS, law enforcement, OPI, etc.).

The provider is responsible for taking appropriate action on both an individual and systemic basis in order to identify potential harm, or to prevent further harm, to the health and safety of all members served and staff involved. Incidents shall be classified by the provider as one of the following:

Abuse, Neglect, or Exploitation (A/N/E)

Anyone providing services to a member utilizing the TBIW who suspects an incidence of A/N/E as defined in the Glossary of this Chapter, must report the incident to Adult or Child Protective Services through West Virginia Centralized Intake for Abuse and Neglect, within mandated time frames. Reports of A/N/E may be made by calling 1-800-352-6513, seven days a week, 24 hours a day. This initial report must then be followed by a written report, submitted to the local county office where the alleged victim resides, within 48 hours following the verbal report. An APS or CPS worker may be assigned to investigate the suspected or alleged abuse. Mandated reporters have no more than 24 hours to call CPS when incidents involve children. All incidents of suspected A/N/E must be entered into the WV IMS as well.

Suspected sexual assault and/or sexual abuse, serious physical abuse (this is defined as physical abuse that causes serious physical injury limited to death, serious or protracted disfigurement, protracted impairment of physical or emotional heath, protracted loss, or impairment of the function of any bodily organ, and if an individual creates an imminent danger of harm to the individual) or exploitation must also be reported to the local law enforcement agency by calling 911. Any incident attributable to the failure of TBIW provider staff to perform their responsibilities that compromises the health or safety of the member is neglect and must be reported to APS/CPS centralized intake. Contact must be made with all provider

agencies involved with the case. Any incidents the provider is made aware of that occurred during non-plan hours must also be reported.

Critical Incidents

Critical incidents are incidents with a high likelihood of producing real or potential harm to the health and welfare of the member or incidents which have caused harm or injury to the member utilizing the TBIW. These incidents might include, but are not limited to, the following:

- Attempted suicide, or suicidal threats or gestures.
- Criminal activity that is suspected or observed by the member themselves, their families, health care providers, concerned citizens, or public agencies that compromise the health or safety of the member.
- An unusual event such as a fall or injury of unknown origin requiring medical intervention or first aid.
- A significant interruption of a major utility, such as electricity or heat in the member's residence, compromises the member's health or safety.
- Environmental/structural problems with the member's home, including inadequate sanitation or structural damage that compromises the member's health or safety.
- Fire in the home resulting in relocation or property loss that does not compromise the member's health or safety.
- Unsafe physical environment in which the personal attendant professional and/or other agency staff are threatened or abused, and the staff's welfare is in jeopardy.
- Disruption of the delivery of TBIW services, due to involvement with law enforcement authorities by the member and/or others residing in the member's home, compromises the member's health or safety.
- Medication errors by the member or their family caregiver that compromises the member's health or safety, such as medication taken that was not prescribed or ordered for the member, and failure to follow directions for prescribed medication, including inappropriate dosages, missed dosages, or dosages administered at the wrong time.
- Disruption of planned services for any reason that compromises the member's health or safety, including failure of the member's emergency backup plan.
- Any other incident judged to be significant and potentially having a serious negative impact on the member, that compromises the member's health or safety.
- Any incident attributable to the failure of TBIW provider staff to perform their responsibilities that compromises the member's health or safety is considered to be neglect and must be reported to APS or CPS through the West Virginia Centralized Intake for Abuse and Neglect or by calling 1-800-352-6513.
- Any incident deemed to be restrictive in nature (i.e., restraint of any type).
- A personal attendant is witnessed to be, or suspected of, performing any tasks prohibited by policy section 512.18.2, the provider agency, or the case manager or resource consultant (if applicable) must be notified immediately and reported in WV IMS.
- Death of a member
- Any unplanned medical visit to an ER, health facility, or admission to a hospital

Simple Incidents

Simple incidents are any unusual events occurring to a member that cannot be characterized as a critical incident and does not meet the level of abuse or neglect or exploitation. Examples of simple incidents include, but are not limited to, the following:

- Fall or other incident that does not require minor first aid or medical intervention.
- Minor injuries of unknown origin with no detectable pattern
- Dietary errors with minimal or no negative outcome

512.17.1 Reporting Requirements, Incident Management Documentation and Investigation Procedures

Any incidents involving a member utilizing the TBIW must be entered into the WV IMS within the next business day of learning of the incident. The agency director, designated agency staff, or case manager will immediately review each incident report. All critical incidents submitted by the provider must be investigated. All incidents involving A/N/E must be reported to APS or CPS (as applicable) and entered in the WV IMS. An Incident Report documenting the outcomes of the investigation must be completed and entered into the WV IMS within 14 calendar days of learning of the incident.

If a death occurs it must be entered into the WV IMS, the case manager must complete the Notification of Death form within the next business day of learning of the death of a member utilizing the TBIW and send the form to the UMC.

All deaths must be reported in the WV IMS within one business day of learning of the incident. For incident type, choose “critical” incident category, then choose “death” as incident sub-type.

For *Personal Options*, the resource consultant must report any incidents into the WV IMS as well as notify the case manager within the next business day of learning of the incident. All incidents involving abuse, neglect and/or exploitation must be reported to APS or CPS (as applicable), but also must be reported into the WV IMS. If the case manager becomes aware of an incident before the resource consultant, the case manager must report the incident to the resource consultant.

The WV IMS does not supersede the reporting of incidents to APS or CPS (as applicable). At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the provider, shall immediately notify APS per WV Code §9-6-9 or CPS per WV Code §49-2-803.
An agency is responsible to investigate all incidents, including those reported to APS or CPS. If requested by APS or CPS (as applicable), a provider shall delay its own investigation and document such request in the online WV IMS. The provider will also contact the UMC with such delay requests.

The criteria utilized for a thorough investigation includes but is not limited to:

- Report was fully documented to include the date of the incident, date the agency learned of the incident, facts of the incident, type of incident, initial determination of the incident and verification that an approved professional conducted the investigation.
- All parties were interviewed, and incident facts were evaluated.
- Member was interviewed.
- Determination of the cause of the incident.

- Identification of preventive measures.
- Documentation of any action taken as the result of the incident (worker training, personnel action, removal of staff, changes in the Person-Centered Service Plan and
- Change in needs were addressed on the Person-Centered Service Plan.

Agencies are responsible to add new staff and remove staff no longer with the agency within the WV IMS in five business days of being hired/employment ending.

512.17.2 Incident Management Tracking and Reporting

Provider agencies must review and analyze incident reports to identify health and safety trends. Identified health and safety concerns and remediation strategies must be incorporated into the agency Quality Management Plan. The Quality Management Plan must be made available to the UMC monitoring staff at the time of the provider monitoring review or upon request.

The F/EA has a tracking/reporting responsibility defined in their contract with the BMS.

512.18 MEDICAID FRAUD AND REPORTING REQUIREMENTS

Providers are required to report all suspected fraud to BMS. Suspected fraud includes any instance in which a provider of any Medicaid service knowingly provides false information to a payer or employer in order to enhance their reimbursement or to receive reimbursement for services never provided. Fraudulent activities include, but are not limited to, the following examples: falsifying documentation such as timesheets, certifications, or medical records, submitting duplicative claims, or knowingly billing for medically unnecessary services. When a provider becomes aware of potentially fraudulent behavior they must immediately complete the fraud referral form available on the OPI page of the BMS website and submit the completed form to OPI at DHHRBMSMedicaidOPI@wv.gov and to the TBIW program manager.

512.19 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

Documentation and record retention general requirements for TBIW program provider agencies include, but are not limited to:

General Requirements:

- TBIW program provider agencies must comply with the documentation and maintenance of records requirements described in *Chapter 100, General Information*; and *Chapter 300, Provider Participation Requirements* of the BMS Provider Manual.
- TBIW program provider agencies must comply with all other documentation requirements of this chapter.
- All required documentation must be maintained by the TBIW provider for at least five years in the file of the member receiving TBIW services file subject to review by authorized BMS personnel or contracted agents. Employee files must be kept for at least five years. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years, whichever is greater.

- All required documentation and records must be available upon request from the BMS or federal monitors, or contracted agents for auditing and/or medical review purposes.
- Failure to maintain all required documentation and in the manner required by the BMS, may result in the disallowance and recovery by the BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to the BMS upon request.

Specific Requirements

TBIW program provider agencies must maintain a specific record for all services received for each member utilizing the TBIW Program including, but not limited to:

- Each TBIW provider who provides case management services is required to maintain all required TBIW documentation for state and federal monitors.
- All TBIW program forms as applicable to the policy requirement or service code requirement.
- Agencies may only use forms developed and published by the BMS (refer to *Chapter 300, Provider Participation Requirements,* for a description of general requirements for Medicaid record retention and documentation).
- All providers of waiver services must maintain records to substantiate that services billed by the TBIW Program provider agency were provided on the dates listed and were for the actual amount of time and number of units claimed.
- Day-to-day documentation for services by a provider agency is to be maintained by the provider agency that provides and bills for said service. Monitoring and review of services as related to the Person-Centered Service Plan or monthly summary (visit) are to be maintained in the case management provider record.
- While monitoring of the Person-Centered Service Plan and services, the case manager may review or request specific day to day documentation. All documentation provided must meet the criteria for documentation as indicated in the policy manual such as date, actual time of service and number of units claimed.
- Required on-site documentation may be maintained in an electronic format as long as the documentation is accessible to individuals who may need to access it.
- Electronic health record and electronic signature requirements described in *Chapter 100, General Information* of the BMS Provider Manual.
- All Personal Attendants must obtain an NPI number for billing purposes when applicable. Personal Attendants living in the members' home are not required to have an NPI number if they do not bill for any other members outside the home or HCBS programs.

PROGRAM ELIGIBILITY AND ENROLLMENT

512.20 TBIW PROGRAM ELIGIBILITY

Documentation of applicants for the TBIW program must meet all the following criteria to be eligible for the programs.

- Be three years of age or older.
- Be a permanent resident of West Virginia.

- Have a traumatic brain injury defined as a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment or an injury caused by anoxia due to near drowning.
- Be approved as medically eligible for nursing facility level of care.
- Score at a Level VII or below on the Rancho Los Amigos Levels of Cognitive Functioning Scale.
- Ages three to 17 years of age must score at a Level II or higher on the Rancho Los Amigos Pediatric Level of Consciousness Scale.
- Be an inpatient in a licensed nursing facility, an inpatient in a hospital, an inpatient in a licensed rehabilitation facility to treat TBI or living in a community setting at the time of application.
- Meet the Medicaid waiver financial eligibility criteria for the program as determined by the county office, or the Social Security Administration (SSA), if an active SSI (Supplemental Security Income) recipient.
- Choose to participate in the TBIW program as an alternative to nursing facility care.

The applicant must first meet the financial eligibility requirements before a determination of the applicant's medical eligibility will be made. A funded slot must be available for him/her to participate in the program. If no funded slots are available, applicants determined financially and medically eligible for the Program will be placed on the Managed Enrollment List (MEL). As funded slots become available, applicants on the Managed Enrollment List will be notified and provided detailed instructions on continuing the enrollment process. Eligible applicants are assigned an available funded slot on a first-on-first off basis, i.e. the first person on the MEL is the first person off the MEL.

512.21 FINANCIAL ELIGIBILITY – PRE-MEDICAL ELIGIBILITY

The financial eligibility process starts once an applicant applies to the TBIW program by submitting the initial MNER Form to the UMC.

The UMC will process a complete and correct MNER and send the following documents to the applicant: Notice of Receipt of MNER, DHS-2 Form (yellow), instructions for determining financial eligibility and Service Delivery Model Selection form and Freedom of Choice- Provider Selection forms (case management and personal attendant agencies) with instructions for returning completed selections forms to the UMC.

The UMC will send the Notice of Receipt of initial MNER to referring entity.

The applicant must submit the DHS-2 (yellow) form to their local county office to determine financial eligibility. The DHS-2 (yellow) form will include an expiration date. It will not be accepted at the county office after the expiration date.

Upon receipt of the completed Freedom of Choice Case Management Selection form the selected case management agency will be informed by the UMC. Within five business days of receipt of this notification, the case manager must make an initial contact by telephone or face-to-face with the applicant to help in determining financial eligibility. The applicant and/or case manager must submit a DHS-2 (yellow) form along with a letter from the UMC to the county office to determine financial eligibility based on TBIW criteria.

Factors such as income and assets are taken into consideration when determining eligibility. An applicant's gross monthly income may not exceed 300% of the current maximum SSI payment per month for participation in the TBIW program. Some assets of the couple are protected for the spouse who does not need nursing home or home and community-based care, and these assets are not counted to determine eligibility for the individual who needs care in the home.

If the applicant is determined financially ineligible by the county office a medical eligibility assessment will not be scheduled by the UMC and the MNER will be closed. The UMC will notify the applicant that the MNER has been closed due to financial ineligibility.

512.22 FINANCIAL ELIGIBILITY - COMING OFF THE MANAGED ENROLLMENT LIST (MEL)

If the applicant has been placed on the Managed Enrollment List (MEL), when a funded slot becomes available, the applicant and the case management agency will be notified by the UMC.

When an applicant is released from the MEL, financial eligibility must be obtained.

Upon receipt of the DHS-2 (white) form, the case management agency will sign and date the form and fax the form to the applicant's county office. The case management agency will inform the applicant that the DHS-2 form has been submitted to their county office.

Once financial eligibility has been determined, the MEL Applicant must be enrolled in the TBIW program within 30 calendar days from the dated DHS-2 form (white).

Case managers must notify the UMC when the financial eligibility process has been initiated. The applicant has a total of 60 calendar days from release of the MEL to be enrolled. If the financial eligibility process and enrollment are not completed within 60 calendar days, the UMC will close the referral and notify the applicant. The letter will include the reason for the closure, the applicable TBIW policy Chapter section(s), notice of free legal services, and a Request for Hearing form to be completed if the applicant wishes to contest the decision. The letter will outline specific timeframes for filing an appeal.

If the applicant wants TBIW services after the closure, a new MNER form is required to be sent to the UMC and the application process started again. The BMS will ensure that all closed referrals will be reviewed before releasing the slot to the next applicant on the MEL.

TBIW services cannot be paid for until an applicant's financial eligibility is established and the enrollment process has been completed with the UMC. (Refer to Section 512.24 Enrollment) If the person has been on another waiver program, no services may be charged prior to an applicant's discharge from the other waiver program.

Termination of the Medicaid benefit itself (e.g., the Medicaid card) always requires a 13-calendar day advance notice prior to the first day of the month that Medicaid stops. Coverage always ends the last day of a month unless otherwise dictated by policy. Examples:

- Advance notice for termination is dated January 27, Medicaid would end February 28.
- Advance notice is dated January 16, Medicaid ends January 31. This is true regardless of when TBIW services end.

512.23 MEDICAL ELIGIBILITY

The UMC is responsible for evaluating medical eligibility, conducting assessments, and determining if medical eligibility requirements for the TBIW program are met. The UMC will use guidelines for age-appropriate developmental milestones as criteria when determining functional levels and abilities for children. The purpose of the medical eligibility review is to ensure the following:

- New applicants and existing members utilizing the TBIW are medically eligible based on current and accurate evaluations.
- The medical eligibility determination process is fair, equitable, and consistently applied throughout the State.

If the person has been receiving services from another waiver program, no services can be reimbursed prior to an applicant's closure from the other waiver program.

512.23.1 Medical Criteria

An applicant/member must have five deficits as described on the Pre-Admission Screening (PAS) form to qualify for nursing facility level of care. These deficits are derived from a combination of the following assessment elements on the PAS.

