TABLE OF CONTENTS

BACKGROUND

The West Virginia Medicaid program is administered in agreement with Title XIX of the Social Security Act and Chapter 9 of West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the 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 mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their certification utilizing professionally accepted best practices of care, and in accordance with all state and federal requirements. Enrolled providers are subject to review of services provided to people enrolled in Medicaid by the BMS whether 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 served by Medicaid and made available to the BMS or its designee upon request.

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

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

Federal regulations governing Medicaid coverage of home and community-based services (HCBS) 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 ADW program is defined as a long-term care alternative, which provides services that enable a person to remain at or return home rather than receive nursing home care. The program provides home and community-based services to West Virginia residents who are eligible to participate in the program. A person must also be at least 18 years of age and choose home and community-based services rather than nursing home placement. Members must be able to provide a safe working environment for personal attendant service program staff, agency direct-care workers, and registered nurses (RNs). The goals and objectives of the program are focused on providing services that are person-centered to promote choice, independence, self- direction, respect, dignity, and community integration. All members receiving services are offered and have a Right to Freedom of Choice of providers for services (unless choice results in a conflicted relationship then another agency choice will be required), and the option for self-directing their services. The BMS contracts with an operating agency (OA) to operate the program.

ADW services are to be provided exclusively to the member eligible for services, and only for necessary activities as listed in the Service Plan. Enrollment on the ADW is contingent on a person requiring services offered in the ADW program to avoid institutionalization. Individuals may not be enrolled in the

ADW for the sole purpose of obtaining Medicaid eligibility or solely ancillary services such as housekeeping, transportation, or essential errands services only.

Services are person-centered and identify a member's strengths, goals, preferences, and desired outcomes. Services also help ensure the member's health and welfare. The services are not to be provided for the convenience of the household or others. Informal supports are not mandatory in the ADW program, however if available and able to assist, this must be addressed in planning. This program is designed to provide formal support services to supplement, the member's existing informal support system when existing and available.

ADW services include:

- Case management
- Personal attendant services
- Skilled nursing,
- Non-medical transportation services, and,
- Personal Emergency Response System (PERS).

Within the ADW program, members may choose from either the Traditional (Agency) Model or the *Personal Options* Model for service delivery. In the Traditional Model, members receive their services from employees of a provider agency certified by the OA and have individualized service hours based on their assessed level of need within the service level that was determined during the Pre-Admission Screening (PAS). In *Personal Options*, members can hire, train, supervise, and terminate their own employees; and are allocated a budget based on their assessed level of need.

A member on the ADW must receive personal attendant services every 30 days, unless temporarily in a nursing home, hospital, or other inpatient medical facility. In such instances, a 180- day hold may be placed on the case to determine if the individual will be returning home. After 180 days the case will be closed, and the individual will need to reapply.

West Virginia does not allow restrictive interventions including restraints and seclusion of ADW members. Any unauthorized utilization of restrictive interventions, to include physical restraints by use of hands, arms, body etc. must be reported in the West Virginia Incident Management System (WV IMS).

TAKE ME HOME (TMH) TRANSITION PROGRAM OVERVIEW

Individuals wishing to transition from long-term facilities to the community often face numerous obstacles including lack of basic household items, 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 participants to promote a successful and safe transition to the community.

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

- Accept and follow up with referrals from the Aging and Disability Resource Center (ADRC),
- Conduct 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,
- 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 participant chooses to include in the transition process.
- Work with the TMH applicant and his/her 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 applicant'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 waiver transition services available to assist individuals in transitioning back to the community. These two services include:

1. Pre-Transition Case Management (Section 501.24.1): To develop a Waiver Participant Interim Service Plan and ensure that the needed community services and supports are in place on the first day of the participants return to the community; and
2. Community Transition Services (Section 501.24.2): One-time expenses that address identified barriers to a safe and successful transition from facility-based living to the community.

501.1 BUREAU FOR MEDICAL SERVICES CONTRACTUAL RELATIONSHIPS

The BMS contracts with an operating agency (OA). The OA acts as an agent of the BMS and administers the operation of the ADW program, both Traditional and *Personal Options* Models. The OA conducts education for ADW providers, members receiving ADW services, advocacy groups, and others as requested.

The BMS contracts with a utilization management contractor (UMC) that conducts initial medical eligibility determinations as well as annual re-evaluations. The UMC provides the framework and a process for authorizing ADW services. The UMC provides authorization for services that are based on the member's assessed needs and provides service registration information to the claims' payer.

The BMS contracts with a Fiscal/Employer Agent (F/EA) to administer *Personal Options* Model, the self-directed program. The F/EA is a subagent of BMS for the purpose of assisting the members wishing to self-direct services with employer functions; perform payroll, information, and resource consultant functions.

ADW agencies must enroll as a Medicaid provider and sign a provider agreement to be able to participate in the provision of services for people receiving ADW services. All ADW agencies must also be certified by the OA. ADW providers must also be in compliance with Chapter 300, *Provider Participation Requirements* of the West Virginia Medicaid Provider Manual.

Please refer to the BMS website for the OA, UMC, and *Personal Options* Model contact information on the ADW website.

501.2 PROVIDER AGENCY CERTIFICATION

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

An agency may provide both case management and personal attendant services, given that they do not provide both services to the same member. In addition, they are required to maintain the following:

- A separate certification and National Provider Identifier (NPI) for each service,
- Separate staffing, for example, an agency RN may not provide both skilled nursing and case management services for the same member; and
- Separate files must be maintained for case management and personal attendant agency services.
- Agencies providing both case management and personal attendant services to an individual due to no other agency being available or other cultural, ethnic etc. reasons, must have safeguards in place and a waiver granted by BMS (see safeguards section below).

Conflicts of Interest

Conflicts of interest are prohibited. A conflict of interest is when the case manager who represents the member works for or has a financial affiliation to the agency that provides personal attendant services. “Affiliated” means that either an employment, contractual or other relationship with a provider agency such that the case manager receives financial gain or potential financial gain or job security when the provider agency receives business serving ADW clients. The case manager cannot be related by blood or marriage to the member for whom he/she writes the Service Plan.

If a case manager affiliated with a provider agency acts on behalf of the member, they represent to obtain services for the member from the company(s) with which the case manager is/was affiliated or influences the Freedom of Choice of the member by steering them towards receiving services from the company(s) with which the case manager is affiliated, then a conflict of interest occurs. Case management and personal attendant services from the same agency cannot be provided to any members. This includes any private agreements between agencies. Case managers must always ensure any affiliation with a provider agency (past or present) does not influence their actions regarding seeking services for the member they represent. Failure to abide by this conflict-of-interest policy may result in the loss of provider ADW certification for the provider involved in the conflict of interest for a period of one year and all current people being served by the suspended provider will be transferred to other case management agencies. Additionally, any case manager who takes improper action described above will be referred to their professional licensing board for a potential violation of ethics and must not bill case management for the month this activity occurred. This is considered influencing an ADW member’s “Right to Choose” (transfer) (The BMS notes that whether any action is taken would be within the sole discretion of the appropriate licensing board and depend upon its specific ethical rules). Reports of failure to abide by this conflict-of-interest policy will be investigated by the OA and the results of this investigation will be reported to the BMS for review and possible action.

Safeguards

Should a conflicted relationship be required due to no other provider agency available in the area or other cultural, ethnic etc. reasons, the state has established the following safeguards to ensure that Service Plan development is conducted in the best interests of the applicant/member. Specify:

The OA notifies members of all available providers and services upon application. The member completes a Freedom of Choice form to identify their preferred provider, which will be forwarded to the provider of choice. The member is also informed that they may choose to receive services from a different provider of their choosing at any time while receiving services.

West Virginia utilizes the following criteria to make determinations regarding geographical exceptions:

- The number of conflict-free case managers could not meet the capacity for the number of members in the geographical area.
- The number of conflict-free case managers certified by waiver type could not meet the capacity to serve members by waiver type.
- Only one provider agency or case management agency serves the geographical area, eliminating the member's opportunity for choice of case manager.
- There were no providers of HCBS or case management services in a geographical area.