Section	Description of Deficits	
#24	Decubitus; Stage 3 or 4	
#25	In the event of an emergency, the person is c) mentally unable or d) physically unable to vacate a building. a) Independently and b) With Supervision are not considered deficits.	
#26	Functional abilities of the person in the home	
a.	Eating	Level 2 or higher (physical assistance to get nourishment, not preparation)
b.	Bathing	Level 2 or higher (physical assistance or more)
c.	Dressing	Level 2 or higher (physical assistance or more)
d.	Grooming	Level 2 or higher (physical assistance or more)
e. f.	Continence, Bowel Continence, Bladder	Level 3 or higher; must be incontinent.
g.	Orientation	Level 3 or higher (totally disoriented, comatose).
h.	Transfer	Level 3 or higher (one-person or two-person assistance in the home)
i.	Walking	Level 3 or higher (one-person assistance in the home)
j.	Wheeling	Level 3 or higher (must be Level 3 or 4 on walking in the home to use Level 3 or 4 for wheeling in the home. Do not count outside the home.)
k.	Vision	Level 3 or higher (Impaired/ Not Correctable)
l.	Hearing	Level 3 or higher (Impaired/ Not Correctable)
m.	Communication	Level 3 or higher (Understandable with aids)

Section	Description of Deficits
#27	The person has skilled needs in one or more of these areas: (a) Physical therapy, (b) Speech Therapy, (c) Occupational Therapy, (e) continuous oxygen (g) suctioning, (h) tracheostomy, (i) ventilator, (k) parenteral fluids, (l) sterile dressings, or (m) irrigations.
#28	The person is not capable of administering their own medications **or** needs prompting/ supervision.
#34	(f) Disoriented), (k) Seriously Impaired Judgment, (m) Cannot communicate basic needs, (p) Physically Dangerous to Self and Others, If Unsupervised

Applicants and members re-determining medical eligibility must also score at the levels on the Ranchos Los Amigos Levels of Cognitive Functioning Scale or the Rancho Los Amigos Pediatric Level of Consciousness Scale as previously stated in this manual. Information on these tools can be found on the TBIW Program website.

512.23.2 Initial Medical Evaluation

Following is an outline of the initial medical evaluation process:

- An applicant shall initially apply for the TBIW Program by having their treating physician (Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.)), physician assistant (PA), neuropsychologist, or nurse practitioner (NP) (here after called the referent) complete and sign a MNER form including ICD diagnosis code(s). The referent, applicant, family member, advocate, or other interested party, may submit this form by fax, mail or electronically to the UMC. The UMC will not process any MNER form if the referent's and/or applicants' signature is more than 60 calendar days old. If the MNER form is incomplete, it will be returned for completion and resubmission within two weeks, and the applicant will be notified.
- Once a correct, completed and signed MNER is received, the UMC will send a DHS-2 (yellow) form to the applicant, so financial eligibility can be established. The Service Delivery Model Selection form, the Freedom of Choice Case Management Selection form and Personal Attendant Selection form will also be included. Making selections does not ensure eligibility for the TBIW program.
- Once the completed DHS-2 (yellow) form is returned, if financially eligible, the UMC will attempt to contact the applicant to schedule the assessment. If contact is made, a notice shall be sent to the applicant informing them of the scheduled appointment, location, date and time.
- The UMC will make up to three attempts to contact the applicant. The UMC will issue a potential referral closure letter to the applicant and the referent. If no contact is made with the UMC within 10 business days, the referral will be closed. If the applicant chooses to have the evaluation after the referral is closed, a new referral is required if the referent's and/or applicants' signature on the MNER is greater than 60 calendar days.
- If the MNER form indicates that the applicant has a court appointed legal guardian, the assessment will not be scheduled without the court appointed legal guardian present to assist the applicant.

If the applicant is not financially eligible, the MNER will be closed, and the applicant will be notified.

512.23.2.1 Results of Initial Medical Evaluation

Approval

If the applicant is determined medically eligible and a funded slot is available, a notice of approved medical eligibility, a copy of the PAS, the Ranchos Los Amigos Levels of Cognitive Functioning Scale or the Rancho Los Amigos Pediatric Level of Consciousness Scale, is mailed to the applicant and the referent. The notice and assessments will be uploaded into the UMC web portal for the case management agency, personal attendant agency or the F/EA (as well as the TMH office, if applicable).

If the applicant is determined medically eligible and a funded slot is not available, a notice of approved medical eligibility will be sent to the applicant and the referent informing them a slot is not currently available and the person will be placed on the MEL, and they will be contacted when one becomes available. When a slot becomes available, the applicant will be sent a letter. The case management agency, referent, and the (F/EA, if applicable) will also be notified. Financial eligibility must be re-determined. [Please see Section 512.22 Financial Eligibility - Coming Off the Managed Enrollment List (MEL)].

Denial

If it is determined that the applicant does not meet medical eligibility, the applicant, referent and case management agency will be notified by a Potential Denial-Additional Information Needed letter. This letter will advise the applicant of the reason for the potential denial, listing the areas in which deficiencies were found. A copy of the PAS, the Rancho Los Amigos Levels of Cognitive Functioning Scale or the Rancho Los Amigos Pediatric Level of Consciousness Scale and the applicable TBIW policy Chapter section(s) will also be included with the Potential Denial-Additional Information Needed letter. The applicant will be given thirty calendar days to submit supplemental medical information to the UMC. Information submitted after the 30-calendar day period will not be considered in the eligibility determination, however, it may be used during a pre-hearing conference or Medicaid Fair Hearing. Please Note: A Potential Denial-Additional Information Needed letter is not a denial of service and a request for Fair Hearing should not be made at this time.

If the review of the supplemental information by the UMC determines the applicant is not medically eligible, the applicant, case management agency and the referent will be notified by a Final Denial letter. The Final Denial letter will provide the reason for the adverse decision. It will also include the applicable TBIW policy Chapter section(s), a copy of the PAS, the Rancho Los Amigos Levels of Cognitive Functioning Scale or the Rancho Los Amigos Pediatric Level of Consciousness Scale, supplemental medical information documentation (if it has been supplied), notice of free legal services, and a Request for Hearing Form to be completed if the applicant wishes to contest the decision.

If the applicant’s medical eligibility is denied and the applicant is subsequently found medically eligible after the Fair Hearing process, the date of eligibility can be no earlier than the date of the hearing decision.

512.23.2.3 Medical Re-evaluation

Annual re-evaluations for medical eligibility for each member utilizing the TBIW must be conducted. The process is as follows:

- The UMC will contact the member ninety (90) days prior to the member's Anchor Date to schedule the reevaluation appointment.
- If the UMC makes the contact, a letter is sent to the member and case management agency noting the date, location, and time of the assessment.
- If the UMC is unable to contact the member within three attempts, a potential closure letter will be sent to the member and the case management agency and personal attendant agency and/or the F/EA (if applicable) also the TMH office (if applicable).
- If no contact is made by the member to the UMC within 10 business days of the date of the potential closure letter, the UMC will send the final closure letter to the member, case management agency and personal attendant agency and/or F/EA (if applicable). Then UMC will close the case.

512.23.3.1 Results of Medical Re-evaluation

Approval

If the member meets the medical eligibility criteria, a Notice of Approved Continued Medical Eligibility is sent to the member along with the completed PAS and Rancho by the UMC. The UMC will fax the Notice of Approved Continued Medical Eligibility letter only to the member's county of residence office.

The UMC will inform the member's current service providers the case management agency, and personal attendant agency, or if self-directing Personal Options that Continue Medical eligibility has been met and provide the case ID# in the web portal for the member's completed PAS, Rancho Assessments, other assessment documents and the Notice of Approved Continued Medical Eligibility letter.

Denial

If it is determined that the member does not meet medical eligibility, the member, the referent, and the case management agency will be notified by a Potential Denial letter. This letter will advise the member of the reason(s) for the potential denial, listing the areas in which deficiencies were found and notice that the medical eligibility standard has not been met. A copy of the PAS, the Rancho Los Amigos Levels of Cognitive Functioning Scale or the Rancho Los Amigos Pediatric Level of Consciousness Scale and TBIW policy will also be included with the Potential Denial Letter. The members will be given 30 days to submit supplemental medical information to the UMC. Supplemental information received by the UMC after the 30-day period will not be considered. However, it may be used during a pre-hearing conference or Medicaid Fair Hearing.

If the review of the supplemental information by the UMC determines that there is still no medical eligibility, the member, referent, personal attendant agency or the F/EA (if applicable) and the case management agency will be notified with a Final Denial letter. The Final Denial letter will provide the reason for the adverse decision. It will also include the applicable TBIW policy Chapter section(s), a copy of the PAS and the Rancho Los Amigos Levels of Cognitive Functioning Scale or the Rancho Los Amigos Pediatric Level of Consciousness Scale, supplemental medical information documentation (if it has been supplied), notice of free legal services, and a Request for Hearing Form to be completed if the member wishes to contest the decision.

If the member elects to appeal any adverse decision, benefits shall continue at the current level only if the

appeal is mailed within 13 calendar days of the notice date and shall continue only until a final decision is rendered by the administrative Hearing Officer. If the hearing decision affirms the denial of medical eligibility TBIW services shall be terminated immediately. Medicaid will not pay for services provided to a medically ineligible person.

512.24 ENROLLMENT

Once an applicant has been determined both financially and medically eligible, the case manager must request program enrollment from the UMC by completing an Enrollment Request Form. The UMC will complete the enrollment and provide a confirmation notice to the case management agency and the personal attendant service provider agency or the F/EA, if the person chooses *Personal Options*.

No Medicaid reimbursed TBIW services may be provided until the case management agency is in receipt of the person's Enrollment Confirmation Notice.

The case management agency is responsible for maintaining a copy of the Enrollment Request Form and the Enrollment Confirmation Notice in the member's file. The personal attendant agency is responsible for maintaining a copy of the Enrollment Confirmation Notice in the member's file.

The F/EA must maintain a file which contains the Enrollment Confirmation Notice for a member choosing *Personal Options*. The confirmation notice initiates the initial phone contact to the member within three business days.

The member's waiver case will be closed if services are not provided within 180 days of the date of enrollment in the program.

If a personal attendant agency is unable to staff a member within 90 days from enrollment, then the personal attendant agency must inform the UMC and the case management agency. The UMC will assist the members by facilitating a transfer to another personal attendant agency.

If the member is self-directing their TBIW services and are unable to hire staff within 90 days of enrollment the resource consultant must inform the UMC and the case management agency to begin the process of an Involuntary Transfer to the Traditional Model for services.

512.25 DESCRIPTION OF SERVICE DELIVERY MODELS

Two service models are offered in the TBIW:

1. Traditional Service Delivery Model
2. Self-Directed Service Delivery Model (as provided by the *Personal Options* FMS)

A member who receives services may choose either service delivery model at any time by completing a Request to Transfer Form.

512.25.1 Traditional Service Delivery Model

The Traditional Service Delivery Model is available to every member who receives TBIW services.

If the member chooses this service delivery model, all services accessed will be done so through a TBIW provider after being determined necessary, appropriate, and within the assessed needs. The TBIW provider has employer authority as well as fiscal responsibility for the services listed on the service plan of the member. These services are provided where the member resides and participates in community activities.

The following services are available via the Traditional Service Delivery Model:

- Personal attendant
- Case management
- Non-medical transportation
- Personal Emergency Response System (PERS)
- Environmental Accessibility Adaptation (EAA) home and/or vehicle

When a member accesses all services via the Traditional Service Delivery Model, the assessed budget is utilized to access services. Based on assessments, the team identifies needed services and addresses those on the Service Plan.

Once the team determines the services, the case manager documents the Service Plan and requests the units agreed upon in the UMC web portal. All requested units must be within the assessed budget.

The hourly wage of agency staff employed by a TBIW provider is determined by the agency that employs the staff person, and must comply with all local, state, and federal employment requirements. All Agency Staff hired by a TBIW provider must meet the requirements listed in the applicable Agency Staff Qualifications in Section 512.16 and its subparts.

As the common law employer, the TBIW provider is responsible to:

- Recruit and hire qualified agency staff.
- Provide required training to agency staff, including training on needs specific to the member.
- Determine agency staff work schedule and how and when agency staff should perform the required tasks.
- Determine agency staff's daily activities.
- Evaluate agency staff performance.
- Maintain and process agency staff payroll.
- Maintain documentation in a secure location and ensure employee confidentiality; and
- Discharge agency staff, when necessary.

With regard to the provision of Traditional Service Delivery Model, the UMC is responsible to:

- Conduct agency satisfaction surveys with a sample of members who receives services, and receive and analyze the survey results and report them to the BMS annually; and
- Conduct provider reviews on a defined cycle using an approved review protocol based on TBIW requirements.
- Authorize services within the member's assessed budget.

512.25.2 Self-Directed Service Delivery Model

The Self-Directed Service Delivery Model, also known as Personal Options, is available to every member who receives TBIW services. Members who choose to self-direct their services are still required to have a case manager from a traditional agency provider to perform case management functions such as Assessment and Service Plan development.

The member who chooses this service model can exercise choice and control over the self-directed services they choose and the individuals and the organizations who provide them (employer authority); and/or how the portion of their budget associated with self-directed services is spent (budget authority). The self-directed services over which members can exercise choice and control are personal attendant, Personal Emergency Response Unit (PERS), Environmental Accessibility Adaptations (EAA) home and/or vehicle and non-medical transportation. When a member is making the choice for a service delivery model the UMC will provide information about the roles and responsibilities with self-direction to be able to make an informed choice of service delivery models.

Once all of the equivalent monies are transferred into their budget, the member, along with their *Personal Options* resource consultant, create a spending plan. At this time, the member chooses the types of services, the amount of services, and the wages of the member's employees within the parameters of their entire budget.

The hourly wage of personal attendant staff employed by a member may not exceed the Medicaid rate minus all mandatory deductions and must be at least the current minimum wage amount. All personal attendant staff hired by the member must meet the requirements listed under Personal Attendant Profession Qualifications Section 512.16.3, Section 512.16.4, Section 512.16.5, Section 512166.6, and Section 512.16.7.

The member who chooses to Self-direct their TBIW services will do so with the support of an FMS vendor. If utilizing *Personal Options,* the member is the common law employer, or employer of record, of the personal attendant staff hired.

As the common law employer, the member is responsible to:

- Work with their resource consultant to become oriented and enrolled in the Self-Directed Service Delivery Model, enroll personal attendant staff, develop a spending plan for the self-directed budget, and create an emergency personal attendant staff back-up plan to ensure staffing, as needed.
- Recruit and hire their personal attendant staff.
- Provide required training to personal attendant staff, including training on needs specific to the member;
- Determine personal attendant staff work schedule and how and when the personal attendant staff should perform the required tasks.
- Determine personal attendant staff daily activities.
- Evaluate personal attendant staff performance.
- Review, sign, and submit personal attendant staff timesheets to the *Personal Options* FMS.
- Maintain documentation in a secure location and ensure employee confidentiality.
- Discharge personal attendant staff, when necessary; and
- Notify the case manager of any changes in service need.

The *Personal Options* FMS acts as the F/EA to the member, and is therefore responsible to:

- Assist common law employers exercising budget authority.
- Act as a neutral bank, receiving and disbursing public funds, tracking and reporting on the budget funds (received, disbursed and any balances) of the member.
- Monitor spending of budget funds in accordance with approved spending plans.
- Submit claims to the state's claim processing agent on behalf of the member.
- Process and pay invoices for non-medical transportation in the member's approved self-directed spending plan.
- Assist members in exercising employer authority.
- Assist the member in verifying workers' citizenship or legal alien status (e.g., completing and maintaining a copy of the USCIS Form I-9 for each personal attendant the member employs);
- Assist in submitting criminal background checks through the WV CARES of prospective personal attendant staff.
- Collect and process personal attendant staff timesheets.
- Operate a payroll service, (including withholding taxes from workers' pay, filing and paying Federal (e.g., income tax withholding, Federal Insurance Contributions Act (FICA) and Federal Unemployment Tax Act (FUTA), state (e.g., income tax withholding and State Unemployment Tax Act (SUTA), and, when applicable, local employment taxes and insurance premiums).
- Distribute payroll checks on behalf of the members.
- Execute simplified Medicaid provider agreements on behalf of the Medicaid agency.
- Provide orientation/skills training to members about their responsibilities when they function as the employer of record of their personal attendant staff.
- Provide ongoing information and assistance to common law employers.
- Monitor, report data pertaining to quality and utilization of the *Personal Options* FMS as required to the BMS.
- Evidence of initial and annual personal attendant training as required by policy.
- Provide program representative training and agreement (if applicable).

The *Personal Options* FMS is not the common law employer of the personal attendant staff of the member. Rather, the *Personal Options* FMS assists the member/Common Law Employer in 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 *Personal Options* FMS operates under §3504 of the IRS code, Revenue Procedure 80-4 and Proposed Notice 2003-70, applicable state and local labor, employment tax and Medicaid program rules, as required.
Personal Options makes available Information and Assistance (I&A) services through the resource consultants to common law employers to support their use of self-directed services and to perform effectively as the common law employer of their personal attendant staff. I&A provided by the *Personal Options* FMS include:

- Common law employer orientation sessions once the member chooses to use self-directed services and enrolls with the FMS *Personal Options*.
- Skills training to assist common law employers to effectively use self-directed services and the FMS and perform the required tasks of an employer of record of personal attendant staff.
- Common law employer orientation provides information on:

- The roles, responsibilities of, and potential liabilities for each of the interested parties related to the delivery and receipt of self-directed services (i.e., common law employer, FMS, *Personal Options*, UMC, case manager, BMS),
- How to use FMS *Personal Options*,
- How to effectively perform as a common law employer of their personal attendant staff,
- How to ensure that the common law employer is meeting Medicaid and FMS *Personal Options* requirements, and,
- How a member would stop using self-directed services and begin to receive traditional services, if they so desire.

The *Personal Options* FMS provides Information & Assistance (I&A) support to members who wish to function as common law employers. Educational materials are provided to interested parties on the roles and responsibilities of the *Personal Options* FMS, as well as the roles and responsibilities of others, such as members, their program representative, personal attendant staff, and the BMS. The materials also address what is required of the member in order to be a common law employer and provide a venue through which a member may enroll in the Self-Directed Service Delivery Model. *Personal Options* FMS also makes available materials to members, to implement and support their use of self-directed services and performing as employer of record.

If the Self-Directed Service Delivery Model is selected by the member the, *Personal Options* FMS, rather than the case manager, provides I&A service that includes:

- Providing or linking common law employers with program materials in a format that they can use and understand.
- Providing and assisting with the completion of enrollment packets for common law employers.
- Providing and assisting the common law employer with employment packets.
- Presenting the common law employer with the *Personal Options* FMS' role regarding payment for services.
- Assisting common law employers with determining budget expenditures (hiring);
- Assisting with the development of an individualized spending plan based upon the annual budget.
- Making available to the member/program representative a process for voicing complaints/grievances pertaining to the *Personal Options* FMS' performance.
- Providing additional oversight to the common law employer as requested or needed.
- Monitoring and reporting information about the utilization of the self- directed budget to the member, program representative, case manager, and the BMS; and
- Explaining all costs/fees associated with self-directing to the member.

With regard to the provision of self-directed services, the F/EA is responsible to:

- Distribute the *Personal Options* FMS satisfaction survey to members and receive and analyze the survey results and report them to the BMS annually.

With regard to the provision of self-directed services, the UMC is responsible to:

- Conduct *Personal Options* FMS performance reviews on a defined cycle using a review protocol based on the *Personal Options* FMS requirements.
  Review and authorize training materials developed by the F/EA.

Program Representative

Members may appoint a program representative to help them with the responsibilities of self-direction. This may be a family member or friend. They cannot be paid for being the program representative in which they are assisting a member with their employer responsibilities or hired by a member to provide personal attendant services. The program representative must be at least 18 years old. The F/EA will provide training and information to the person the member has chosen to be their program representative, then the person can choose to accept or decline the program representative appointment. If the person the member has chosen declines the appointment, the member must choose another person. (Refer to the F/EA *Personal Options* Program, Employer Guide and TBIW policy for more information and details).

Self-Direction

Involuntary Transfers

If a member continually has difficulties managing their services, the F/EA will provide additional training in the areas the member is having difficulty. The F/EA will keep documentation of initial and additional training areas.

If after 30 days from when the additional training (for each area needed) has taken place the member is still having difficulty managing their services, the F/EA resource consultant will make a request to BMS to require the member to appoint a program representative to assist with employer responsibilities. If the member refuses to choose a program representative, the member will be required to transition to the Traditional Service Model using the Involuntary Transfer Form with supporting documentation. BMS will make the final decision whether a member will be required to make the transition. If the member is required to transfer to the Traditional Service Model, the UMC will contact the member to facilitate the transfer.

Reasons for Involuntary Transfer of service delivery model may include:

- Non-compliance with the Self-Direction program requirements
- Non-compliance with TBIW program requirements
- Demonstrated inability to supervise their employee(s)
- Demonstrated inability to complete and keep track of employee paperwork.
- Inability to hire an employee (within 90 days of enrollment)
- Program representative left, and member does not have another choice for replacement.

It is possible for a member to transition back from the Traditional Service Model after an Involuntary Transfer has taken place. BMS will consider if the member's circumstances surrounding the reason for the Involuntary Transfer have changed. For example:

- The member now has someone that can be their program representative, or the member can now hire an employee. In such instances, a transition back to Self-Direction could be granted. The UMC will facilitate the transfer.

Involuntary Transfers for the following reason would require a six month wait before being able to transfer back to self-direction:

- Non-compliance with the Self-direction program requirements.
- Non-compliance with TBIW program requirements; and

- Demonstrated inability to supervise their employee(s)

512.26 PERSON-CENTERED ASSESSMENT

Assessment is the structured process of interviews which is used to identify the member's abilities, needs, preferences, and supports; determine needed services or resources; and provide a sound basis for developing the Person-Centered Service Plan. A secondary purpose of the assessment is to provide the member with a good understanding of the program, services, and expectations. Once the Enrollment Confirmation Notice has been received by the case management agency the case manager will schedule a home visit within seven business days to complete the Person-Centered Assessment.

The case manager must work with all service providers to ensure that the program meets the member's needs.

A new Person-Centered Assessment must be completed when one or more of the following conditions are recorded on the case manager's Monthly Contact form:

1. Member indicated that their needs for assistance has changed:
2. Member did not use their Personal Attendant Services during that month.
3. Member indicated that they had problems paying for or getting food, housing, utilities or medications.
4. Recent hospitalization with a change in medical condition resulting in a functional change,
5. Loss of informal support that assisted ADLs.
6. Decrease in functional ability to complete ADLs.

Changes in a member's needs are to be incorporated into the Person-Centered Service Plan. Case managers are to share any changes in a member's assessment with all service providers listed on the member's Person-Centered Service Plan. The personal attendant provider agency is to share any changes observed in the member with the case manager. A copy of all assessments must be provided to the member and the personal attendant provider agency and the F/EA, if self-directing.

512.27 PERSON-CENTERED SERVICE PLAN DEVELOPMENT

The case manager is responsible for development of the Person-Centered Service Plan in collaboration with the members. All Service Plans must be developed using a person-centered approach as required by the CMS. CMS specifies that service planning must be developed through a person-centered planning process that addresses health and welfare and long-term services and support needs in a manner that reflects individual preferences and goals. It is required that the person-centered planning process be directed by the member receiving waiver services and may include representatives and others chosen by the member to contribute to the process. The minimum requirements for person-centered plans developed through this process, include:

- A person-centered plan with individually identified goals and preferences,
- Will assist the member in achieving personally defined outcomes in the most integrated community setting,
- Ensure delivery of services in a manner that reflects personal preferences and choices, and
- Contribute to the assurance of health and welfare.
- Risk Assessment and Mitigation Planning

- 24-hour emergency backup planning
- Required Person-centered Discovery Tools-The purpose of the PCD tools is to find out what is important to the member.
- Additional PCD tools are available and may be used in addition to the required tools to assist in person-centered Service Plan development.

Risk Assessment and Mitigation Planning

A critical step in the assessment process is the comprehensive analysis of risk. A risk analysis is not a one-time exercise but rather a process by which the analysis of risk and the development of risk mitigation strategies are continually revisited. The Person-Centered Assessment requires the team to review areas of risk and or potential risk and include in the Service Plans methods to mitigate risks.

If a member has a doctor prescribed EpiPen for allergic reactions, this must be documented on the Person-Centered Service plan and the personal attendant must have documented training on how and when to use.

24-Hour Emergency Back Up Planning

The purpose of 24-hour emergency backup planning is to ensure that critical services and support are provided to safeguard members health and safety whenever there is a breakdown in the delivery of planned services. The BMS approved Person-Centered Service Plan requires the team to address this during initial/annual and six-month plan reviews.

Participation in the development of the Initial Person-Centered Service Plan is mandatory for the member and case manager. The case manager will upload the Service Plan documents into ANG within seven business days of the Service Plan meeting.

The F/EA will upload the following documents into the UMC web portal: the completed spending plan and the program representative form (if applicable).

The Service Plan meeting must be scheduled and held within seven calendar days of the member's assessment. If agreed upon by the case manager and the member, the assessment and Service Plan meeting can be held at the same time or sooner. The assessment and Service Plan meetings cannot exceed the total time frame of 14 business days from the date of the confirmation of enrollment without prior notification to the UMC. The case manager must upload the completed and Assessments and Service Plan into the UMC web portal within seven business days.

The Service Plan must detail all services (service type, provider of service, frequency) the member is receiving, including any informal/natural supports (family, friends, etc.) that aid and address all needs identified in the PAS, the Rancho Los Amigos Levels of Cognitive Functioning Scale or the Rancho Los Amigos Pediatric Level of Consciousness Scale, and the assessment, etc. For children enrolled in the public school system, the Service Plan must identify the type of educational services (in the public-school setting, in another school environment or if the child is home schooled by the parent/guardian or designee appointed by the parent/guardian) and the hours during the day in which these services are provided. The Service Plan must also address the members' preferences and outcomes. It is the case manager's responsibility to ensure that all assessments are reviewed with the member and considered in the development of the Person-Centered Service Plan.

The case manager must send the member's Service Plan, assessment, and Request for Service Authorization form (which identifies the member's budget) to the UMC within seven business days of the Service Plan meeting. The UMC will review the request for service authorization and when approved will provide the Prior Authorization Notice and approved final Budget to the case management agency, Personal Attendant Agency or the F/EA (if applicable). It is the case management agency's responsibility to send a copy of the Service Plan, Person-Centered Assessment and the approved final budget to the member within seven business days from receipt of approval from the UMC. The case management agency must have the original documents in the member's file.

The Person-Centered Service Plan must contain reference to any other service(s) received by the member, regardless of the source of payment. A TBIW provider agency that provides private-pay services to a member must ensure that documentation is maintained separately.

TBIW services are not intended to replace support/services that a child would receive from the school system during a school day or educational hours provided during home schooling.

Services listed in the definition of Room and Board under the Bureau for Social Services -Specialized Family Care Program cannot be duplicated on the Person-Centered Service Plan for a TBIW member.

If there is a disagreement regarding services listed on the Person-Centered Service Plan being developed, the member can follow the agency's grievance process. The member will receive services listed on the Person-Centered Service Plan that is being disagreed with throughout the grievance process.

Note: Case managers working with members, the personal attendant agency and staff during a transition through the Take Me Home Transition Program is required to provide assessments and Service Plan development to be in place on day one of the members' transition. The case manager must upload the Service Plan into the UMC web portal so that an authorization can be provided the day of transition prior to discharge from a facility.

512.27.1 Six-Month Ongoing Person-Centered Service Plan Development and Service Plan Addendum

Participation in the six-month Person-Centered Service Plan and Annual Person-Centered Service Plan development is mandatory for the member, the case manager, and the personal attendant provider agency. The member may choose to have whomever else they wish to participate in the process such as personal attendant professional, family members, other service providers, informal supports, resource consultant (if applicable) etc.

The personal attendant staff providing services can bill one (1) hour for attendance at the members' service plan meetings using the personal attendant services code.

The six-month review meeting is held six months from the Initial/Annual Service Plan meeting and includes a review of the Initial/Annual Assessment and Service Plans that were created. This review does not result in a new assessment and service plan but modifications to the existing assessment and/or plan would be documented on the six-month review page. Changes, modifications, or revisions to the Assessment and/or

Service Plan are documented on the 6-month review page and signatures are obtained from those in attendance.

Copies of the six-month review are sent to the Member and their legal representative by the Case Manager. The Case Manager is responsible for uploading the six-month review documents in the UMC Web portal.

Service Plan Addendum

A Service Plan Addendum is completed to document a change in the members' needs. These changes would include such things as the member indicated that their needs for assistance has changed, member did not use the PA services during an entire month, member indicates they had problems paying for or getting food, housing, utilities or medication, a recent hospitalization with a change in medical condition resulting in a functional change, loss of informal supports that assists with ADLs and/or decrease in functional ability to complete ADLs or address a member/provider controlled settings assessment results. All Addendums must be uploaded into the web portal within 5 business days. **A Service Plan Addendum does not take the place of a required six-month or annual Service Plan meeting.**

An addendum should also be used if a Responsibility Agreement needs to be implemented and/or EAA, PERS or other covered service changes. The addendum should discuss the reasons that lead to the need for the Responsibility Agreement and/or need for additional services.

The Responsibility Agreement must be updated each time that a Person-Centered Service Plan is reviewed.

512.27.2 Interim Person-Centered Service Plan Development

In order to begin services immediately to address any health and safety concerns, an Interim Person-Centered Service Plan may be developed and implemented upon the confirmation of a member's enrollment by the UMC. The Interim Person-Centered Service Plan can be in effect up to 30 calendar days from the date of a member's Enrollment Confirmation Notice to allow time for assessments to be completed, the Service Plan meeting to be scheduled and the Person-Centered Service Plan to be developed.

If the case management agency develops an Interim Person-Centered Service Plan, the personal attendant provider agency must initiate personal attendant services within three business days. An Interim Person-Centered Service Plan is only available to members who have chosen to use the Traditional Service Model or the Take Me Home Transition waiver program services.

512.28 Budget Development

A member's budget is developed once their Person-Centered Service Plan is completed. A member utilizing the TBIW program would have access to an annual maximum budget of $36,600.00. Not everyone will receive the maximum budget amount. An individual budget is based on the frequency of program covered services as outlined in the Person-Centered Service Plan.

The UMC will prorate a member's budget when necessary to align with the member's anchor date.

Members choosing *Personal Options*, will also develop a Spending Plan based on the budget developed from the Person-Centered Service Plan. The Spending Plan helps members determine how their budget will be used. The resource consultant will upload the Spending Plan into the UMC web portal once services have been authorized within 3 business days.

The maximum amount of a member's self-directed budget is the equivalent monetary value of personal attendant units, PERS unit, EAA home and/or vehicle and non-medical transportation units as outlined in the member's Person-Centered Service Plan.