Members will be given the opportunity to file a grievance/complaint. OA oversees grievances/complaints by the members and providers. A member will contact the OA to dispute the state's assertion that there is not another entity or individual that is not that member's provider to develop the person-centered service plan. BMS approves applications for exceptions after thorough vetting, including requests for additional information, if needed. Exceptions are awarded for one year, unless another willing and able provider becomes available, to provide agencies with sufficient program operation time before revisiting the continued need for an exception. During the one-year exception period, BMS or their designees have the right to review agency policies and operations.

West Virginia will monitor the conflict-free case management (CFCM) process via retro-reviews conducted by the state OA and may periodically request additional reports from the OA.

West Virginia restricts the entity that develops the Person-Centered Service Plan from providing services without the direct approval of the state. The BMS will allow for cultural and geographical exceptions based on the availability of willing and qualified providers in the member's catchment area. If a member disagrees with the BMS regarding the availability of willing and qualified providers, this may be grieved through the OA.

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

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 HCBS supervisor(s) and the case management supervisor(s).
- Explain how members are given choice of case manager.
- Explain how members are given choice of HCBS and other natural supports or services offered in the community.
- Explain how the agency ensures that the case manager is free from influence of direct-service providers regarding member Service Plans.

- Any case manager working for a case management agency that will also be providing personal attendant services will need to sign a case manager Conflict of Interest Assurance form.
- The completed and signed form must be placed in the member file at the case management agency. Failure to have the form in the file when reviewed will result in sanctions.
- Evidence of administrative separation on organizational chart that includes position titles and names of staff.
- Attestation/Conflict of Interest Exception Application for home and community-based waiver services by agency owner/administrator of the following:
- The agency has administrative separation of supervision of case management and HCBS.
- The attached organization chart shows two separate supervisors, one for case management and one for HCBS.
- Case management members are offered choice for HCBS between and among available service providers.
- Case management members are not limited to HCBS provided only by this agency.
- Case management members are given choice of case managers within the agency.
- Disputes between case management and HCBS units are resolved.
- Members are free to choose or deny HCBS without influence from the internal agency case manager and HCBS staff.
- Members choose how, when, and where to receive their approved HCBS.
- Members are free to communicate grievance(s) regarding case management and/or HCBS 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 an ADW provider, agency applicants must meet and maintain the following requirements:

- A business license issued by the State of West Virginia.
- Recent audit indicating six months of payroll dollars available in budget.
- Recent business plan.
- A federal tax identification number (FEIN).
- 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 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 or agency staff are not discharged, discriminated, or retaliated against in any way if they have been a complainant, on whose behalf a complaint has been submitted or who has participated in an investigation process that involves an ADW 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 secure VPN (Virtual Private Network) connection
  - Informs agency employees that during an investigation, information on their personal cell phone is discoverable.
  - Requires all electronic devices be encrypted.
- Written policies and procedures for people to transfer.
- Written policies and procedures for the discontinuation of a member's services.
- Written policies and procedures regarding the prohibition for personal attendants to subcontract their work responsibilities to another person.
- Written policies and procedures for supporting documentation and reporting of incidents if/when a member presents an unsafe work environment for direct-care workers i.e. personal attendants, nurses, and case managers.
- Written policies and procedures to ensure that members, staff, and family members are free from retaliation or adverse consequences because they reported incidents or allegations of Abuse/ Neglect/ Exploitation (ANE) or other staff misconduct.
- Written policies and procedures to ensure that court-appointed guardians are informed of reported incidents as soon as possible after agency learns of incident and in all cases, within 72 hours of agency learning of an incident.
- Written policy and procedures outlining agency personal attendant staff actions when the member is not home/does not respond to calls and the personal attendant has arrived to provide scheduled services.
- Written policy and procedure outlining case manager's actions when the member is not responding to a home visit and/or call.
- Provider must comply with the Centers for Medicare and Medicaid Services (CMS) settings rule.
- Have written policy regarding member's right to request their records.
- Written policies and procedures to avoid conflict of interest (if agency is providing both case management and personal attendant services) must include 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.
  - Process for reporting to the BMS.
  - Process for complaints to professional licensing boards for ethics violations.
- Office space that allows for confidentiality of the member.

- An Agency Emergency Plan (for members receiving ADW 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 OA within 48 hours.
    - Providers must inform people receiving ADW services of their Emergency Back-Up Plan.
- The provider must accept referrals in the UMC's web portal within five business days or forfeit the referral.
- All providers are required to have and implement policies and procedures for people 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 is not discharged unless a viable discharge/transfer plan is in place that effectively transfers all services that the member needs to another provider(s) and is agreed upon by the member and/or their legal representative 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.
- Providers cannot require personal attendants to sign any type of agreement that limits employment opportunities that would affect member choice of provider agency or worker.

Provider agencies will be reviewed by the OA within six months of initially providing services and annually thereafter. (Refer to Section 501.2.3.4 Provider Reviews).

More information regarding provider participation requirements in Medicaid services can be found in *Chapter 300, Provider Participation Requirements*. Please note, providers will be held accountable for information contained in all Medicaid Policy Manuals.

Providers are encouraged to contact the OA for training needs and technical assistance at any time. Clinical supervision is to be provided by agency staff to their employees and not be expected from the OA.

The hourly wage of agency staff employed by an ADW 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. ADW 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 ADW 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 ADW provider must meet the requirements listed Section 501.5 Agency Staff Qualifications.

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 ADW providers in their catchment area. Any effort to coerce a member to transfer to the purchasing ADW provider will be considered a conflict of interest and will result in the purchasing ADW provider being removed from the ADW provider selection list for one calendar year. (see section 501.30 Involuntary Agency Closure). If a provider sells their business, they must notify BMS and the OA in writing at least 30 days prior. The Case Management Agency with assistance from the OA (if needed) will facilitate member transfers.

501.2.1 Criminal Background Checks

Refer to Chapter 700 West Virginia Clearance for Access: Registry & Employment Screening (WV CARES) for criminal background check information.

501.2.2 Office Criteria

ADW providers must designate and staff at least one physical office location 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 no more than eight contiguous counties in West Virginia as designated in the application. ADW providers wishing to make changes in the approved counties they serve **must** make the request in writing to the OA. The OA will decide on the request and inform the provider in writing. No changes in counties served can be made unless approved by the OA.
- Providers may discontinue serving a county at any time pending transfer of any current members being served.
- Be readily identifiable to the public.
- 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 water are made available as needed.
- Maintain a primary telephone that is listed under 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 others inside your agency, (unless communicating through a secure agency network), the BMS and the OA for all staff.
- At a minimum, must have an email address and access to a computer, fax, scanner, and internet.
- Utilize any database system, software, etc., compatible with/approved and/or mandated by the BMS.

- Be open to the public at least 40 hours per week. Observation of state and federal holidays is at the provider's discretion. Hours of operation must be clearly posted.
- Agencies that provide electronic devices to their staff must ensure all personally identifiable information is secure.
- Contain space for securely maintaining program and personnel records. (Refer to *Chapter 100, General Administration and 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 by the OA.
- 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 applying to become an ADW provider cannot obtain certification via BMS for the sole purpose of serving Veteran Administration (VA) clients only. BMS is not responsible for certifying VA agencies or their workers.

501.2.3 Quality Improvement System

The Quality Improvement System (QIS) is designed to:

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

501.2.3.1 Centers for Medicare and Medicaid Services Quality Assurances

- ADW 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.
- 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 participants.
- Health and Welfare: The state demonstrates it has designed and implemented an effective system for assuring waiver member's 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 ADW provider reviews, WV IMS, complaints/grievances, abuse, neglect, exploitation reports, administrative reports, the Home and Community Based Consumer Assessment of Healthcare Providers and Systems (CAHPS), oversight of delegated administrative functions, and the Quality Improvement Advisory (QIA) Council.

501.2.3.2 Quality Improvement Advisory Council (QIA)

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

- Recommend policy changes.
- Recommend program priorities and quality initiatives.
- Monitor and evaluate the implementation of ADW priorities and quality initiatives.
- Monitor and evaluation of policy changes.
- Serve as a liaison between the ADW and interested parties; and
- Establish committees and work groups consistent with its purpose and guidelines.