Once all the equivalent monies are transferred into the member's self-directed budget, the member, along with their *Personal Options* resource consultant, create a spending plan. At this time, the member choose the types of services, the amount of services, and the wages of the member's employees within the parameters of the entire participant-directed budget.

For members new to *Personal Options*, the first month's budget should be prorated to reflect the actual start date of services.

Note: Refer to the Section 512.30 Covered Services of this Chapter and the BMS TBIW website to review the current rates.

512.29 ACTIVATION OF PERSONAL ATTENDANT SERVICES

Once the Person-Centered Service Plan is developed, the agency providing personal attendant services will begin providing personal attendant services within 15 calendar days from the Service Plan development, using the Personal Attendant Worksheet to document all services provided. If the current agency providing personal attendant services is unable to meet this timeline, they must notify the UMC of any delays in staffing and an emergency transfer request must be made unless the member has informal supports in place to safely wait for provider staffing.

TBIW service hours not provided that are listed on the Personal Attendant Worksheet can be made up on a different day within the same two-week period of the Personal Attendant Worksheet but cannot be carried over into a new month. This applies to both Traditional and Self-directed service models. Permanent or long-term changes in the services/service hours listed on the Personal Attendant Worksheet must be made through an addendum to the Service Plan by the case manager for both Traditional and Personal Options models.

A copy of all original Personal Attendant Worksheets must be maintained in the member's file to verify services provided.

POLICY

512.30 COVERED SERVICES

The following services are available to people on the TBIW if they are deemed necessary and appropriate during the development of and listed on their Person-Centered Service Plan:

- Case management services
- Personal attendant services

- Non-medical transportation services
- PERS
- EAA home and/or vehicle

TBIW services, eligible for reimbursement by Medicaid, are to be provided exclusively for the member utilizing the program and only for necessary activities as listed in their Person-Centered Service Plan. They are not to be provided for the convenience of others living in the household or others whom the member has contact with. Informal support is not mandatory in the TBIW program. The program is designed to provide formal support services to supplement the member's existing informal support system if available.

512.31 CASE MANAGEMENT SERVICES

Case management activities are indirect services that assist the member in obtaining access to needed TBIW services, other State Plan services, as well as medical, social, educational, and other services, regardless of the funding source. Case management responsibilities also include the completion of the member's assessment, the development of the member's Person-Centered Service Plan, and budget development, the ongoing monitoring of the provision of services included in the Person-Centered Service Plan, monitoring continuing eligibility, health, safety, welfare, and advocacy. Case managers are required to make a monthly phone contact and at minimum a quarterly face-to-face home visit with the member.

Case management includes the coordination of services that are individually planned and arranged for members whose needs may be life-long. The practice of case management helps to avoid duplication and provision of unnecessary services, and to ensure a balance of services. The case manager takes an active role in service delivery; although services are not provided directly by the case management agency, the case manager serves as an advocate and coordinator of care for the member. The case manager must be available to respond to a member in crisis whenever needed. This involves collaboration with the members receiving TBIW services, family members, friends, informal supports, health care, and social service providers.

Procedure Code: G9002 U2
Service Unit: 1 Unit per month
Service Limit: 12 units per year
Prior Authorization: This service must be prior authorized before being provided.

Documentation Requirements: All contacts with, or on behalf of a member, must be legibly documented, member specific, and errors in documentation cannot be completely covered over but must be indicated with a line through the error and noted/initialed by the person making the correction within the member's record, including date and time of contact (includes start and stop time), a description of the contact, and the signature and credentials of the case manager. At a minimum, the case manager must make a successful monthly phone contact and at minimum a quarterly face-to-face home visit with the member and document the contact on the Case Management Monthly Contact Form to secure billing. Reimbursement for Case management services is outside of the member's annual budget. Case management agencies may not bill for non-medical transportation services.
Resource consultants working for the F/EA are not case managers.

512.31.1 Case Management Responsibilities

The case manager is responsible for follow-up with the members to ensure that services are being provided as described in the Person-Centered Service Plan, ensure quality of services and to identify any potential issues. Initial contact, via telephone or face-to-face, must be made within seven calendar days after personal attendant services have begun by the personal attendant provider agency. At a minimum, a monthly phone contact and at minimum a quarterly face-to-face home visit is required with the member. If the member cannot be reached by phone, then the case manager must attempt to reach the individual(s) listed on the members 24-hour emergency backup plan within one business day. In addition, the case manager will contact the personal attendant provider agency (if the Traditional Model is used) to see if there has been any disruption of services. Within 48 hours from the initial attempt to contact the member goes by without hearing from the member or the contact person a face-to-face home visit is required. If there is no answer at the member's home, then a well person/welfare/wellness check must be requested of the local police by the case manager. If the member is not found in the home by the police, then the case manager must enter a critical incident in the WV IMS. All telephone contact must be documented on the Case Management Monthly Contact Form. At a minimum, the case manager must complete a six-month Service Assessment and Service Plan. This must be a face-to-face home visit with the members.

Specific activities to assure that needs are being met also include:

- Assure financial eligibility remains current.
- Assure the health and welfare of the members.
- Address a member's changing needs as reported by the member, personal attendant professional, or informal support.
- Address changing needs determined by monthly contact with the member.
- Refer and procure any additional services the member may need that are not services the personal attendant provider agency can provide.
- Coordinate with all current service providers to develop the six-month Service Plan and the Annual Service Plan (or more often as necessary). It is mandatory that the member, the case manager, and the personal attendant provider agency be present at the initial and six-month Service Plan meeting and the Annual Service Plan meeting.
- Provide the Service Plan to all applicable service providers that are providing services to the member, the Take Me Home Program's transition coordinator (if applicable) and to the *Personal options* resource consultant (if applicable) within seven business days.
- Provide copies of all necessary documents to the member within time designated time frames (Refer to Section 512.23 *and* Section 512.24)
- Provide the HCBS Settings Rule Brochure to the member and explain the contents upon initial enrollment.
- Annually conduct the member-controlled settings rule assessment.
- Upload all required documents into the UMC web portal such as the Service Plans (initial, annual), member-controlled settings rule assessment, prior authorizations, budgets, assessments, court appointed legal guardian information, MPOA information and any other pertinent information.
- Evaluate social, environmental, service, risks and support needs of the member.
    - In collaboration with the member, develop and write a Person-Centered Service Plan which details all services that are to be provided including both formal and informal (if

available) services that will assist the member to achieve optimum function.

- Coordinate the delivery of care, eliminate fragmentation of services, and assure appropriate use of resources.
- Proactively identify problems and coordinate services that provide appropriate high-quality care to meet the individualized and often complex needs of the member.
- Provide advocacy on behalf of the member to ensure continuity of services, system flexibility, integrated services, proper utilization of services and resources, and accessibility to services.
- Ensure that a member's wishes and preferences are reflected in the development of a Person-Centered Service Plan by working directly with the member and all service providers.
- Inform and assist member of their rights, including information about grievance (Refer to Section 512.48 Grievance Process) and Fair Hearing processes (Refer to Section 512.49 Medical Eligibility Appeals).
- Inform member about their choices of service delivery models (Refer to Section 512.25 Description of Service Options)
- Assure that a member's legal and human rights are protected.
- Monitoring the member's risk management, safety and welfare and notifying the UMC of concerns.
- Ensuring a seamless transition between Traditional and *Personal Options* Service Delivery Models.
- Report suspicion of abuse/neglect or exploitation to APS or CPS as applicable, case managers are mandatory reporters.
- Discuss whether a legal/non-legal representative is desired and/or needed by a member and inform the UMC and the *Personal Options* resource consultant (if applicable) of any changes in legal/non-legal representatives on the next business day that the case manager became aware of such a change.
- Providing or linking members with program materials in a format that they can use and understand.
- Explaining person-centered planning and philosophy to members.
- Explaining to members the roles and supports that will be available through each service delivery model.
- Reviewing and discussing the member's budget which is determined by individual needs documented in the member's Service Plan and authorized by the UMC.
- Ensuring that member knows how and when to notify the case manager about any operational or support concerns or questions.
- Notifying the UMC and the resource consultant (if applicable) of concerns regarding potential issues which could lead to a member's disenrollment.
- Follow-up with the member regarding additional services or support based on the submission of a critical incident.
- Notify the Take Me Home Program's Transition Coordinators when members are re-institutionalized, die or have additional pre-transition service needs and the member continues to have available funds.

512.32 PERSONAL ATTENDANT AGENCIES RESPONSIBILITIES

The personal attendant agencies are responsible to act on an Agency Assignment by either accepting or rejecting the assignment within two business days of notice by the UMC.

The personal attendant agency can choose to reject a member by notifying the UMC for the following reasons:

- Already at max capacity.
- Inappropriate referral.
- Temporarily unable to take on new members.
- Unable to meet member needs.
- Withdrawn by member request.
- Other-provider explanation.

Qualified personal attendant staff must be working with the members within 15 calendar days from the completion of the Person-Centered Service Plan. (See Section 512.29, Activation of Personal Attendant Services).

If the personal attendant agency is unable to provide qualified staff within 90 days of a member's enrollment date, the personal attendant supervisor must contact the UMC and the case management agency. The UMC will assist in transferring the members to another personal attendant agency, if available, in the member's county of residence. If the current personal attendant agency is the only willing and qualified provider in the member's county, the agency is required to develop a recruitment plan to locate/hire and train qualified staff.

The personal attendant agency will send a designated staff person to the members' six month and Annual Person-Centered Service Plan meetings. This must be someone who is responsible for the personal attendant hiring and training. If the member wishes for their personal attendant to attend Service Plan meetings the personal attendant can bill up to two hours under the personal attendant Service Code S5125 UB**.**

Prior to submitting claims for billing to the state's Fiscal Agent, the TBIW Personal Attendant Worksheets must be reviewed, signed and approved by the agency's designated personal attendant supervisor. The personal attendant supervisor's signature on the Personal Attendant Worksheet is validation that the activities provided to the member is on their Person-Centered Service Plan.

The personal attendant agencies will complete and submit required administrative and program data documentation as requested by BMS or the UMC.

The personal attendant agency will report to the case management agency when the member is not available to receive personal attendant scheduled services.

512.32.1 Personal Attendant Services

Personal attendant services are defined as long-term direct care and support services that are necessary in order to enable a member to remain at home rather than enter a nursing home, or to enable a member to return home from a nursing home.

More than one personal attendant agency can provide personal attendant services to a member receiving services on the TBIW. Before a second personal attendant agency is contacted to provide services, the personal attendant agency must contact the UMC to explain why a second agency is necessary. The UMC must approve the second personal attendant agency before the process continues. The agency the

members selected on their Freedom of Choice Personal Attendant Form is the primary agency and is responsible for coordinating services. The Service Plan must indicate which agency is the primary agency. There cannot be a duplication of services.

Traditional Model Procedure Code: S5125 UB (S5125 UB UK for personal attendants living in the home)

***Personal Options* Model Procedure Code:** S5125 UC (S5125 UC UK for personal attendants living in the home)

Service Unit: 15 minutes
Ratio: 1:1
Site of Service: This service may be provided in the home of the member who receives services and/or the local public community. This service may not be provided in a Personal Attendant's home. This would exclude members who live with a family member/friend that is the paid Personal Attendant.
Service Limits: Personal Attendant Services are limited by the member's budget.
Prior Authorization: All units of service to the Traditional provider must be prior authorized before being provided.
Documentation Requirements: All services provided to a member must be legibly documented, member specific and errors in documentation cannot be completely covered over but must be indicated with a line through the error and noted/initialed by the person making the correction on the Personal Attendant Worksheet and maintained within the member's record. The use of the EVV documentation does not replace the required Personal Attendant Worksheet.

512.32.2 Personal Attendant Responsibilities

The personal attendant's primary function is to provide hands-on personal care assistance outlined in the Service Plan. Such assistance also may include the supervision of members as provided in the service plan. As time permits, Personal Attendants may also provide other incidental services to personal care assistance such as changing linens, meal preparation, and light housekeeping (sweeping, mopping, dishes, and dusting). The scope of personal attendant services may include performing incidental services however, such activities may not comprise the entirety of the service. Personal attendants may also assist the members to complete essential errands and community activities and supervision of health and welfare risk factors in the home and community. All services provided must appear on the Service Plan and must be fully documented on required forms and comply with BMS documentation standards. The personal attendant must inform the personal attendant agency supervisor of any changes in the member's health, safety, or welfare. (Examples: a member falls (whether the personal attendant was present or not), bruises (whether personal attendant knows origin or not), etc.) or if the member is not available to receive scheduled personal attendant services. The personal attendant agency supervisor will notify the case manager.

Personal attendant services can be provided on the day of admission and the day of discharge from a nursing home, hospital or other inpatient medical facility.

Personal attendant services may include direct care assistance with the following types of ADLs:

- Bathing
- Grooming
- Dressing

- Eating
- Toileting
- Transferring
- Mobility
- Prompt for self-administration of medications

Personal attendants may provide supervision to the member, if they require prompting and supervision for ADLs/IADLS. In addition, personal attendants may aid with Range of Motion (ROM) exercises, including walking, if there is a current/valid order from a physical therapist (PT) and/or a doctor. If there is no order, the activity should be provided as Informal Support until the case management agency is able to secure an order.

Communication and cognitive exercises may be a covered activity by the personal attendant to the member if the activity is on the member's Service Plan and there is a written occupational therapy and/or speech therapy home program.

Essential Errands: Essential errands are activities that are essential for the member receiving TBIW services to live as independently as possible and remain in their own home. Essential errands involve going outside of the member's home for the purpose of conducting the errand with the person or on behalf of the member (when the member is unable to travel outside the home). The case manager must document the Service Plan or the Service Plan Addendum if the member is unable to travel outside the home for any given period. These activities are not intended for the benefit of the personal attendant, family, friends, or others. If informal support, family, friends, or other resources are available, these resources should be utilized before personal attendant services. Special caution is advised for those members who live with their personal attendant, or their personal attendant is a relative to ensure services are for the sole benefit of the eligible member to avoid disallowances. Travel must be conducted in the members' immediate community unless otherwise documented on the Service Plan. The essential errand must have a beginning and ending destination.

Activities include the following types of IADLs for essential errands:

- Shopping for groceries and cleaning supplies or food pantries
- Pick up prescriptions or over-the-counter medications at the pharmacy.
- Local payment of bills (utility bill(s), phone bill, etc.)
- Banking transactions such as deposits and withdrawals
- Post Office to pick up bills or pay bills.
- Assistance with other benefits or financial eligibility
- Laundromat

Family paid personal attendants will not be able to take the members to family events as a formal support i.e., billable service. This would be considered informal support provided by the family.

- A family paid personal attendant cannot bill to take the member to visit their parent in their own residence/nursing home/hospital. However, a non-family member paid personal attendant may bill to take the member on such visits.

The personal attendant may bill for the following:

- Accompanying the member to a medical appointment and the member is using Non-Emergency Medical Transportation (NEMT).
- Aiding the member with an ADL while at an outpatient medical appointment.
- Waiting with the member while at a medical appointment (excludes services such as chemotherapy, dialysis and other services where nursing services are included in the services).
- If the personal attendant will be paid as the friend/family under NEMT program, they can also bill the TBIW for their time riding with a member to/from a medical appointment.

Community Activities

Community activities are those that offer the member an opportunity to participate and integrate into their local communities and neighborhoods. The purpose of community activities is for members to have the opportunity to interact with others in their immediate community and utilize community resources where other individuals without a disability might go and engage in community life. The member's immediate community is in reasonable proximity to the member's home.

The member must accompany the personal attendant on the community activity. These activities are not intended for the benefit of the personal attendant, family, friends, or others. If informal support, family friends or other resources are available, these resources should be utilized before Personal Attendant services.

Special caution is advised for those members who live with their personal attendant, or their personal attendant is a relative to ensure services are for the sole benefit of the member. Community activities may not exceed 30 hours per month. The community activity must have a starting and ending destination.

Activities such as those listed below are examples but not exclusive:

- Going to a local restaurant for a meal
- Shopping at a local department or specialty store
- Checking out books, movies or compact discs (CDs) at the local library
- Haircut at the local beauty salon or barber shop

All personal care assistance needs as outlined on the Service Plan must take place before essential errands or community activities can occur.

Personal attendants must complete the personal attendant worksheet daily documenting the time of services (including start and stop times).

Personal Attendant Limitations

Provider agency staff and employees of member's using the *Personal Options* model cannot perform any service that is a professional skilled service or any service that is not on the member's Service Plan.

Personal attendant services are not intended to replace support services that a child would receive from the school system during a school day/year or educational hours provided during home schooling.

Functions/tasks that **cannot** be performed include, but are not limited to, the following:

- Care or change of sterile dressings.
- Colostomy irrigation.
- Gastric lavage or gavage.
- Care of tracheostomy tube.
- Suctioning.
- Vaginal irrigation.
- Give injections, including insulin.
- Perform catheterizations, apply external (condom type) catheter.
- Tube feedings of any kind.
- Make judgments or give advice on medical or nursing questions.
- Application of heat or cold.
- Nail trimming if the person is diabetic.
- Administer any medications, prescribed or over the counter. This would include placing medication in the member's mouth. This would exclude the use of an EpiPen. (See Personal Attendant Training in Sections 512.16.4 and 512.16.5)
- Fill a member's daily/weekly/monthly pill container.

If at any time a personal attendant is witnessed to be, or suspected of, performing any prohibited tasks, the provider agency, or the case manager or resource consultant (if applicable) must be notified immediately. This would require an incident entry into the WV IMS.

512.33 NON-MEDICAL TRANSPORTATION SERVICES

Non-medical transportation provides reimbursement for personal attendants that perform essential errands for or with a member receiving TBIW services or community activities with a member. (See Section 512.16.7 for more information on essential errands and community activities).
Non-medical transportation must be utilized for the member's needs and cannot be for the benefit of the Personal Attendant, member's family or member's friends. Family, neighbors, friends, or community agencies that can provide this service, without charge, must be utilized first. The member may be transported by the Personal Attendant in order to gain access to incidental services and activities as specified in the Service Plan. Mileage can be charged for essential errands and community activities related to the Service Plan.

Non-medical transportation must occur in the member's local home community unless otherwise stated in the Service Plan and must be at the closest location to the member's home.

Non-medical transportation services can be used to transport members to health care appointments not covered by Medicaid. NEMT is available through the Medicaid State Plan for transportation to and from Medicaid paid medical appointments and must be utilized.

If the personal attendant will be paid as the friend/family under NEMT program, they can also bill the TBIW for their time riding with a member to/from a medical appointment.

The case manager must document on the Service Plan the availability of the member's family, friends, or other community agencies to provide non-paid non-medical transportation first. Special caution is advised for those members who live with their personal attendant, or their personal attendant is a relative to ensure services are for the sole benefit of the eligible member to avoid disallowances.

Non-medical transportation services may be provided within thirty miles of the West Virginia border only to members residing in a county bordering another state.

Traditional Model Procedure Code: A0160 UB
***Personal Options* Model Procedure Code:** A0160 U2
Service Unit: 1 unit - 1 mile
Service Limit: 3600 units annually
Prior Authorization: All units of service must be prior authorized before being provided.
Documentation Requirements: All transportation with, or on behalf of, the member must be included in the Service Plan and include the date, miles driven, travel time, destination, purpose of travel and type of travel (essential errand or community activity). The Service Plan must document the purpose of the travel and the destination. The personal attendant must document on the Personal Attendant Worksheet accurate miles traveled, exact location of the beginning and ending destination and reason for the travel.

512.34 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

This is a small device that is used to request help from a monitoring center in the event of an emergency. The monitoring center can alert emergency medical services to help the individual.

The PERS provider must provide an emergency response center with fully trained operators who can receive signals for help from a member's PERS equipment 24-hours a day, 365, or 366 days per year as appropriate, of determining whether an emergency exists, and of notifying an emergency response organization or an emergency responder that the PERS service member needs emergency help.

Traditional Model Procedure Code: S5161 U5
Personal Options Model Procedure Code: S5161 U5 UK
Service Unit: 1 unit - 1 per month
Service Limit: 12 Months
Prior Authorization: All units of service must be prior authorized before being provided.
Documentation Requirements: The TBIW personal attendant provider will choose a PERS vendor(s) to provide the service for the members that they are servicing who desire or need the service. The service provision will be documented in the Service Plan by the Case Manager. In the case where a member transfers to another personal attendant agency they will be required to use the PERS vendor of the agency they are transferring to. The personal attendant agency will need to work together to determine a transfer date of the service so PERS billing will not conflict with each other.

512.35 ENVIRONMENTAL ACCESSIBILITY ADAPTATION

Environmental Accessibility Adaptations-Home (EAA-Home) are physical adaptations to the private residence of the member who receives services or the family in which the member resides and receives services which maximize physical accessibility to the home and within the home. EAA-Home must be documented in the Service Plan by the Case Manager. Additionally, these adaptations enable the member who receives services to function with greater independence in the home. This service is used only after all other non-family funding sources have been exhausted.

Environmental Accessibility Adaptations-Vehicle (EAA-Vehicle) are physical adaptations to the vehicle including paying for accessibility adaptations if the member who receives services has the capacity to

drive or needs regular transportation from a family member. EAA-Vehicle must be documented in the members Service Plan by the case manager. The purpose of this service is to maximize accessibility to the vehicle only.

The case manager must add the EAA to the member's Service Plan. All EAA requests must be submitted to the UMC for approval. If approved, an authorization is issued for the personal attendant provider agency F/EA to begin the process of obtaining the EAA. The provider agency F/EA is responsible for ensuring the adaptation to the home/vehicle is completed as specified in the plan. Documentation including dated and itemized receipts of the completed adaptation must be maintained by the personal attendant provider/FEA and a copy shared with the case manager. The case manager will also verify that the EAA was provided as outlined in the members' Service Plan. Once the case management agency verifies that the required documentation is obtained and the vendor is qualified, they will notify the personal attendant agency that the work can be completed. The personal attendant agency will process the claim to obtain the funds, issues payment to the vendor and notify the case management agency when the work is completed. The case manager must upload all required documentation into the UMC web portal.

Traditional Model Procedure Code: Home-S5165 U2 Vehicle-T2039 U2
Personal Options Model Procedure Code: Home- S5165 U3 Vehicle-T2039 U3
Service Unit: $1.00
Service Limit: $1000.00 total per Service Plan Year
Prior Authorization: All units of service must be prior authorized before being provided.
Documentation Requirements: The case management agency or personal attendant agency must submit the West Virginia TBIW EAA Home/Vehicle form and additional required supporting documentation. Additional required documentation is a contractor's business license.

EAA - Home

The amount of service is limited by the individualized budget of the program member. EAA-Home is not intended to replace the responsibility of the member who receives services, their family, or their landlord for routine maintenance and upkeep of the home. These include but are not limited to:

- Cleaning
- Painting
- Repair/replacement of roof
- Windows (unless a modified window is needed that is large enough for an adult to use to exit in case of fire)
- Flooring
- Structural repairs
- Air purifiers, humidifiers or air conditioners (unless the person has a documented respiratory/allergy condition or diagnosis)
- Heating equipment or furnaces
- Generators unless used for specific medical equipment (cannot be for the entire house),
- Plumbing and electrical maintenance
- Fences, gates or half-doors
- Security systems

- Adaptations that add to the square footage of the home except when necessary to complete an approved adaptation, (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair)
- Computers, communication devices, tablets, and other technologies
- Landline telephones or cell phones
- Swimming pools, hot tubs or spas or any accessories, repairs or supplies for these items
- Railing for decks or porches (railing for a ramp is permitted)
- Appliances that are not adapted/modified
- Yard work
- Household cleaning supplies
- Utility payments
- Household furnishings such as comforters, linens, drapes, etc.
- Furniture unless it is a lift chair for someone with documented mobility issues
- Outdoor recreational equipment unless specifically adapted for the member's needs
- Driveway or walkway repairs or supplies unless specifically to exit or enter home to and from vehicle
- Covered awnings
- Adaptations made to rental residences must be portable. Permission must be obtained from the property owner.
- $1000 available per Service Plan year in combination with Traditional and Self-Directed Environmental Accessibility Adaptations - Vehicle.

The personal attendant agency F/EA must not pay EAA funds to the member who receives services, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service.

The amount of service is limited by the individualized budget of the program member. If a member is self-directing this service, then the number of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Personal Attendant services or Non-Medical Transportation.

EAA - Vehicle

- The amount of service is limited by the individualized budget of the member who receives services.
- $1000 available per Service Plan year in combination with Traditional and Self-Directed Environmentally Accessibility Adaptations.
- This service may not be used for adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the member who receives services.
- This service may not be used to purchase or lease a vehicle.
- This service may not be used for regularly scheduled upkeep, maintenance, or repairs of a vehicle except for upkeep and maintenance of the modifications.
- This service may not be used for running boards, insurance, or gas money.
- Car seats, unless specifically adapted/modified for the member.

The personal attendant agency F/EA must not pay EAA funds to the member who receives services, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service.

The amount of service is limited by the individualized budget of the program member. If a member is self-directing this service, then the number of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Personal Attendant services or Non-Medical Transportation.

512.36 PRE-TRANSITION CASE MANAGEMENT

Procedure Code: T1016 U2
Service Unit: 15 minutes
Service Limit: 24 units
Prior Authorization Required: Yes
Service Definition:

The purpose of the pre-transition case management service is to ensure that waiver services are in place on the first day of the member's transition to the community. Prior to the member's transition from the facility, pre-transition case managers will:

- Participate in the transition assessment and planning process to help ensure that home and community-based services and support needs are thoroughly considered in transition planning.
- Conduct the person-centered assessment as required by waiver policy.
- Complete the required waiver interim Service Plan.
- Facilitate the development of the assessment for those eligible for and planning to enroll in the TBIW program when returning to the community.
- Facilitate the development of the Service Plan by the selected waiver personal attendant agency.
- Coordinate with the personal attendant agency to ensure that personal attendant services are in place the first day the member returns home.
- Enroll the members in the waiver program immediately prior to their transition home. Individuals who have been determined eligible are not "enrolled" in the program until they are ready to receive services. Residents of nursing homes may apply and be determined eligible but are not enrolled into the waiver until they have been discharged from the facility (transitioned) and begin waiver services.

Note: Case managers working with members, the personal attendant agency, and staff during a transition through the Take Me Home program is required to provide assessments and Service Plan development to be in place on day one of the members' transition. The case manager must upload the Service Plan into the UMC web portal so that an authorization can be provided the day of transition prior to discharge from a facility.

Limits

Individuals eligible to receive this service:

- Live in a nursing facility, hospital, Institution for Mental Disease (IMD), or a combination of any of

the three for at least 60 consecutive days; and
- Have been determined medically and financially eligible for the TBIW program; and
- Wish to transition from facility-based living to their own homes or apartments in the community consistent with the CMS Settings Rule (1915(I)); and
- Have a home or apartment in the community to return to upon leaving the facility that is consistent with the CMS Settings Rule (1915(I); and
- Require waiver transition services to safely and successfully transition to community living; and
- Can reasonably be expected to transition safely to the community within 180 days of initial date of transition service.

The pre-transition case management service may be billed up to 24 units (a unit is 15 minutes) only one-time following transition to the community. This service is not available once the resident transitions to the community and enrolls in the waiver. The case management agency will receive authorization for this service via the Pre-Transition Case Management Services Authorization letter that will be sent from Take Me Home Program's transition manager, or the designee, to the case management agency provider.

NOTE: Pre-transition case management qualifications are the same as case manager qualifications listed in Section 512.16.1.

512.37 Community Transition Services

Procedure Code: T2028 U2
Service Unit: Unit = $1.00
Service Limit: 4000 units
Prior Authorization Required: Yes

Service Definition

The community transition service is the primary waiver service available to support qualifying applicants with a safe and successful transition from facility-based living to the community. Community Transition Services are one-time expenses necessary to support applicants wishing to transition from a nursing facility, hospital or Institution for Mental Disease (IMD) to their own home or apartment in the community. Allowable expenses are those necessary to address barriers to a safe and successful transition identified through a comprehensive Transition Needs Assessment and included in an approved individualized Transition Plan. Community transition services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the applicant is unable to meet such expense or when the services cannot be obtained from other services. Community Transition Services do not include monthly rental or mortgage expenses; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes. The components of the Community Transition Service include:

- Home accessibility adaptation modification - assistance to applicants requiring physical adaptations to a qualified residence. This service covers basic modifications such as ramps, widening of doorways, purchase and installation of grab-bars and bathroom modifications needed to ensure health, welfare and safety and/or to improve independence.
- Home furnishings and essential household items - assistance to applicants requiring basic household furnishings to help them transition back into the community. This service is intended to help with the initial set-up of a qualifying residence.

- Moving expenses - includes rental of a moving van/truck or the use of a moving or delivery service to move an applicant's goods to a qualified residence. Although this service is intended as a one-time set-up service to help establish a qualified residence, under certain circumstances it may be used throughout the transition period to relocate a member.
- Security deposit - used to cover rental security deposit.
- Utility deposits - used to assist applicants with required utility deposits for a qualifying residence.
- Transition support - services necessary for the member's health and safety such as pest eradication and one-time cleaning prior to occupancy. All transition services must be reasonable and necessary, not available to the member through other means, and clearly specified in the waiver member's service plan.

Members will be directly responsible for their own living expenses post transition.

Limits Community Transition Services

The total expenditure for Services cannot exceed $4000 per transition period. Community Transition Services cannot be used to cover the following items. Please note that this is not intended to be an all-inclusive list of exclusions:

- Rent.
- Home improvements or repairs that are considered regular maintenance or upkeep.
- Recreational or illegal drugs.
- Alcohol.
- Medications or prescriptions.
- Past due credit card or medical bills.
- Payments to someone to service as a representative.
- Gifts for staff, family or friends.
- Electronic entertainment equipment.
- Regular utility payments.
- Swimming pools, hot tubs or spas or any accessories, repairs or supplies for these items.
- Vehicle expenses include routine maintenance and repairs, insurance and gas money.
- Internet service.
- Pet/Service/Support Care, including food and veterinary care.
- Experimental or prohibited treatments.
- Education.
- Personal hygiene services (manicures, pedicures, haircuts, etc.),
- Personal Emergency Response Services (PERS),
- Equipment,
- Specialized Medical Supplies,
- Transportation
- Discretionary cash; or
- Assistive technology

Any service or support that does not address an identified need in the Transitional Plan, or decrease the need for other Medicaid services, or increase the member's safety in the home, or improve and maintain the member's opportunities for full membership in the community is excluded.

Members, ages 22-64, transitioning from an IMD will not receive community transition services.

The FMS vendor is responsible for validating vendor qualifications prior to processing invoices and verifies that the item is on an approved transition plan. The TMH transition manager verifies the item is not on the exclusions list and a receipt is present for the purchase.

512.38 PRIOR AUTHORIZATIONS

Prior authorization requirements governing the provision of all West Virginia Medicaid services apply pursuant to *Chapter 300, Provider Participation Requirements* of the BMS Provider Manual.