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

501.2.3.3 Initial/Continuing Certification of Provider Agencies

Following the receipt of a completed Certification Application, the OA will contact the applicant to provide technical assistance to ensure understanding of requirements. The OA will schedule an onsite review to verify that the potential provider meets the certification requirements outlined above in Section 501.2, Provider Agency Certification. The OA will notify the BMS fiscal agent for claims, upon satisfactory completion of the onsite review. The BMS fiscal agent will provide the applicant with an enrollment packet which includes the Provider Agreement. The applicant must return the Provider Agreement, signed by an authorized representative, to the BMS fiscal agent. A letter informing the agency they may begin providing and billing for ADW services will be sent to the agency and to the OA. Medicaid services cannot be provided from an office location that has not been certified by the OA.

When a provider is physically going to move their agency to a new location or open a satellite office, they must notify the OA 45 days **prior** to the move. The OA will schedule an on-site review of the new location to verify the site meets certification requirements. The provider must submit a new Certification Application to the OA which includes information regarding the new location.

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

Once certified and enrolled as a Medicaid provider, ADW providers 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 ADW 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 Administration and Information*, and *Chapter 300, Provider Participation Requirements*, for more information on maintenance of records).
- Maintain a current list of members receiving ADW services.
- Comply with the WV IMS *(*Refer to Section 501.6, Incident Management Overview) and maintain an administrative file of Incident Reports.

501.2.3.4 Provider Reviews

The primary means of monitoring the quality of the ADW services is through provider reviews conducted by the OA as determined by the BMS on a defined cycle.

The OA performs annual on-site or remote reviews (as deemed by the OA) and desk documentation reviews as requested by the BMS to monitor program compliance. The OA also performs annual Continuing Certification reviews for agency and staff compliance. Targeted on-site ADW reviews and/or desk reviews may be conducted in follow up to incident management reports, complaint data, plans of corrections, etc.

Agency Continuing Certification Reviews

Providers are required to submit designated evidence to the OA every 12 months to document continuing compliance with all agency and staff certification requirements. This evidence must be attested to by an appropriate official of the provider agency (e.g., Executive Director or Board Chair). If appropriate documentation is not received by the OA either prior to or on the established date, a pay hold will be placed on the provider's claims and the provider will be removed from all selection forms until documentation is received. A provisional certification will be issued; however, an on-site visit will be waived if required documentation is received within 30 days. If after 60 days documentation is not received, steps will be taken to execute an emergency transfer of all people receiving services on the ADW. If the provider wants to resume/continue service provision, they must submit all required documentation and an on-site continuing certification review will be conducted by the OA staff.

The OA will review all submitted certification documentation and provide a report to the BMS. The provider must remove employees who do not meet requirements from provision of services until certification standards are met. If the documentation is not received within 30 days of the request, the BMS will:

- Place a payment hold on all future claims until the provider can prove they meet all certification requirements.
- Remove the provider from all selection forms; and

- Terminate the provider's participation as an ADW provider if all issues are not resolved within 60 calendar days of the date of the report.

Random sampling of 10 percent of employees, from each Continuing Certification Review Report will be generated annually for an onsite validation review.

If noncompliance is found during a Continuing Certification Validation Review, then the agency must complete a self-audit and submit the self-audit and payment to BMS's Office of Program Integrity (OPI) For more information on self-audits (refer to Chapter 501.2.3.6)

Program Reviews

Program reviews include a statewide representative sample of records of those receiving ADW services. The OA will review program records using the BMS approved Monitoring Tools. These tools are available on the West Virginia Bureau of Senior Services (BoSS) website and the ADW Program website. A proportionate random sample will also be implemented to ensure that at least two records from each provider site are reviewed.

Upon completion of the review, the OA conducts a face-to-face or remote (as deemed by the OA) exit summation with the agency director and/or designee. The agency has until 3:00 pm the following business day to provide any missing documentation the OA required for the review. Following the exit summation, the OA will make available to the provider a draft report and Corrective Action Plan (CAP) to be completed by the ADW provider. If potential disallowances are identified, the ADW provider will have 30 days from receipt of the draft report to send comments and additional documentation back to the OA. After the 30-day comment period has ended, the BMS will review the draft report and any comments submitted by the ADW provider and issue a final report to the ADW provider's director. A cover letter to the ADW provider's director will outline the following options to effectuate repayment:

- Payment to the BMS within 60 days after the BMS notifies the provider of the over-payment: or
- Placement of a lien by the BMS against future payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the over-payment: or
- A recovery schedule of up to a 12-month period, through monthly payments.

If the ADW provider disagrees with the final report, the ADW provider may request a document/desk review within thirty days of receipt of the final report pursuant to the procedures in *Chapter 100, General Administration and Information* of the BMS Provider Manual. The ADW provider must still complete the written repayment arrangement within thirty days of receipt of the Final Report, however, scheduled repayments may begin before or after the document/desk review decision. If the document/desk review determines repayment was not required, arrangements will be made with the agency for reimbursement from BMS. The BMS may place a lien on future payments if a written repayment form is not submitted within 30 days of receipt of the final report. The request for a document/desk review must be in writing, signed and set forth in detail to the items in contention. Please note, the items of contention must have been noted on the draft report and addressed by the provider before requesting a document/desk review of the contended items. Requesting a document/desk review means that the provider and the OA could not reach an agreement on the contested items on the draft report, therefore a third party is asked to intervene. The letter must be addressed to:

Bureau for Medical Services

Legal Department-Document Desk Review
350 Capitol St, Room 251
Charleston, WV 25301-3706

The West Virginia Participant Experience Survey (PES) will also be conducted with people whose charts are selected in the representative sample for review.

Corrective Action Plan (CAP)

In addition to the draft report sent to the ADW providers, the OA will also send a draft CAP. The ADW providers are required to complete the CAP and submit it to the OA for approval within thirty calendar days of receipt of the draft report from the OA. The BMS may place a hold on claims if an approved CAP is not received by the OA within the specified time frame, unless the provider requests and has been granted an extension. Requests for extensions must be made in writing to the OA detailing the reason for the request. The CAP 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 the Corrective Action Plan will be completed; and
- Any provider-specific training requests related to the deficiencies.

If an agency requires a CAP, the OA will conduct a six-month follow up to see if the approved CAP has been implemented as stated.

For information relating to additional audits that may be conducted for services contained in this chapter please see *Chapter 800, Quality and Program Integrity(B)* of the BMS Provider Manual that identifies other state/federal auditing bodies and related procedures.

501.2.3.5 Training and Technical Assistance

The OA develops and conducts training for ADW 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 ADW agencies must send at least one representative to mandatory quarterly provider meetings. That representative is responsible for disseminating the information learned at the quarterly provider meeting to all other pertinent agency personnel. If it is determined that a representative was not present, it becomes the agency's responsibility to obtain the information shared and follow any directives provided. Continued and on-going non-participation may result in sanctions.

501.2.3.6 Self-Audit

ADW 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 BMS.

ADW providers must use the approved format for submitting self-audits to the OPI. Failure to submit an assigned self-audit may result in BMS withholding Medicaid payments until the self-audit is submitted. ADW providers are required to send all completed forms in an electronic format to OPI along with the original Excel spreadsheet and repayment forms. This information it not to be submitted to the program manager.

501.2.4 Record Requirements

Providers must fully complete all required ADW forms and follow published forms instructions. Forms with corrective fluid, tape or removeable labels used on them will not be accepted. Any alteration or change in documentation after medical professional, member or Medicaid provider has signed it could result in a targeted review and disallowances. Forms and instructions can be found on the ADW website.

Providers must meet the following record requirements:

Program Records:

- The provider must keep a file on each member they serve.
- Files must contain all original and required documentation for services provided to the member by the provider responsible for development of the document including the Service Plan, PAS, the completed assessments, contact notes, personal attendant log worksheets, etc.
- Original documentation on each member must be kept by the Medicaid provider for five years or three years after audits, 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 into the UMC web portal within twelve calendar days of completion:
    - Person-Centered Service Plan.
    - Case manager, RN and/or Public Partnerships, LLC (PPL) assessment.
    - Personal Attendant Log (PAL); and
- Any legal documents pertaining to power of attorney, legal guardianship, conservatorship, etc.

Provider Personnel Records:

- Original or legible copies of personnel documentation including training records, licensure, confidentiality agreements, fingerprint-based background checks, signed conflict of interest statements, etc. must be maintained on file by the certified provider.
- Minimum credentials for professional staff RN, social worker, case manager with four-year Human Services Degree/BMS Case Management Certification, and counselor must be verified upon hire and thereafter based upon applicable professional license requirements for each year of employment.
- All documentation on each staff member must be kept by the Medicaid provider and the provider must be able to make the records available to the OA for review.

Certified ADW providers must agree to abide by all applicable federal and state laws, policy manuals, and other documents that govern the ADW program. Providers must also agree to make themselves, board members, their staff, and all records pertaining to 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.

501.3 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 ADW 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 his/her 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 and sign the initial medical eligibility assessment,
- Attend and sign subsequent annual Medical eligibility assessments,
- Sign the initial and annual Medical Necessity Evaluation Request (MNER), and
- Attend the meetings to develop the Service Plan and sign the initial and annual required assessments.

Note: Adult Protective Services (APS) as the appointed guardian is responsible for attending Multi-Disciplinary Treatment Plans (MDTs), Interdisciplinary Team Meetings (IDT), Individual Program Plans (IPP), Discharge Plan meetings and Care Plans (Plan of Care meeting) 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)

501.4 ELECTRONIC VISIT VERIFICATION

As required by the Cures Act, BMS will implement an Electronic Visit Verification (EVV) system to verify in home visits by Personal Care (PC) Services and at-home visit providers. The EVV system will verify:

- Type of service performed.
- Individual receiving the service.
- Date and location of service delivery.

- Individual providing the service; and
- Time the service begins and ends.

For services requiring EVV, direct-care staff and case managers 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 EVV vendor will provide training and an EVV guide that will be available when the system is implemented. Personal attendants that live in the member's home will not be required to use EVV.

501.5 STAFF QUALIFICATIONS AND TRAINING REQUIREMENTS

All staff must be trained to provide ADW services in a culturally and linguistically appropriate manner. All training material must be approved by the OA.

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

Members choosing *Personal Options* and their personal attendant employees may access a resource consultant for OA 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 needed to perform certain tasks and/or activities. The curriculum should have goals, objectives, and an evaluation system to demonstrate competency in training areas. Competency is defined as passing a graded posttest at no less than 75%.

EVV requires all personal attendants and case managers to have their own NPI number to link the worker to the member they are providing services for and when. 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 ADW member they do not live with, then they will be required to obtain an NPI number for billing with those members.

501.5.1 Case Manager Qualifications

A case manager must be licensed in West Virginia as a social worker, counselor, or RN. Licensure documentation must be maintained in the employee's file. Provisionally and temporarily licensed Social Workers must successfully complete and pass the BMS Case Management Certification training prior to billing for ADW services. Case managers may also possess a four-year degree in an approved Human Services field and successfully complete and pass the BMS Case Management Certification training prior to billing for ADW services. If you are unclear if a degree falls within the Human Services Field, submit course study requirements of the specific degree being considered to the ADW Program Manager for review. Documentation that covers all the employee's employment period must be present (example: If an employee has been with your agency for three years, the 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 Administration and Information*), and

references shall be maintained on file by the provider. The provider shall have an internal review process to ensure that employees providing ADW services meet the minimum qualifications.

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

The ADW 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.

501.5.2 Case Management Initial and Annual Training Requirements

- *Conflict free Case Management training (including a signed Conflict of Interest Statement signed initially and annually thereafter)
- *Training on *Personal Options* Service Delivery Model
- *Abuse/Neglect/Exploitation identification training – Initially and annually
- *HIPAA training -initially and annually
- *Person-Centered planning/ Service plan development – initially and annually
- Must maintain professional license training requirements – initially and annually.

*Providers may use training modules provided by the OA for these mandatory trainings or develop their own with the same components that must be approved by the OA. All trainings must be competency based. All documentation must be signed and dated. Failure to follow staff training requirements/documentation may result in disallowances.

501.5.3 Personal Attendant Qualifications

A Personal attendant is an individual paid to provide the day-to-day care to members utilizing the ADW including both Traditional and *Personal Options* Service Delivery models.

Medicaid prohibits legally responsible persons from providing ADW services for purposes of reimbursement. Legally responsible persons include spouse and parent of a minor child. Court appointed legal guardians are also prohibited from providing reimbursed service. A Medical Power of Attorney (MPOA), Power of Attorney (POA), healthcare surrogate or any other legal representative may provide services. However, if an MPOA, POA, healthcare surrogate, or any other legal representative is providing services they must:

- Work for an ADW provider agency, or
- If the member self-directs, they must have a program representative that is not the MPOA, POA, healthcare surrogate, or any other legal representative.

Personal attendants must be at least 18 years of age and possess the ability to perform the tasks required for the member. In addition, they must have completed the required initial competency-based training before providing service and any annually training thereafter as required.

All documented evidence of personal attendant qualifications such as licenses, transcripts, certificates, fingerprint-based background checks, signed confidentiality statements and references shall be

maintained on file by the provider. The provider must have an internal review process to ensure that the Personal attendant providing ADW services meets the minimum qualifications as required by policy.

In *Personal Options*, all documented evidence of staff qualifications such as licenses, transcripts, certificates, signed confidentiality statements, and references shall be maintained on file by the Resource Consultant.

An ADW member receiving ADW services cannot also be a paid personal attendant/direct-care worker through a Home and Community Based Services program to another individual including other family members.

EVV requires all personal attendant workers to have their own NPI number to link the worker to the member.

501.5.4 Personal Attendant Initial Training Requirements

- Cardiopulmonary resuscitation (CPR) training - Provided only by certified trainers of OA approved courses. Additional CPR courses may be approved by the OA. All CPR courses must include a return skills-based demonstration. Documentation that each trainee successfully completed the course and is certified must by maintained by the agency and made available upon request. 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.
- First Aid Training – Documentation that each trainee successfully completed the course and is certified must be maintained 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 request. On-line First Aid courses are allowed, but it must be an OA approved course. An agency's RN education and skill set are sufficient to provide the First Aid Training.
- Competency-based Universal Precautions training.
- Competency-based Personal Attendant Skills – training on assisting people with Activities of Daily Living (ADLs) – must be provided by the agency RN.
- *Abuse/Neglect/Exploitation identification training
- *HIPAA training
- Competency-based Direct-Care Ethics – training on ethics such as promoting physical and emotional well-being, respect, integrity and responsibility, justice, fairness, and equity - must be provided by the agency nurse, social worker/counselor, a documented specialist in this content area, or a qualified internet training provider.
- Member Health and Welfare – training must be provided by the agency nurse and must include emergency plan response (signs of heart attack, stroke, infection, confusion), fall prevention, home safety and risk management.
- * Person-Centered Planning
- Extreme Situations Guide Training (personal attendant safety training)

Competency-based training curriculum is defined as a training program which is designed to give participants the skill, 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 75%. If a staff fails to meet competency requirements, the provider agency must conduct additional training and retest the staff (until a score of at least 75% is obtained) before the staff can work with member.

When a personal attendant leaves an agency, then returns to the same agency, initial training requirements must be repeated if the gap in employment is greater than 180 days. (excluding CPR/First Aid. The date of the card states expiration of training).

*Providers may use training modules provided by the OA for these mandatory trainings or develop their own with the same components that must be approved by the OA.

501.5.5 Personal Attendant Annual Training Requirements

CPR, First Aid, Universal Precautions, A/N/E Identification, and HIPAA training must be kept current.

- CPR is current as defined by the terms of the approved certifying agency.
- First Aid, if provided by the American Heart Association, American Red Cross, or other qualified provider, is current as defined by the terms of that entity. Training provided by the agency RN (but not under a certifying agency such as American Red Cross), must be renewed within 12 months or less. Training will be determined current in the month it initially occurred. (Example: If First Aid training was conducted May 10, 2020, it will be valid through May 31, 2021).
- Universal Precautions, Abuse/Neglect/Exploitation Identification, and HIPAA training must be renewed within 12 months or less. Training will be determined current in the month it initially occurred. (See example above).