In order to receive payment from the BMS, a provider must comply with all prior authorization requirements. The BMS in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not guarantee payment. All services provided within the TBIW program must be authorized by the UMC. The case manager is responsible for ensuring that all prior authorizations requests are forwarded to the UMC.

512.39 BILLING PROCEDURES

Claims cannot be processed for less than a full unit of service. Consequently, in filing claims for Medicaid reimbursement the amount of time documented in minutes must be totaled and divided by the minutes in a unit of service to arrive at the number of units billed. After arriving at the number of billable units, billing must take place on the last date in the service range. **The billing period cannot overlap calendar months and should not include billing for more than one month.**

Medicaid is the payer of last resort. Claims will not be honored for services (inclusive of service code definitions) provided outside of the scope of this Chapter or outside of the scope of federal regulations.

It is the providers responsibility to check Medicaid eligibility via the fiscal agent portal before providing services initially and then monthly (*See Chapter 400, Member Eligibility*).

TBIW providers are required to bill daily and include the Personal Attendant worker's individual NPI number. By billing daily, it means that each day will be billed separately, thereby eradicating span billing. This will enable program integrity and reduce opportunities for Medicaid fraud, abuse or waste. Personal attendants that live in the member's home are not required by BMS to use EVV.

512.40 PAYMENTS AND PAYMENT LIMITATIONS

TBIW providers must comply with the payment and billing procedures and requirements described in *Chapter 600, Reimbursement Methodologies* of the Provider Manual.

No TBIW services may be charged while a member is inpatient in a nursing home, hospital, rehabilitation facility, or other inpatient medical facility, except for personal attendant services on the day of admission and day of discharge. 30 days prior to discharge from one of these programs, case management services may be billed to plan the member's discharge to ensure services are in place.

Note: This section is referring to non-Take Me Home Transition program members.

512.41 SERVICE LIMITATIONS, SERVICE EXCLUSIONS AND RESTRICTIONS

Services governing the provision of all West Virginia Medicaid services apply pursuant to *Chapter 300, Provider Participation Requirements* of the BMS Provider Manual and applicable sections of this Chapter. Reimbursement for services is made pursuant to *Chapter 600, Reimbursement Methodologies*; however, the following limitations also apply to the requirements for payment of services that are appropriate and necessary for the TBIW Program services described in this chapter.

TBIW services are made available with the following limitations:

- All members must live in West Virginia and be available for required services.
- All TBIW regulations and policies must be followed in the provision of the services. This includes the requirement that all TBIW providers obtain a business licensed in the State of West Virginia and enroll in the West Virginia Medicaid Program.
- The services provided must conform with the stated goals and objectives of the member's Person-Centered Service Plan.
- Members' budgets and limitations described in this manual must be followed.
- No duplication of services assisting the member with ADLs or ancillary tasks that are being provided by another program such as but not limited to (Medicare, Medicaid, Veterans Administration or private pay). An exclusion to this would be for someone that was incontinent and might require an additional bath and laundry. This would need to be documented in the assessment.
- TBIW members cannot be a paid care giver in another waiver program or the PC Services program.
- Any setting where the provider of home and community-based services also owns and operates an individual's residential service is considered provider controlled and therefore not in alliance with the CMS home and community-based services settings rule. TBIW services cannot be provided in this type of setting, An Adult Family Care (AFC) setting would not be an approved setting.
- TBIW service hours not provided that are listed on the Personal Attendant Worksheet can be made up on a different day within the same two-week period of the Personal Attendant Worksheet but cannot be carried over into a new month. This applies to both Traditional and Self-directed service models. Permanent or long-term changes in the services/service hours listed on the Personal Attendant Worksheet must be made through an addendum to the Service Plan by the case manager for both Traditional and Personal Options models.

In addition to the exclusions listed in *Chapter 100, General Information* of the BMS Provider Manual, members who receive case management services under the TBIW are excluded from receiving Health Home Care Management and/or Targeted Case Management services. Payment for TBIW Case Management Services must not duplicate payments made to other entities for a comparable service.

Restrictive Intervention

The TBIW prohibits intentional restrictive interventions of a member's movement or behavior. Restrictive interventions that are prohibited include but are not limited to: physical restraints such as ropes, handcuffs, bungee cords, phone cords, electrical cords, zip ties, tape of any kinds, gags, locking in a

room, blocking an emergency fire exit, physical four-point restraint and other extreme forms of restraint. Evasive maneuvers may be utilized when a member is physically aggressive in an unsafe environment.

Door alarms and GPS trackers used by families for members that wander would not be considered a restraint however must be reflected on the member's Risk Analysis and Mitigation Plan.

Emergency Safety Intervention

The BMS allows limited interventions of emergency safety in predictable environments only where the member may be confused or agitated and has one or more of the following diagnoses:

- Dementia
- Alzheimer's Disease.
- Stroke.
- Parkinson's Disease.
- TBI; or
- Other brain disease or injury, Cognitive Impairment and/or behaviors that create memory loss with difficulties in thinking, problem-solving or language, agitation, anxiety, irritability and motor restlessness that often led to such behaviors as wandering, pacing and night-time disturbances.

When a member experiences confusion, agitation, wandering or behavior that may create an emergency risk to the member's safety, emergency safety interventions covered may include alarms for doors, Global Positioning System (GPS) identification or monitoring devices, personal emergency response systems and other methods of locating or warning of emergency safety incidents and bed rails. The case manager must document in the Assessment and the Risk Analysis and Mitigation Plan the rationale for the use of an emergency safety intervention. The UMC monitoring staff will review the use of emergency safety interventions during the provider on site review.

Reimbursement for TBIW services **cannot** be made for:

- Services provided outside a valid Service Plan.
- Services provided when medical and/or financial eligibility has not been established.
- Services provided when there is no Service Plan.
- Services provided without supporting documentation.
- Services provided by unqualified staff.
- Services provided outside the scope of the service definition; or
- Services that exceed service limits.
- Incidental services (light housekeeping, changing linens, meal preparation and laundry) will not be reimbursed if performed by the Personal Attendant for minor children (under the age of 18). This includes both the Traditional and Self-direction Service Delivery Model.
- TBIW services are not intended to replace support/services that a child would receive from the school system during a school day or educational hours provided during home schooling.

In addition to the exclusions listed in *Chapter 100, General Information* of the BMS Provider Manual, members who receive case management services under the TBIW are excluded from receiving Health Home Care Management or Targeted Case Management services. Payment for TBIW case management services must not duplicate payments made to other entities for a comparable service.

512.42 DUAL PROVISION OF TBIW AND PERSONAL CARE (PC) SERVICES

PC services are to be used as an additional service to supplement the TBIW services when member needs exceed what the waiver can provide.

The case manager must ensure that the member meets the TBIW criteria for dual services before applying for Personal Care services and documents the need for additional services in the members Service Plan. This should be done at the initial, six month or annual Service Plan meeting. If the need is identified outside of Service Planning meetings, the Service Plan addendum should be used to add PC services.

PC services must not duplicate activities/services in another service/program and is not for respite, monitoring/supervision, or companion care. PC activities that will be performed outside the routine of the day must have a rationale on the Personal Care RN Assessment explaining the need for the personal care activity at that time of day. Example: A second bath in the evening for a member who is incontinent.

Members enrolled in TBIW who wish to request additional services through the PC Services program and who meet the TBIW/PC Dual requirements may apply for PC as indicated below:

- For **initial PC requests**, the PC applicant, TBIW case manager, personal attendant agency or referent will submit an Initial PC-MNER to the UMC via fax or mail. The UMC will verify the TBIW member has maximized their TBIW budget. If Waiver requirements are met, the UMC will key the TBIW PAS previously completed into the PC web portal and reach out to the PC applicant to acquire their choice of PC agency within their catchment area. If approved for PC, the UMC will refer the new PC member to their chosen PC agency via the PC web portal. If Waiver requirements are not met, the UMC will close the request, and the person may reapply for PC if/when the person meets the Waiver requirements.
- For **Annual re-evaluation requests** of PC services, The PC agency will receive an annual eligibility alert 90 days prior to the anchor date through the web portal. After receipt of the alert, the PC agency should update any member demographics, diagnosis, or significant information on the MNER screen, then submit within the web portal. The UMC will utilize the TBIW PAS for annual redetermination, If Waiver requirements are met, the UMC will key the TBIW PAS previously completed (by the UMC) into the PC web portal for determination of PC eligibility. If Waiver requirements are not met, the PC member will be discharged.
- If an existing PC member becomes eligible for TBIW and is offered a slot, but does not meet TBIW requirements for dual services, the member must choose between TBIW or PC services. However, the PC services are to remain in place until the TBIW service begins.

For members approved for dual services the PC agency will utilize the medical eligibility TBIW anchor date.

Once Dual Services are approved for a TBIW/PC member, the TBIW Person-Centered Assessment and the TBIW Personal Attendant Worksheet will be used when developing the PC Plan of Care.

- The PC RN is responsible for submitting the PC Plan of Care to the case manager and uploading it in the UMC personal care web portal.

- Case management agencies cannot also serve the same member who is receiving Direct-Care Worker services through the Medicaid State Plan PC Services program. However, it may be necessary for an Exceptions determination to be made for the case management agency if they are the only willing and qualified provider in a county within a 25-mile distance from the member's residence.
- If at any time, after the approval of dual services, the TBIW personal attendant agency is unable to initially hire a worker or is unable to meet the maximum budget requirements for dual services due to staffing issues, the PC direct-care worker services can continue for 30 days,
- The TBIW personal attendant agency must document why they are unable to provide the personal attendant services listed in the members Service Plan.
- The PC agency must request written permission from the operating agency to continue to provide PC direct-care services and keep said documentation in the member's file.

512.43 PROVISION OF TBIW AND HOME HEALTH AGENCY SERVICES

Members who have been determined eligible for and are enrolled in the Home and Community-Based TBIW Program may receive services from a Home Health agency that does not duplicate TBIW services. Home Health agency services provided to the TBIW member must be coordinated by the TBIW case management agency, and in general may only include skilled nursing care or therapy services for post-hospitalization stays or acute episodes of chronic conditions. The need for Home Health services must be documented in the members' Service Plan. Documentation of the referral from the members attending physician must be maintained in the member's records of both the TBIW agency and the Home Health agency. Please refer to *Chapter 508, Home Health Services* for additional information.

Other Medicaid services a member may be eligible to receive at the same time would be Hospice (*Chapter 509, Hospice Services*) and Private Duty Nursing (*Chapter 532, Private Duty Nursing*). Duplication of services is not allowed. Please refer to the chapters referenced above for additional information.

512.44 VOLUNTARY AGENCY CLOSURE

A provider agency may terminate their participation in the TBIW program with 60 calendar day's written notification of voluntary termination. The written termination notification must be submitted to the BMS fiscal agent and to the UMC. The provider must provide the UMC with a complete list of all the members that will need to be transferred.

The UMC will provide selection forms to each of the members on the agency's list, along with a cover letter explaining the reason a new selection must be made. If possible, a joint home visit with the member will be made by both the agency ceasing participation and the new one selected in order to explain the transfer process. Services must continue to be provided until all transfers are completed by the UMC. If a joint visit is not possible, both providers must document how contact was made with the member to explain the transfer process.

The agency terminating participation must ensure that the transfer of the member is accomplished as safely, orderly and expeditiously as possible. All program records must be maintained and/or destroyed according to BMS common chapters.

The agency must submit their final continuing certification for any part of the year they provided services prior to closing. The agency must reconcile any outstanding corrective action plans or issues with incident management prior to closure to avoid monetary penalties such as fines and pay holds.

In the event a provider sells their business the members do not automatically transfer with the sale. Members must be provided freedom to choose from available TBIW providers in their catchment area. Any effort to coerce a member to transfer to the purchasing TBIW provider will be considered a conflict of interest and will result in the purchasing TBIW provider being removed from the TBIW provider selection list for one calendar year. See Section 512.3 Provider Agency Certification "Conflicts of Interest".

512.45 INVOLUNTARY AGENCY CLOSURE

The BMS may terminate a provider from participation in the TBIW Program for violation of the rules, regulations, or for the conviction of any crime related to health care delivery. If the provider is a corporation, its owners, officers, or employees who have violated said rules and/or regulations or have been convicted of a crime related to health care delivery, may likewise be excluded from further participation in the TBIW Program. Refer to *Chapter 100, General Information,* for more information on this procedure.

Prior to closure, the provider will be required to provide the UMC with a complete list of all members that will need to be transferred. The UMC will provide selection forms to each member on the agency's list, along with a cover letter explaining the reason a new selection must be made. The UMC will ensure that the transfer of all members is accomplished as safely, orderly and expeditiously as possible.

The agency must submit their final continuing certification for any part of the year they provided services prior to closing and if not BMS may withhold payment.

All program records must be maintained and/or destroyed as per common chapters of the West Virginia Medicaid Manual.

512.46 ADDITIONAL SANCTIONS

If the BMS or the UMC receives information that clearly indicates a provider is unable to serve members on the waiver due to staffing issues, or has a demonstrated inability to meet recertification requirements, BMS may remove the agency from the Provider Selection Forms and from the provider information on the BMS TBIW website until the issues/concerns are addressed to the satisfaction of BMS. Health and Safety deficiencies deemed critical may include other sanctions including involuntary agency closure.

Failure to meet policy requirements will prompt the BMS to issue a letter notifying the provider of the specific areas of noncompliance. A Plan of Correction will be requested from the provider to address each area of noncompliance. The provider will have 15 days to develop a provisional Plan of Correction and submit it to the BMS. For each step of progressive remediation, a noncompliance notification letter will be issued by BMS to the provider. However, BMS can escalate the remediation process (per provider/per case) to any step of the overall process.

Progressive Remediation

Over the next 30 days, targeted technical assistance will be provided to the provider and they must

submit a Plan of Correction to BMS for approval before the end of the 30-day time frame:

- **Technical Assistance and Provisional Plan of Correction:** The first step in remediation is technical assistance which will be provided to the provider by the UMC, requiring the development of a provisional Plan of Correction and implementation.
- **30-Pay Hold**: If the provider continues to be noncompliant, a thirty day pay hold will be placed on the provider.
- **Census Hold:** The next step in the remediation process is a census hold in addition to the thirty day pay hold.
- **Census Reduction**: If the provider continues to be noncompliant, a census reduction of up to 10% will be placed on the provider in addition to the thirty days pay hold and the census hold. The Provider must submit an amended Plan of Correction to BMS.
- **Termination of TBIW Provider Status**: BMS may either accept the amended Plan of Correction or issue a final noncompliance notification and termination of TBIW provider status.

512.47 MEMBER RIGHTS AND RESPONSIBILITIES

Case management agencies must communicate with each member initially, upon admission to the agency "transfer" and annually the following:
Their right to:

- Transfer to a different provider agency, from Traditional services to *Personal Options*, or from *Personal Options* to Traditional services.
- Address dissatisfaction with services through the provider agencies or *Personal Options*' grievance procedure.
- Access the West Virginia Fair Hearing process when appropriate (see Chapter *400, Member Eligibility* Section 400.1.9).
- Considerate and respectful care from their provider(s).
- Freedom from abuse, neglect, and exploitation.
- Take part in decisions about their services delivery process and Person-Centered Planning.
- Confidentiality regarding TBIW services.
- Access to all of their files maintained by the agency providers and/or the F/EA.
- Freedom from retribution when expressing dissatisfaction with services or appealing service decisions
- Freedom from restrictive interventions including restraints and seclusion.
- Choice of provider agencies that provide their services and meets Conflict Free Case Management criteria.