In addition, four hours of training focusing on enhancing direct care service delivery knowledge and skills must be provided annually. Member-specific on-the-job-training can be counted toward this requirement. It is recommended that the same trainings not be repeated from year to year. It is suggested that providers evaluate and identify trends at their agencies when identifying potential training topics.

Failure to meet training requirements for staff may result in disallowances.

501.5.6 Registered Nurse Qualifications

An RN must be employed by a certified personal attendant agency and have a current West Virginia RN license. Licensure documentation must be maintained in the employee's file. Documentation that shows the RN was licensed for the employee's entire employment period must be present. (For example – if an employee has been with the 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 Administration and Information*) and references shall be maintained on file by the provider. The provider shall have an internal review process to ensure that employees providing ADW services meet the minimum qualifications.

501.5.7 Registered Nurse Training Requirements

- *Person-Centered Planning (required initially)
- Must maintain professional license training requirements.

* Providers may use training modules provided by the OA for these mandatory trainings or develop their own with the same components that must be approved by the OA.

501.5.8 Training Documentation

Documentation for training conducted by the agency nurse, social worker/counselor, or a documented specialist in the content area must include the training topic, date, beginning time of the training, ending time of the training, location of the training and the signature of the instructor and the trainee or, for *Personal Options*, the member (or legal representative). Training documentation for internet-based training must include the person's name, the name of the internet training provider, credit hours (time spent) and either a certificate or other documentation proving successful completion of the training. A card or certificate from the American Heart Association, the American Red Cross or other training entity is acceptable documentation for CPR and First Aid. Providers must use the approved ADW form to document training found on the ADW website.

CPR/First Aid Documentation

Direct-care workers must have a CPR/First Aid card. While an agency is waiting for the card, if the agency staff, a certified trainer from an OA approved certifying agency, provided the training, then 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.

Personal Options

Personal Attendant workers must have a CPR/First Aid card. BMS will accept a letter-on-letter head from the certifying agency that training 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 onto the staff record after 30 days.

501.5.9 Non-Medical Transportation Services Qualifications

In addition to meeting all requirements for ADW personal attendant, 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 the F/EA.

They must also abide by local, state, and federal laws regarding vehicle licensing, registration and inspections upon hire and checked annually thereafter.

501.6 INCIDENT MANAGEMENT

ADW providers 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, how). All inconsistencies must be explored. The provider must

ensure the safety of all involved (the member and/or the staff) during the investigation. In addition, all required entities must be notified as applicable (APS), law enforcement, Medicaid Fraud Control Unit, etc.).

The provider is responsible for taking appropriate action on both an individual and systemic basis to identify potential harms, or to prevent further harm, to the health and safety of all members served and staff involved.

Anyone providing services to a member who suspects an allegation of abuse, neglect, or exploitation must report the incident to West Virginia Centralized Intake immediately by calling 1-800-352-6513, seven days a week, 24 hours a day. This initial referral must then be followed by a written report, submitted to the local Department of Health and Human Resources (DHHR) where the alleged victim resides, within 48 hours following the verbal referral. An APS worker may be assigned to investigate the alleged abuse, neglect and/or exploitation.

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 ADW provider staff to perform his/her responsibilities that compromises the health or safety of the member is considered to be neglect and must be reported to APS. 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. Incidents shall be classified by the provider as one of the following:

Critical Incidents

Critical incidents are occurrences 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. It could also include any type of suspected criminal activity. For this system, critical incidents do not result from abuse/neglect/exploitation. These incidents may include, but are not limited to, the following:

- Attempted suicide, or suicidal threats or gestures.
- Suspected and/or observed criminal activity by the member, member's families, health care providers, concerned citizens, and 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 if abuse and neglect is not suspected.
- A significant interruption of a major utility, such as electricity or heat in the member's residence that compromises the health or safety of the member.
- Environmental/structural problems with the member's home, including inadequate sanitation or structural damage that compromises the health or safety of the member.
- Fire in the home resulting in relocation or property loss that compromises the health or safety of the member.
- Unsafe physical environment in which the personal attendant and/or other agency staff are threatened or abused, and the staff's welfare is in jeopardy.

- Disruption of the delivery of ADW services, due to involvement with law enforcement authorities by the member and/or others residing in the member's home that compromises the health or safety of the member.
- Medication errors by a member or his/her family caregiver that compromises the health or safety of the member, 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 doses, or doses administered at the wrong time.
- Disruption of planned services for any reason that compromises the health or safety of the member, including failure of member's emergency backup plan.
- Any incident deemed to be restrictive in nature (i.e. restraint of any type).
- Any other incident judged to be significant and potentially having a serious negative impact on the member receiving ADW services.
- Any incident attributable to the failure of ADW provider staff to perform his/her responsibilities that compromises the member's health or safety is neglect and must be reported to APS.

Simple Incidents

Simple incidents are any unusual events occurring to a member that cannot be characterized as a critical incident and do not meet the level of abuse or neglect. 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.

501.6.1 Reporting Requirements, Incident Management Documentation, and Investigation Procedures

Any incidents involving a member must be entered into the WV IMS within one business day of learning of the incident. The agency director, designated RN, or case manager will immediately review each incident report. All critical incidents must be investigated. All incidents involving A/N/E must be reported to APS but also must be noted in 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. Each Incident Report must be printed, reviewed, and signed by the Director and placed in an administrative file for review upon request by the OA. Providers are to report in the WV IMS monthly if there were no incidents.

If a death occurs, the worker of the provider agency who learned of the death first must complete the report regarding the death in the IMS within one business day of learning of the death of a member. The agency must report in the WV IMS the cause of the death, source of report of the death, location of member at time of death, current known medical conditions reported on the most recent MNER and PAS for the member, manner of death (terminal, disease, natural, accident), If the death was suspicious, untimely or unexplained, the reporting agency must also include information about applicable agencies or authorities who were notified (i.e. APS, police, Medicaid Fraud Control Unit, physician, legal representative/family), description of life-saving measures attempted if applicable and if none, why none were attempted, and a description of circumstances preceding death.

For *Personal Options*, the resource consultant must report any incidents in the WV IMS within one business day of learning of the incident as well as notify the case manager. If a case manager becomes aware of an incident before the resource consultant, the case management agency must enter it in the WV IMS and report it to the *Personal Options* program manager at the OA and the resource consultant. The OA reviews each incident, investigates, and enters outcomes of the investigation within 14 calendar days of learning of the incident.

The WV IMS does not supersede the reporting of incidents to APS. At any time during the course of an investigation should an allegation or concern of abuse, neglect or exploitation arise, the provider shall immediately notify APS W.Va. Code §9-6-9.

An agency is responsible to investigate all incidents, including those reported to APS. If requested by APS, a provider shall delay its own investigation and document such request in the online WV IMS. The provider will also contact the OA with such delay requests. When reporting to APS, the agency needs to obtain the report number, so they can follow up with APS investigations results.

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 Service Plan) and
- Change in needs were addressed on the Service Plan.

Due to the seriousness of reporting suspected abuse/neglect/exploitation, any staff, Traditional or *Personal Options*, that fails to report or consistently fails to meet the timelines for reporting may put their agency at risk of losing their ADW provider status or contractual relationship.

501.6.2 Incident Management Tracking and Reporting

Providers 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 OA monitoring staff at the time of the provider monitoring review or upon request.

The resource consultant has a tracking/reporting responsibility defined in their contract with BMS.

501.7 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

General Requirements

- ADW program provider agencies must comply with the documentation and maintenance of records requirements described in *Chapter 100, General Administration and Information*;

and *Chapter 300, Provider Participation Requirements* of the BMS Provider Manual. This can be found on the BMS website.

- ADW program provider agencies must comply with all other documentation requirements of this chapter.
- All required documentation must be maintained by the ADW provider for at least five years or three years after audits, with all exceptions having been declared resolved by the BMS, in the member's file subject to review by authorized BMS personnel or contracted agents. 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 by 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

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

- Each ADW provider who provides case management services is required to maintain all required ADW documentation for state and federal monitors.
- All ADW 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). This can be found on the BMS website at http;//www.dhhr.wv.gov/bms/Pages/Manuals.aspx.
- All providers of waiver services must maintain records to substantiate that services billed by the ADW 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 if the documentation is accessible to individuals who may need to access it.
- Electronic health record and electronic signature requirements described in *Chapter 300, General Administration and Information* of the BMS Provider Manual.
- All personal attendants and case managers must obtain an NPI number for billing purposes when applicable.

ADW providers should begin billing each day separately (not including more than one day per claim). Each provider should bill one claim per date of service, per personal attendant. (i.e., If you have two personal attendants for the same member, the provider needs to submit two separate claims.)

Additional information regarding the implementation of daily billing will be provided by BMS with implemented.

PROGRAM ELIGIBILITY AND ENROLLMENT

501.8 ADW PROGRAM ELIGIBILITY

Applicants for the ADW program must meet all the following criteria to be eligible for the program:

- Be 18 years of age or older.
- Be a permanent resident of West Virginia. The individual may be discharged or transferred from a nursing home in any county of the state, or in another state, if his/her permanent residence is in West Virginia.
- Meet the Medicaid waiver financial eligibility criteria for the program as determined by the county DHHR office, or the Social Security Administration (SSA), if an active Supplemental Security Income (SSI) recipient.
- Be approved as medically eligible for nursing home level of care and in need of services.
- Choose to participate in the ADW program as an alternative to nursing home care.
- Members must be able to provide a safe working environment for ADW program staff and agency personal attendants, RNs, and case managers.

The applicant must first meet the financial eligibility requirements before a determination of the applicant's medical eligibility will be made. If an individual is medically and financially eligible, a slot must be available for him/her to participate in the program. If funded slots are not available, applicants determined financially and medically eligible for the Program will be placed on a waiting list known as the Managed Enrollment List (MEL). As funded slots become available, applicants on the MEL 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. The BMS does not issue, or rank applicant's need for emergency slots.

501.9 FINANCIAL ELIGIBILITY - PRE-MEDICAL ELIGIBILITY

The financial eligibility process starts once an applicant applies to the ADW program by submitting the initial MNER Form to the UMC. Within two business days of receipt of a complete MNER, the UMC will send a letter to the applicant notifying them that they must complete financial eligibility before they can proceed with medical eligibility. The letter will include a yellow DHS-2 form and a Case Management Selection form.

The applicant may choose a case management agency upon application to the ADW program. The Case management agency will be notified by the UMC when chosen. 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 assist in determining financial eligibility and answer any questions the applicant might have. The applicant and/or case manager must submit a yellow DHS-2 form along with a letter from the UMC to

the county DHHR office to determine financial eligibility based on ADW criteria. The yellow DHS-2 form will include an expiration date. It will not be accepted at the county DHHR office after the expiration date.

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 ADW program. Some assets of a 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. Case managers are not to act as financial planners in making recommendations regarding assets.

Medical eligibility determinations will not occur until the yellow DHS-2 form is returned to the UMC and states that the applicant is financially eligible. The medical eligibility assessment will also not be scheduled if the applicant is determined financially ineligible. If the yellow DHS-2 form is not returned to the UMC within 60 calendar days of the expiration date, the referral will be closed.

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

If the applicant has been placed on the (MEL), when a slot becomes available, the applicant and the case management agency (if already chosen) will be notified by the UMC. Continued financial eligibility must be confirmed using the DHS-2 form. The applicant has a total of 60 calendar days from the date the DHS-2 form is signed by the case manager to establish financial eligibility and enroll with the OA. Applicants must establish financial eligibility at a local DHHR office. This is evidenced by the signed DHS-2 form by the staff at the local DHHR office verifying the applicant is either financially eligible or ineligible. This process can take up to thirty days for final determination. Therefore, it is imperative the process begin immediately. If the applicant presents the DHS-2 form after the expiration date, financial eligibility for the ADW program is denied.

Case managers (if already selected) must notify the OA when the financial eligibility process has been initiated using the Case Management Contact Form. If the financial eligibility process and enrollment are not completed within 60 calendar days, the OA will close the referral and notify the applicant. The letter will include the reason for the closure, the applicable ADW policy manual 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 ADW services after the closure, a new MNER must be submitted to the UMC to begin the application process again. The BMS will ensure that all closed referrals will be reviewed before releasing the slot to the next applicant on the MEL.

ADW services cannot be paid until an applicant's financial eligibility is established and the enrollment process has been completed with the OA. (Refer to Section 501.12 Enrollment) If the member has been on another waiver program, no services may be charged prior to an applicant's discharge from the other waiver program. The only exception is Case Management which may bill thirty days prior to discharge.

Termination of the Medicaid benefit itself (e.g., the Medicaid card) always requires a 13-calendar day advance notice prior to the first of the month 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 ADW services end.

501.11 MEDICAL ELIGIBILITY

The UMC is the entity that is responsible for conducting medical necessity assessments to confirm an applicant's medical eligibility for waiver services. The purpose of the medical eligibility review is to ensure the following:

- New applicants and existing members are medically eligible based on current and accurate evaluations.
- Each applicant/member determined to be medically eligible for ADW services receives an appropriate Service Level that reflects current/actual medical condition and short and long-term service needs.
- The medical eligibility determination process is fair, equitable, and consistently applied throughout the State.

501.11.1 Medical Criteria

An individual must have five deficits as described on the PAS to qualify medically for the ADW program. 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 individual 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 individual in the home	
a.	Eating	Level 2 or higher (physical assistance to get nourishment, not
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 or two-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)
#27	Individual has skilled needs in one or more of these areas: (g) suctioning, (h) tracheostomy, (i) ventilator, (k) parenteral fluids, (l) sterile dressings, or (m) irrigations	
#28	Individual is not capable of administering his/her own medications	

501.11.2.1 Service Level Criteria

There are four service levels for personal attendant services. Points will be determined as follows based on the following sections of the PAS:

Section	Description of Points
#23	Medical Conditions/Symptoms – 1 point for each (can have total of 12 points)
#24	Decubitus - 1 point
#25	1 point for **b**., **c**., or **d**.
#26	Functional Abilities: Level 1 - 0 points Level 2 - 1 point for each item **a.** through **i.** Level 3 - 2 points for each item **a.** through **m., i.** (walking) must be at Level 3 or Level 4 to get points for **j.** (wheeling) Level 4 – 1 point for **a** 1 point for **e**, 1 point for **f**, 2 points for **g** through **m**
#27	Professional and Technical Care Needs - 1 point for continuous oxygen.
#28	Medication Administration - 1 point for **b.** or **c.**
#34	Dementia - 1 point if Alzheimer's or another dementia
#35	Prognosis – 1 point if Terminal

Total number of points possible is 44.

501.11.2.2 Service Level Range of Hours

Traditional Service Levels

Level	Points Required	Range of Hours Per Month (for Traditional)
A	5-9	0 - 62
B	10-17	63 - 93
C	18-25	94 -124
D	26-44	125 -155

The hours of service are determined by the service level and the Case Management and RN or PPL Assessment. Please note, the levels are a range of hours and are to be used to meet daily needs. Maximum hours are not guaranteed if the need is not identified. If the minimum hours awarded are not being utilized, the reason must be documented in the Service Plan. If a member reports formal Personal Attendant services to assist with ADLs are not needed, a request for closure must be submitted.

For members new to *Personal Options*, the first month's budget must be prorated by the F/EA to reflect the actual start date of services.

501.11.2.3 Initial Medical Evaluation

Following is an outline of the initial medical evaluation process as predominantly directed in the 2005 Cyrus decree:

- An applicant shall initially apply for the ADW program by having his/her treating physician (Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.)), Nurse Practitioner (NP) or physician's assistant (PA) (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. If the MNER form is incomplete, it will be returned for completion and resubmission to the entity (applicant, contact person, or referent) that has not completed the form properly, and the applicant will be notified.
- Once a completed and signed MNER is received, the UMC will send a yellow DHS-2 form to the applicant, so financial eligibility can be established. A list of Case Management providers in the applicant's county will also be sent. An applicant may choose a Case Management Agency to assist them with the application process. Selecting a Case Management Agency does not ensure eligibility for the ADW program.
- Once the completed DHS-2 form is returned, if financially eligible, the UMC will attempt to contact the applicant (or legal representative) to schedule the assessment, allowing at least two weeks notification of the appointment. If contact is made, a notice shall be sent to the applicant and/or contact person detailing the scheduled home visit date and time.
- The UMC will make up to three attempts to contact the applicant. If unable to contact after three attempts, the case management agency (if applicable) will be notified and the UMC will issue a potential referral closure letter to the applicant and contact person (if applicable). (or legal representative). 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 signature on the MNER is greater than 60 calendar days.
- If the MNER form indicates that the applicant has Alzheimer's, multi-infarct, senile dementia, or related condition; and/or if he/she has a guardian or legal representative, the assessment will not be scheduled without the guardian, contact person or legal representative present to assist the applicant.
- If the applicant is not financially eligible, the local DHHR office will notify the applicant of the denial of financial eligibility. The referral will be closed by the UMC. No letter will be sent by the UMC.
- If the applicant has not selected a case management agency to assist with the application process, the UMC nurse will provide Case Management Agency/Personal Attendant Agency Selection Forms, Service Delivery Model Forms, and collect them at the end of the medical assessment.
- It is not the UMC's responsibility to extend invitations to any other participants for this assessment. If the applicant wants others to attend, it is their responsibility.