And their responsibility to:

- Notify the TBIW personal attendant service agency within 24 hours prior to the day services are to be provided if services are not needed.
- Notify personal attendant service agency, case management agency or the resource consultant promptly of changes in Medicaid coverage.
- Comply with the Person-Centered Service Plan and Responsibility Agreement (if applicable).
- Notify their case management agency, personal attendant agency and the resource consultant (if applicable) of a change in residence or an admission to a hospital, nursing facility or other facility.

- Notify their case management agency, personal attendant agency and the resource consultant (if applicable) of any change of medical status or personal attendant care needs.
- Maintain a safe physical home environment for all service providers.
- Verify services were provided.
- Communicate any problems with services to the case management agency or the resource consultant (if applicable).
- Report any suspected Medicaid fraud to the case management, personal attendant agencies or OPI Unit at (304) 558-1700 or email at DHHRBMSMedicaidOPI@wv.gov
- Report any incidents of abuse, neglect or exploitation to the case management, personal attendant agencies or the resource consultant (if applicable), and/or APS/CPS at 1-800-352-6513.
- Report any suspected illegal activity to their local police department or appropriate authority as well as the provider agency or resource consultant (if applicable).
- Cooperate with all scheduled in-home visits.
- Notify the case manager and resource consultant (if applicable) of any changes in their legal representation and/or guardianship and provide copies of the appropriate documentation.
- Not ask personal attendant professionals to provide services that are excluded by policy or not on their Service Plan. (Refer to Section 512.32.1 Personal Attendant Services).
- Utilize family, friends, neighbors and community agencies that can provide transportation before utilizing TBIW non-medical transportation services.
- Notify their resource consultant within 24 hours when they terminate an employee if the member is utilizing *Personal Options*.
- Provide a safe environment for personal attendants, UMC and agency staff.

If a member is being investigated for or is in the process of being closed by an agency for non-compliance or in an unsafe environment, they cannot transfer to another agency. If a member has had a closure due to an unsafe environment and reapplies for the TBIW or other Home and Community Based Services programs, the unsafe environment closure information will be shared with selected providers.

The TBIW Handbook, which includes member rights and responsibilities, is available for use when conducting this conversation. It can be found on the TBIW website.

512.48 GRIEVANCE PROCESS

A member who is dissatisfied with the services they receive from a provider agency has a right to file a grievance. All TBIW provider agencies will have a written grievance procedure. The UMC will explain the grievance process to all applicants and members at the time of initial application/re-evaluation. Applicants/members will be provided with a Grievance Form at that time. However, each provider may have their own grievance form. Service providers will only afford members a grievance procedure for services that fall under the service provider's authority; for example, a case management agency will not conduct a grievance procedure for personal attendant service agency activities, nor will a personal attendant service agency conduct a grievance procedure for case management agency activities.

A member may bypass the level one grievance and file a level two grievance with the UMC if they choose. The grievance process is not utilized to address decisions regarding medical or financial

eligibility, a reduction in services or case closure. These issues must be addressed through the Medicaid Fair Hearing process.

The grievance procedure consists of two levels:

Level One, TBIW Provider:

- A TBIW provider has 10 business days from the date they receive a Grievance Form to hold a meeting, in person or by telephone. The meeting will be conducted by the agency director or their designee with the members. The agency has five days from the date of the meeting to respond in writing to the grievance. If the member is dissatisfied with the agency's decision, they may request that the grievance be submitted to the UMC for a Level Two review and decision.

Level Two, UMC:

- If a TBIW provider is not able to address the grievance in a manner satisfactory to the member and the member requests a Level Two review, the UMC will, within 10 business days of the receipt of the Grievance Form, contact the member and the TBIW provider to review the Level One decision. Level Two decisions will be based on Medicaid policy and/or health and safety issues.

512.49 MEDICAL ELIGIBILITY APPEALS

If a member/applicant is determined not to be medically eligible, a written Notice of Final Decision, a Request for Hearing form and the results of the assessments are sent by certified mail by the UMC to the member/applicant. A notice is also sent to the member's case manager.

The termination may be appealed through the Fair Hearing process if the Request for Hearing form is submitted to the Board of Review within 90 days of receipt of the Notice of Final Decision.

If the member wishes to continue existing services throughout the appeal process, the Request for Hearing form must be submitted to the Board of Review within 13 days of the member's receipt of the Notice of Final Decision.

If the Request for Hearing form is not submitted to the Board of Review within 13 days of the members receipt of the Notice of Final Decision, reimbursement for all TBIW services will cease.

Once a Fair Hearing has been requested, a pre-hearing conference may be requested by the member/applicant at any time prior to the Fair Hearing and the UMC will schedule the meeting. At the pre-hearing conference, the member/applicant, the UMC, and the BMS will review the information submitted for the medical eligibility determination and the basis for the termination. If the member/applicant and BMS come to an agreement during the pre-hearing conference the UMC will withdraw the members/applicants hearing request from the Board of Review. All parties will be notified by the UMC in writing that the issue(s) have been resolved and the hearing request has been withdrawn.

If the denial of medical eligibility is upheld by the hearing officer, services that were continued during the appeal process must cease on the date of the hearing decision. If the member/applicant is eligible financially for Medicaid services without the TBIW program, other services may be available for the

individual. If the termination based on medical eligibility is reversed by the Hearing Officer, the members' services will continue with no interruption.

In addition, the Fair Hearing process is limited to hearings involving the following:

- Medical eligibility (see above)
- Reduction of services
- Suspension of services
- Termination of services

See *Chapter 400, Medicaid Eligibility, Section 400.1.9* for additional information.

NOTE: Due to the nature of Unsafe Environment closures a member would not be eligible for the option to continue existing services during the fair hearing process. (See Section 512.52 Discontinuation of Services).

512.50 TRANSFERS TO ANOTHER AGENCY OR *PERSONAL OPTIONS*

A member utilizing the TBIW program may request a transfer to another provider agency or *Personal Options* at any time. If a member wishes to transfer to a different provider agency a Request to Transfer form must be completed and signed by the member and/or their legal representative (if applicable). The form may be obtained from the current provider agency, the new provider agency, or the UMC. Once completed and signed by the member the form must be submitted to the UMC. The UMC will then coordinate the transfer and set the effective date based on when required transfer documents are received. The effective date of transfers will be 30 days from receipt of a correct and completed Request to Transfer form by the UMC.

At no time should the transfer take more than 45 calendar days from the date that the transfer request signed by the member is received at the UMC, unless there is an extended delay caused by the member in returning necessary documents.
Transferring agency responsibilities:

- To continue providing services until the UMC notifies them that the transfer has been completed.
- If it is a case management agency transfer, the receiving case manager will have access to the member's eligibility assessment and other pertinent documentation in the UMC web portal prior to the date of transfer.
- If it is a personal attendant service agency transfer, the receiving personal attendant agency will have access to the member's eligibility assessment and other pertinent documentation in the UMC web portal.
- To maintain all original documents for monitoring purposes.

Receiving agency responsibilities:

- Personal attendant service agencies must meet with the members within seven business days to review the Service Plan.
- If it is a case management agency transfer, a service plan addendum must be conducted within seven business days of the transfer effective date.

- Provide copies of the Service Plan addendum to the member, personal attendant agency, resource consultant (if applicable) and to the UMC within seven business days.

The Service Plan from the transferring case management and/or personal attendant service agency must continue to be implemented, with any changes reflected in the Service Plan addendum held because of the transfer. A provider may not request a transfer for an unsafe environment or member non-compliance. If there is an unsafe environment or member noncompliant issue, the provider must follow the process outlined in Section 512.52 Discontinuation of Services.

Members who transfer from Traditional services to *Personal Options*, as well as, from *Personal Options* to Traditional services are processed by the UMC and will include both the case manager and the resource consultant to ensure that all necessary documentation is shared and that there is no gap in the delivery of service.

When a member remains with the same agency but transfers to a different service area, records must be kept at the office in which the member received or is receiving their services for that time period.

Transfers that occur because of Conflict-Free Case Management situations are granted 90 days to ensure a smooth transition. BMS cannot permit waiver members to remain in conflict based on choice. If the member does not qualify for a geographic, or cultural/linguistic exceptions and/or refuses to make a selection that removes the existing conflict of providers, BMS will make the selection for the member and the UMC will assist in the transfer to resolve the conflict. If the member disagrees with the BMS agency selection, then the member will be given the opportunity to file a grievance of complaint.

512.51 EMERGENCY TRANSFERS TO ANOTHER AGENCY OR *PERSONAL OPTIONS*

A request to transfer that is considered an emergency, such as when a member suffers abuse, neglect, exploitation, harm or a health and welfare risk, including inability to provide services, will be reviewed by the UMC and the UMC will take appropriate action. The case management agency, the personal attendant service agency that the member is transferring from or the member using the *personal options* must submit supporting documentation that explains why the member is in emergency status. The UMC will expedite the request as necessary, coordinating with the members and agencies involved.

512.52 DISCONTINUATION OF SERVICES

The following require a Request for Discontinuation of Services Form be submitted and approved by the UMC:

- No personal attendant services have been provided for 180 continuous days – for example, an extended placement in long-term care or rehabilitation facility.
- Unsafe Environment – Members must be able to provide a safe working environment for TBIW case manager and personal attendant staff and/or other agency staff including but not limited to (this includes the member and/or persons in the member's home):
    - Yelling, verbal abuse, or cussing the personal attendant.
    - Touching the personal attendant inappropriately or talking about touching the personal attendant inappropriately.

- Homes full of debris and clutter and member prevents the personal attendant from cleaning the area as described in member's Service Plan.
- Animals that are dangerous to or that could harm the personal attendant or any TBIW staff are unconfined during service hours and visits.
- People in member's home during service time who pose a problem to the personal attendant staff doing services – examples of how the person could pose a problem to personal attendant staff include anyone with a history of harassing or touching or threatening the personal attendant staff.
- Members or others in or around the member's home threaten the personal attendant.
- Members or others in or around the member's home participating in any criminal activity during personal attendant service time or allowing it to occur in the member's home during personal attendant service time.
- The agency has been forewarned by a mental health professional/law enforcement of harm or ideations of harm by the member.
- The member or other household members repeatedly demonstrate sexually inappropriate behavior; display verbally and/or physically abusive behavior; and/or threaten a personal attendant or other agency staff with guns, knives, or other potentially dangerous weapons, including menacing animals.
- The member or other household members display an abusive use of alcohol and/or drugs or engages in the manufacture, buying and/or selling of illegal substances.

If the closure is due to an unsafe environment, the CM agency will contact the UMC for assistance. The case manager must notify APS or CPS if an unsafe situation warrants such notification by calling the West Virginia Centralized Intake for Abuse and Neglect at 1-800-352-6513.

Personal attendant providers should try to implement a Responsibility Agreement with the member regarding unsafe environment issues prior to requesting a Discontinuation of Services when appropriate.

Note: If a member has had a closure due to an unsafe environment and reapplies for the TBIW program or other Home and Community Based services (such as the Personal Care Services program), the unsafe environment closure information will be shared with the providers.

- The member is non-compliant with the Service Plan, the responsibility agreement (if applicable), the program requirements by policy, the Member Handbook, or the member rights and responsibilities, etc.
- Member no longer desires services:
- Members no longer require services.
- The members can no longer be safely maintained in the community with TBIW services.

If an applicant that has received a TBIW slot does not accept the required case management services and/or will not allow a Service Plan to be developed, the UMC will make a Request for Discontinuation of Services and submit it to BMS for approval.

The Request for Discontinuation of Services Form must be submitted to the UMC. The UMC will review all requests for a discontinuation of services. If it is an appropriate request, and the UMC approves the discontinuation, the UMC will send notification of discontinuation of services to the member with a copy to

the case management agency or F/EA. Fair Hearing rights will also be provided except if the member no longer desires services. The effective date for the discontinuation of services is 13 calendar days after the date of the UMC notification letter, if the member does not request a hearing. If it is an unsafe environment, services may be discontinued immediately upon approval of the UMC and all applicable entities are notified, i.e., police, APS/CPS.

When the UMC receives an unsafe closure request, they will review and make a recommendation to the BMS based upon the evidence submitted. Documentation to support the unsafe environment should come from multiple sources, if possible, i.e., the personal attendant agency and the case management agency.

Recommendations include:

- Suspend services for up to 90 days to allow the member time to remedy the situation. The case manager will reassess at 30, 60 and 90 days and make a recommendation to the UMC at any time during the 90 days suspension to reinstate services.
- Immediate closure.

It is the case management agency's responsibility to conduct the 30-, 60- and 90-day assessments to ensure the health and safety of the member during any time that services are suspended. In all cases, the members must be provided their right to a Fair Hearing by the UMC. However, due to the nature of unsafe environment closures a member would not be eligible for the option to continue existing services during the fair hearing process.

The following do not require a Request for Discontinuation of Services Form but must be reported on the Case Management Monthly Report:

- Death
- Moved out of state.
- Medically ineligible
- Financially ineligible

512.53 HOW TO OBTAIN INFORMATION

For additional information, forms, resources, policy clarifications, the policy manual, please refer to the TBIW Program website.

GLOSSARY

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

1:1 ratio: The ratio for billing purposes of one personal attendant to one member.

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

Activities of Daily Living (ADL): Activities that a person ordinarily performs during the ordinary course

of a day, such as mobility, personal hygiene, bathing, dressing, eating, and skills required for community living.

Advanced Practice Registered Nurse (APRN): As defined in West Virginia Code §30-7-1**:** A registered nurse who has acquired advanced clinical knowledge and skills preparing him or her to provide direct and indirect care to patients, who has completed a board-approved graduate-level education program and who has passed a board-approved national certification examination. An advanced practice registered nurse shall meet all the requirements set forth by the board by rule for an advance practice registered nurse that shall include, at a minimum, a valid license to practice as a certified registered nurse anesthetist, a certified nurse midwife, a clinical nurse specialist or a certified nurse practitioner.

"Anchor" Date: The annual date by which the person's medical eligibility must be recertified and is determined by the anniversary date that is the first day of the month following the date when initial medical eligibility was determined by the UMC. This fixed date will serve as the 'due date' for the Annual Person-Centered Assessment and Service Plan and the reevaluation of the person's medical eligibility, as well as the start date for TBIW service authorizations.

Board of Review: The agency under the West Virginia Office of Inspector General that provides impartial hearings to people and/or applicants who are aggrieved by an adverse action including denial or termination of eligibility.

Budget Authority: People choosing *Personal Options/Self-direction*, the Participant-Directed Model for services, have choice in the types and amounts of services, wage rates (allowed by the BMS) and of their employees to meet their needs and are within their annual budget approved by the UMC.

Community Integration: The opportunity to live in the community and participate in a meaningful way to obtain valued social roles as other citizens.

Community Location: Any community setting open to the general public such as libraries, banks, stores, post offices, etc. within a justifiable proximity to the person's geographical area.

Competency Based Curriculum: A training program which is designed to give participants the skills they need to perform certain tasks and/or activities. The curriculum should have goals, objectives and an evaluation system to demonstrate competency in training areas. Competency is defined as passing a graded post-test at no less than 70%. If a member of staff fails to meet competency requirements, the Agency must conduct additional training and retest the staff (must score at least 70%) before the staff is allowed to work with members.

Conflict Free Case Management: Conflict-free case management (CFCM) requires that **assessment and coordination of services are separate from the delivery of services**, with the goal to limit any conscious or unconscious bias a Case Manager or agency may have, and ultimately promote the Member's individual choice and independence.