501.11.2.4 Results of Initial Medical Evaluation

Approval

If the applicant is determined medically eligible and a slot is available, a notice of approved medical eligibility, which includes the range of personal attendant hours the member may receive and a copy of the PAS, is sent to the applicant and/or legal representative/designated contact. The notice will be sent by

mail to the applicant. The case management agency will also be notified, as will the TMH office, as applicable. The case manager must use the Initial Contact Log at this point. Continued financial eligibility must be confirmed, using the white DHS-2 form. If the applicant chose *Personal Options,* the case manager will inform the resource consultant.

The applicant must be enrolled within sixty calendar days from the date the Case Manager signs the DHS-2 form. It will not be accepted at the county DHHR office after the expiration date. If not enrolled, the applicant forfeits the slot and must reapply. The OA and the BMS will review all 60-day closures to assess whether the enrollment delay was outside the applicant's control. If so, an extension may be granted.

If the applicant is determined medically eligible and a slot is not available, a notice of approved medical eligibility will be sent to the applicant, legal representative/designated contact informing them a slot is not currently available and they will be contacted when one becomes available. The applicant will be placed on the MEL. When a slot becomes available, the applicant, legal representative/ designated contact will be sent a letter. The case management agency will also be notified, as well as the TMH office, as applicable. The case manager must use the Initial Contact Log at this point. Continued financial eligibility must be confirmed. If the applicant chose *Personal Options*, the case manager will notify the resource consultant.

Denial

If it is determined that the applicant does not meet medical eligibility, the applicant, legal representative/ designated contact 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 and ADW policy will also be included with the Potential Denial-Additional Information Needed letter. The applicant will be given 14 days to submit supplemental medical information to the UMC. Information submitted after 14 days will not be considered in the eligibility determination. However, it may be used during a pre-conference hearing 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, legal representative/designated contact will be notified by a Final Denial letter. The case management agency will also be notified, as well as the TMH office, as applicable. The Final Denial letter will provide the reason for the adverse decision. It will also include the applicable ADW policy manual section(s), a copy of the PAS, supplemental 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.

501.11.2.5 Medical Re-evaluation

Annual re-evaluations for medical eligibility for each member must be conducted. The process is as follows (as predominantly directed in 2005 Cyrus decree):

- A MNER form with current updated contact information must be submitted to the UMC after being signed and dated by the member, legal representative/designated contact, and referent (physician, NP, PA). The forms must be provided to the UMC and a copy of the original form with the signatures must be maintained in the member's file. The referents and member's legal representative/designated contact signatures on the MNER must be no older than 60 days of the date the MNER is submitted/received by the UMC. The case manager must check the reevaluation line at the top of the form. A referent's signature is required annually and must include the ICD diagnosis code(s).
- The request can be submitted up to ninety calendar days prior to the expiration of the current PAS, as dictated by the anchor date, and no later than 45 calendar days prior to the expiration of the current PAS. A member's medical eligibility is at risk if the PAS request is submitted less than 45 calendar days before it expires. The expiration of a PAS does not constitute a reason for an appeal.
- After receiving the reevaluation request, the UMC will attempt to contact the member, legal representative/designated contact to schedule an assessment, allowing at least two weeks notification.
- If the MNER form indicates that the applicant has Alzheimer's, multi-infarct, senile dementia, or related condition; or if he/she has a guardian, contact person or legal representative, the assessment will not be scheduled without the guardian, contact person or legal representative present to assist the member.
- If the UMC makes the contact, a letter is sent to the member, legal representative/designated contact and notification is sent to the case management agency noting the date and time of the assessment.
- If the UMC is unable to contact the member, legal representative/designated contact within three attempts, a Potential Closure letter will be sent to the member, legal representative/designation contact. Notification is sent to the case management agency, *Personal Options* vendor, and the TMH office, as applicable.
- If no contact is made with the UMC within 10 business days of the date of the Potential Closure letter, the UMC will send the Final Denial letter to the member, legal representative/designated contact. The OA, case management agency, *Personal Options* vendor, and the TMH office, as applicable will be notified. The OA will close the case.

501.11.3.1 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, legal representative/designated contact. The case management agency, the TMH office, and *Personal Options* vendor will be notified when applicable. For people enrolled in the Traditional Model, this notice includes the approved Service Level and the range of hours of service per month. For people enrolled in *Personal Options*, this notice includes the approved Service Level and the maximum budget level. All people also receive a notice of free legal services, and a Request for Hearing form.

The case management agency is responsible for sending the Notice of Approved Continued Medical Eligibility to the personal attendant agency and *Personal Options* vendor when applicable.

Denial

If it is determined that the member does not meet medical eligibility the member, legal representative/designated contact. will receive a Potential Denial letter. The case management agency, the TMH office and the *Personal Options* vendor will be notified, as applicable. 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 and ADW policy will also be included with the Potential Denial letter. Information submitted after 14 days will not be considered in the eligibility determination. However, it may be used during a pre-conference hearing 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 that there is still no medical eligibility, the member, legal representative/designated contact. will be sent the Final Denial letter. The OA, case management agency, *Personal Options* vendor, and the TMH office will be notified as applicable. The Final Denial letter will provide the reason for the adverse decision. It will also include the applicable policy manual section(s), a copy of the PAS, supplemental 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, ADW services shall be terminated immediately. Medicaid will not pay for services provided to a medically ineligible person.

If upon re-evaluation, the service level decreases, the member has 14 days to submit additional information to support remaining at the previous level. If documentation supports the previous level, it will be restored. If the documentation is not received within the time frame or does not support the previous level, the member will be notified in writing. The level change will occur on the member's anchor date unless a request for a Medicaid Fair Hearing is received. If the request for hearing is received within 13 days of the letter notifying the member of the results of the medical re-evaluation, services will continue at the previous level until a decision is made.

501.12 ENROLLMENT

No Medicaid reimbursed ADW services may be provided until the member has been determined both financially and medically eligible and the OA has activated the applicant n the UMC web portal.

The *Personal Options* vendor must make initial phone contact with the member within three business days of the activation date.

The member's waiver case will be closed if personal attendant 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 OA and the case management agency. The case manager

will assist the member by facilitating a transfer to another personal attendant agency and notify the OA of the outcome.

If the member is self-directing their ADW services and are unable to hire staff within 90 days of enrollment, the resource consultant must inform the case manager to begin the process of an involuntary transfer to the Traditional Model for services. The Case Manager must notify the OA.

501.13 DESCRIPTION OF SERVICE OPTIONS

Two service options are offered in the ADW and are available to every member eligible for the ADW.

1. Traditional Service Option
2. Participant-Directed Service Option (*Personal Options* Financial Management Service)

A member who receives services may choose either service delivery model option at any time by completing a Request to Transfer form to their case manager.

501.13.1 Traditional Service Option, Traditional Model

The Traditional Model is available to all people on the ADW program. In the Traditional Model, people receive services from certified ADW case management and personal attendant providers. The providers are responsible for all facets of the program, taking into consideration the member's individual wishes and needs. Providers must try to match Personal Attendants with reasonable criteria set forth by the member, i.e., member requests non-smoker. Services are provided when the member needs them, within the assessed need and not at the convenience of the provider.