Conservator: A person appointed by the court who is responsible for the estate and financial affairs of a protected person. WV Code §44A-1-4.

Cueing: Giving a signal or reminder to do something.

Cultural Competence: Services, supports or other assistance that are conducted or provided in a manner that is responsive to the beliefs, interpersonal styles, attitudes, language and behaviors of individuals who are receiving services, and in a manner that has the greatest likelihood of ensuring their maximum participation in the program.

Days: Calendar days unless otherwise specified.

Direct Access: Physical contact with or access to a person's property, personally identifiable information, or financial information.

Documented Specialist: A specialist is a person who concentrates primarily on a particular subject or activity; a person highly skilled in a specific and restricted field. This designation of specialist needs to be documented via, training verifications, certifications, or vitae with listed experience that would designate the individual as a specialist in the preferred area, and any degrees that designate as such in the subject area.

Dual Services: When a person is receiving TBIW services and PC services at the same time.

Duplication of Services: TBIW services are 1:1 staff to member ratio services. No single Personal Attendant can bill for more than one member during a single 15-minute period. A Personal Attendant and Direct Care Workers from another program cannot bill for the same tasks for the same member. (i.e. environmental tasks shared across multiple Medicaid recipients or funding sources).

Duration: As it relates to service planning, the duration is the length of time a service will be provided.

Electronic Visit Verification (EVV): An electronic monitoring system used to verify a personal attendant worker and case manager for the following:

- Type of service performed.
- Individual receiving the service.
- The date of service.
- The location of service delivery.
- The individual providing the service.
- The time the services begin and end.

Emergency Plan: A written plan which details who is responsible for specific activities in the event of an emergency, whether it is a natural, medical or man-made incident.

Felony: A serious criminal offense punishable by imprisonment and/or alternative sentencing at the discretion of a judge within limits by statute.

Financial Exploitation: Illegal or improper use of a person's or incapacitated adult's resources. Examples of financial exploitation include cashing a person's checks without authorization; forging a person's signature; or misusing or stealing a person's money or possessions. Another example is deceiving a person into signing any contract, will, or other legal document.

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

Fiscal/Employer Agent (F/EA): The contracted agent, under *Personal Options/Self-direction*, which receives, disburses, and tracks funds based on a members-approved service plans and budgets; assists people with completing *Personal Options/Self-direction* enrollment and worker employment forms; conducts criminal background checks of prospective workers; and verifies worker's information (i.e., social security numbers, citizenship or legal alien verification documentation). The F/EA also prepares and distributes payroll including the withholding, filing, and depositing of federal and state income tax withholding and employment taxes and locality taxes; generates reports for state program agencies, and people receiving TBIW services; and may arrange and process payment for workers' compensation and health insurance, when appropriate.

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

Home and Community-Based Services (HCBS) Settings Rule: In January 2014, the federal CMS issued a new federal rule (CMS-2249-F/CMS-2296-F) impacting sections of Medicaid law under which states may use federal funds to pay for home and community-based services (HCBS). The rule supports enhanced quality in HCBS programs and adds protections for individuals receiving services. In addition, this rule reflects CMS intent to ensure that individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and can receive services in the most integrated setting. An Adult Family Care (AFC) setting would not be an approved setting.

Home and Community Based Services (HCBS): Services which enable individuals to remain in the community setting rather than being admitted to a Long-Term Care Facility.

Incapacitated Adult: A person incapable of handling their medical, financial or personal affairs and through a legal process has been deemed to be incapacitated.

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

Incidental Services: Secondary activities performed by the personal attendant such as light housecleaning, making and changing the bed, dishwashing, and laundry for the sole benefit of the person receiving TBIW services.

Informal Supports/Informal's: Family, friends, neighbors or anyone who provides a service to a person and not reimbursed.

Instrumental Activities of Daily Living (IADL): Skills necessary to live independently such as abilities used to shopping for groceries, handling finances, performing housekeeping tasks, preparing meals, and taking medications.

Legal Guardian/Guardian: A person appointed by the court who is responsible for the personal affairs of a protected person. [WV Code §44A-1-4(5)]

Legal Representative: One who stands in the place of and represents the interest of another (i.e. Power of Attorney, Medical Power of Attorney, Medical Surrogate).

Legally Responsible Person: A spouse or a parent of a minor child (under the age of 18) that is legally responsible for providing support that they are ordinarily obligated to provide.

Medicaid Fair Hearing: The formal process by which a person receiving waiver services or applicant may appeal a decision if the individual feels aggrieved by an adverse action that is consistent with state and federal law, including eligibility denials and terminations. This process is conducted by an impartial Board of Review Hearing Officer.

Medicaid Fraud: Suspected fraud includes any instance in which a provider of any Medicaid service knowingly provides false information to a payer or employer in order to enhance their reimbursement or to receive reimbursement for services never provided. Fraudulent activities include, but are not limited to, the following examples: falsifying documentation such as timesheets, certifications, or medical records, submitting duplicative claims, or knowingly billing for medically unnecessary services.

Minor Child: A child under the age of 18.

Misdemeanor: A less serious criminal offense than a felony which is punishable by a fine or imprisonment in jail for less than a year.

National Provider Identifier (NPI): An NPI number assigned to each Personal Attendant and each TBIW provider agency for tracking Medicaid billing.

Neglect: "Failure to provide the necessities of life to an incapacitated adult" or "the unlawful expenditure or willful dissipation of the funds or other assets owned or paid to or for the benefit of an incapacitated adult" (See WV Code §9-6-1). Neglect would include inadequate medical care by the service provider or inadequate supervision resulting in injury or harm to the incapacitated member. Neglect also includes, but is not limited to: a pattern of failure to establish or carry out a member's individualized program plan or treatment plan that results in negative outcome or places the member in serious jeopardy; a pattern of failure to provide adequate nutrition, clothing, or health care; failure to provide a safe environment resulting in negative outcome; and/or failure to maintain sufficient, appropriately trained staff resulting in negative outcome or serious jeopardy. This may also include medication errors and dietary errors resulting in a need for treatment for the member.

Person-Centered Planning: A process-oriented approach which focuses on the person and their needs by putting him/her in charge of defining the direction for their life, not on the systems that may or may not be available.

Personal Attendant: The individual who provides the day-to-day care to people on the TBIW including both Traditional and *Personal Option*s/*Self-direction* Models.

Personal Attendant Services: Long-term direct care and support services that are necessary in order to enable a person to remain at home rather than enter a nursing home, or to enable a person to return home from a nursing home.

Physician's Assistant: An individual who meets the credentials described in West Virginia Code Annotated, §30-3-13 and §30-3-5. A graduate of an approved program of instruction in primary health care or surgery who has attained a baccalaureate or master's degree, has passed the national

certification exam, and is qualified to perform direct patient care services under the supervision of a physician.

Pre-Hearing Conference: A meeting requested by the applicant or person receiving Medicaid services and/or legal representative (if applicable) to review the information submitted for the medical eligibility determination and the basis for the denial/termination. A Medicaid Fair Hearing pre-hearing conference may be requested any time prior to a Fair Hearing.

Prior Authorization: A utilization review method used to control certain services which are limited in amount, duration, or scope. The prior approval necessary for specified services to be delivered for an eligible person by a specified provider before services can be rendered, billed, and payment made.

Program Representative: An individual selected by a person receiving TBIW services using the *Personal Options/Self-direction* Model, to assist them with the responsibilities of self-direction.
Qualified Residence: Take Me Home (TMH) Transition Program defines as:

- A person's own home;
- A person's family's home;
- A person's own apartment.

Quality Management Plan: A written document which defines the acceptable level of quality for a waiver agency and describes how plan implementation will ensure this level of quality through documented deliverables and work processes.

Remediation: The act of correcting an error or a fault.

Resource Consultant: A representative from the F/EA FMS who assists the person receiving services and/or their legal/non-legal representative who choose this Self-Directed Option with the responsibilities of self-direction; developing a plan and budget to meet their needs; providing information and resources to help hire, train and manage employees; provides resources to assist the person with locating staff, helping to complete required paperwork for this service option; and helping the person select a representative to assist them, as needed.

Responsibility Agreement: A Responsibility Agreement is between the TBIW program member and the provider agency. The agreement must address the specific actions/outcomes that are expected by the member for their services to continue. Some examples of when a responsibility agreement should be developed can include the following: noted pattern of member's noncompliance with program policies such as nonattendance for required Service Planning Meetings, refusal to allow Case Manager to conduct required home visits in member's residence not permitting Personal Attendant staff to perform services or asking personal Attendant staff to perform services not outlined in member's Service Plan. Safety concerns in the member's home should be addressed promptly when first displayed or notice and address in a Responsibility Agreement. The agreement must be written on the BMS approved TBIW Responsibility Agreement template.

Room and Board: (Bureau for Social Services' Specialized Family Care Program Policy definition 8/26/2015) Room and Board Services are defined as the provision of food and shelter including private and common living space; linen, bedding, **laundering** and laundry supplies; **housekeeping duties** and

common lavatory supplies (i.e., Hand soap, towels, toilet paper); maintenance and operation of home and grounds, including all utility costs.

Scope of Services: The range of services deemed appropriate and necessary for a person.

Sexual Abuse: Any of the following acts toward an incapacitated adult or child in which an individual engages in, attempts to engage in, or knowingly procures another person to engage in such act, notwithstanding the fact that the incapacitated individual may have suffered no apparent physical injury as a result of such conduct:

- Sexual intercourse/intrusion/contact; and
- Any conduct whereby an individual displays their sex organs to an incapacitated adult or child for the purpose of gratifying the sexual desire of that individual, of the person making such display, or of the incapacitated adult or child, or for the purpose of affronting or alarming the incapacitated adult or child.

Sexual Exploitation: When an individual, whether for financial gain or not, persuades, induces, entices, or coerces an incapacitated adult or child to display their sex organs for the sexual gratification of that individual or third person, or to display their sex organs when that individual knows such display is likely to be observed by others who would be affronted or alarmed.

Social Worker: An individual who is fully licensed with the ability to practice in West Virginia.

Spending Plan: A budgeting tool used in the *Personal Options/Self-direction* Model to help people accurately plan how and when their budget will be used.

Transfer: Changing from the provider from which a person is receiving services to another provider or changing service delivery model from Traditional to *Personal Options/Self-direction* or vice versa.

Transition Coordinator: An individual with the Take Me Home Administrative Services who works one-on-one with eligible participants and their transition teams to plan and facilitate the transition process.

UMC Web Portal: A HIPAA compliant software system that couples technology with clinical practice to offer an effective, efficient platform for UMC services.

Utilization Management Contractor (UMC): The contracted vendor responsible for day-to-day operations and oversight of the TBIW Program including conducting medical eligibility evaluations, determining medical eligibility for applicants and people enrolled in the program, initial and ongoing certification of provider agencies and providing prior authorization for services provided to people enrolled in the West Virginia Medicaid TBIW Program.

West Virginia Incident Management System (WV IMS): A web-based program used by providers and *Personal Options/Self-direction* staff to report simple and critical incidents as well as abuse, neglect, and exploitation incidents to the UMC and BMS.

CHANGE LOG

SECTION NUMBER	CHANGE	EFFECTIVE DATE
Entire Chapter	Traumatic Brain Injury Waiver (TBIW)	October 1, 2015
Entire Chapter	Updated Sections on Take Me Home; Overview; Pre-Transition Case Management; and Community Transition	January 1, 2019
	Take Me Home (TMH) Transition Program - Name change from Take Me Home West Virginia 512.2 Added Conflict-Free Case Management Added service provision, settings rule, member rights to records, agency policies, and requirement to notify guardians of critical incidents. 512.2.4 Added WVCARES website. 512.2.5 Added restrictions on subcontracting of services and BMS not being responsible for certification of agencies that provide Veterans services. 512.2.6.4 Name change of reviews 512.3 Added Electronic Visit Verification (EVV) requirement 512.4 Added a description 512.5 Added requirement for NPI numbers for service providers/workers 512.5.1 Added BA Human Service Degree to Case Management qualifications 512.5.2 Added Case Management Certification Training requirements 512.5.4 and 512.5.5 Added training requirements for personal attendants 512.5.6 Added detail for CPR and First Aid qualifications 512.10.1 Added continuous oxygen 512.11 Added timelines for enrollment and hiring staff 512.14 Added details regarding Risk Analysis and Mitigation; 24hr. backup plan; and Responsibility Agreements 512.10 Added Personal Emergency Response System (PERS) units 512.17 Added service limitations and notifications to Take Me Home Transition Coordinators. 512.18 Added detail regarding personal attendant services and responsibilities; service code and unit limit 512.19 Added to billing practices 512.25 Added TBIW members cannot be paid workers for other programs; settings information; Restrictive Intervention and Emergency Intervention information 512.28 Additional requirements added 512.30 Added progressive remediation	April 1, 2021

	512.31 Added requirement to provide safe working environment 512.36 Added information regarding member not being served safely in the community and member not accepting case management services 512.21.2 Addition/change to services	
Entire Chapter	512.1 New Section-HCBS Settings Requirements 512.3 Added Exceptions Application, Attestation, policy/procedure to report Medicaid Fraud and documentation training 512.4 Clarified CM not required to use EVV 512.6 Removed 8 contiguous counties/notice, cannot become a TBIW Provider for the benefit of serving other programs 512.7 Clarified “calendar” days 51.14 Added Documentation, length to keep employee documentation, what must be uploaded into the web portal 512.16.1 Added Human Service degree with BMS Certification 512.16.2 Added Trainings-Medicaid Fraud, Settings Rule, documentation 512.16.3 Added CAN training, member on a HCBS program cannot be paid caregiver for a HCBS program 512.16.4 Allowing online CPR, Medicaid Fraud. Clarified who can provide trainings 512.16.5 Medicaid Fraud, CPR must have demo, Person Centeredness 512.16.6 Removed time on logs, Use of certificates as proof of training 512.17 Added requirement of policy/procedure, suspected sexual abuse, assault/abuse language 512.17.1 E-files, Agency responsible for adding/deleting staff in IMS within timelines 512.17.2 Expanded Abuse/Neglect/Exploitation details 512.18 New section added Medicaid Fraud and Reporting Requirements 512.19 Employee File retention, PAs living in member home not required to have NPI# 512.22 Process changed 512.23.2.1 Uploading documentation in the web portal 512.23.2.3 View Documents in the web portal 512.25.1 Added Environmental Accessibility Adaptions (EAA) Home and vehicle 512.25.2 Clarified CMs required, added PERS and EAA, timeline to hire Pas, enrollment home visit 512.26 Changed “calendar days to “business” day	Aug. 1, 2023

	512.27 Added Discovery tools, changed “calendar” day to “business” day, list school environment, TMH Assessment and Service Plan development timeline changed 512.27.1 Using an Addendum 512.28 RCs will upload Spending Plans into the web portal for members who self-direct their services 512.29 Changed from 5 days to 15 days 512.30 Added EAA 512.31 Change in required contacts 512.31.1 HCBS Settings Rule info to members 512.32 Number of days to have staff working 512.32.1 Documentation Training 512.32.2 Add to functions Personal Attendants cannot perform 512.34 Added definition of service 512.35 New covered service added 512.36 Removed Interim Service Plans 512.39 Added other BMS Chapter numbers 512.41 Added statement about door alarms and GPS trackers, statement about Targeted Case Management 512.42 Removed the annual MNER and use of new form 512.47 Choice of CM Agency must meet CFCM criteria 512.50 Removed limits to transfer, access to records, transfer require an addendum to the SP rather than a full new Service Plan development 512.52 CFCM statement, added/reworded items in list Glossary - Added definition for Medicaid Fraud	