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

- Personal attendant
- Case management
- Skilled nursing
- Non-medical transportation
- Personal Emergency Response system (PERS)

The hourly wage of agency staff employed by the ADW 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 the ADW provider must meet the requirements set forth in the ADW manual.

501.13.2 Participant-Directed Service Option, *Personal Options Model*

The Financial Management Service (FMS) Model available to members to support their use of participant-directed services is *Personal Options*. Under *Personal Options*, the member is the Common Law Employer of the Personal Attendants they hire directly. The member may appoint a representative to assist with these functions, but the member remains the common law employer. The member will also select a case management agency to provide case management services.

A member's program representative cannot be a member's employee providing *Personal Options* ADW services to the member.

All Personal Attendants hired by the member must meet the requirements listed in Section 501.5.3, Personal Attendant Qualifications.

The *Personal Options* FE/A is responsible for managing the receipt and distribution of individuals' participant-directed budget funds, processing and paying the personal attendants' payroll and reimbursements for transportation. The *Personal Options* F/EA is also required to provide information and assistance to members and their representatives as appropriate.

Under *Personal Options* FMS option, the member is the common law employer of the personal attendants they hire directly. The common law employer is responsible to:

- Elect the member-directed option.
- Work with their resource consultant to become oriented and enrolled in the Member-Directed Option, enroll personal attendants, develop a spending plan for the member-directed budget, and create an emergency personal attendant back-up plan to ensure staffing, as needed.
- Recruit and hire their personal attendant(s).
- Provide required and member-specific training to personal attendant(s).
- Determine personal attendants' work schedule and how and when the personal attendant should perform the required tasks.
- Supervise personal attendant's daily activities.
- Evaluate their personal attendant's performance.
- Review, sign, and submit personal attendant's time sheets to the *Personal Options* FE/A.
- Maintain documentation in a secure location and ensure employee confidentiality.
- Discharge their personal attendant, when necessary.
- Notify their case manager and resource consultant of any changes in service need.
- Maintain a safe environment for all employees.

Personal Options F/EA is responsible for:

- Assisting common law employers exercising budget authority.
- Acting as a neutral bank, receiving, and disbursing public funds, tracking, and reporting on the member's budget funds (received, disbursed and any balances).
- Monitoring members' spending of budget funds in accordance with members' approved spending plans.
- Submitting claims to the state's claim processing agent on behalf of the member/employer.
- Processing and paying invoices for transportation and services in the member's approved participant-directed spending plan.
- Assisting members exercising employer authority.
- Assisting the member in verifying workers' citizenship or legal alien status (e.g., completing and maintaining a copy of the Employment Eligibility Verification USCIS form I-9 for each personal attendant the member employs).
- Assisting in submitting criminal background checks of prospective Personal Attendants.
- Collecting and processing personal attendant's timesheets.
- Operating a payroll service, [including withholding taxes from personal attendants' 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];
- Distributing payroll checks on the member's behalf.
- Executing simplified Medicaid provider agreements on behalf of the Medicaid agency.
- Providing orientation/skills training to members about their responsibilities when they function as the employer of record of their personal attendants.
- Providing ongoing information and assistance to common law employers; and
- Monitoring and reporting data pertaining to quality and utilization of the *Personal Options* FMS as required to the BMS.
- Maintain monthly contact and six months face-to-face visits with the *Personal Options* member (this includes the annual and six-month Service Plan meetings).
- Ensuring initial and annual personal attendant training as required per policy.
- Providing program representative training.

The *Personal Options* F/EA is not the common law employer of the member's Personal Attendant(s). Rather, the *Personal Options* Fiscal/Employer Agent 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* F/EA 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 to common law employers to support their use of member-directed services and to perform effectively as the common law employer of their Personal Attendants. I&A provided by *Personal Options* include:

- Common law employer orientation sessions once the member chooses to use member-directed services and enrolls with *Personal Options*, and,
- Skills training to assist common law employers to effectively use member-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 member-directed services (i.e., common law employer, *Personal Options*, UMC, case management, and the BMS),
    - How to participate in *Personal Options*,
    - How to effectively perform as a common law employer of their personal attendants,
    - How to ensure that the common law employer is meeting Medicaid and *Personal Options* requirements, and
    - How a member would stop using member-directed services and begin to receive traditional waiver services if they so desire.
    - Skills training curricula reinforce Medicaid, *Personal Options*, federal and state labor, tax and citizenship and legal alien status requirements and provide a review of best practices for performing the tasks required of a common law employer of a personal attendant (i.e., the common law employer may be having difficulty reviewing, signing, and submitting Personal Attendants' time sheets and skills training could be provided to help them improve their performance completing this task).

Personal Options provides information and assistance supports to members and their representatives (when applicable) who wish to function as common law employers. The educational presentations provide interested members with information on the role and responsibilities of *Personal Options* and each of the other interested parties (i.e., member, representative, personal attendant, and the BMS) and what is required of the member to be a common law employer to his or her personal attendant(s). These presentations provide the venue through which a member may enroll in the member-directed option. *Personal Options* makes available I&A supports to members and their representatives (when applicable), to implement and support their use of member-directed services and performing as an employer of record.

When *Personal Options* is selected by the member, the resource consultant provides information and assistance 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.
- Discussing and/or helping determine the member-directed budget with the common law employer.
- Presenting the common law employer with the *Personal Options* F/EA's role regarding payment for services.
- Assisting common law employers with determining member-directed budget expenditures.
- Assisting with the development of an individualized spending plan based upon the member's annual member-directed budget.
- Making available to the member/representative a process for voicing complaints/grievances pertaining to the *Personal Options* F/EA's performance.
- Providing additional oversight to the common law employer as requested or needed.
- Monitoring and reporting information about the member's utilization of the member-directed budget to the member, representative, case manager and BMS.
- Explaining all costs/fees associated with the member directing their own services.

About the provision of *Personal Options* FMS, the OA is responsible for:

- Distributing the *Personal Options* FMS satisfaction survey, developed by the BMS, to *Personal Options* members or their representatives (when applicable) and receiving and analyzing the survey results and reporting them to the BMS annually.
- Conducting *Personal Options* FMS performance reviews on a defined cycle using a review protocol based on the *Personal Options* FMS requirements.

Program Representative

Members may appoint a program representative to assist them with the responsibilities of self-direction. This may be a family member or friend. They cannot be paid for being the program representative to the member that they are assisting with their employer responsibilities nor can they be the personal attendant to the member. The program representative must be at least 18 years old. The F/EA will provide training, information, and a readiness assessment to the person the member has chosen to be their Program Representative. The program representative can choose to accept or decline the appointment at any time. If the program representative no longer wants to perform this function, the member will need to

choose another representative or change service delivery models if a Program Representative is required.

Involuntary Transfers

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

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 the case manager to require the member to appoint a program representative to assist with the employer responsibilities. If the member refuses to choose a program representative the member will be required to transition to the Traditional Service Model following the Involuntary Transfer process. Information will be presented to BMS from the resource consultant and case manager. The BMS will make final decision. If the member is required to transfer to the Traditional Service Model, the case manager will contact the member to facilitate the transfer.

Reasons for Involuntary Transfer of service delivery model:

- Non-compliance with the Self-direction program requirements
- Non-compliance with the ADW 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 is needed and member refuses to choose or cannot locate a person for this role.

It is possible for a member to transition back to *Personal Options* Model 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. The case manager with facilitate the transfer if deemed appropriate.

501.14 ASSESSMENTS

Assessment is the structured process of interviews which is used to identify the member's abilities, needs, preferences, risks and supports; determine needed services or resources; and provide a sound basis for developing the Service Plan. A secondary purpose of the assessment is to provide the member a good understanding of the program, services, and expectations. There are two assessments that are completed :

1. Case management assessment; and
2. RN or Public Partnerships, LLC (PPL) assessment .

Once enrollment has been completed with the OA, in the Traditional Model, the case manager and the RN will schedule a home visit within seven calendar days to complete the Initial Case management and RN Assessments. The home visit must only be scheduled within seven days and agencies have up to 14 days for the Service plan meeting may take place.

These assessments must be completed at least every six months from the date of the initial Assessment and annually thereafter.

The case manager, RN and resource consultant when applicable, must work together to ensure that the program meets the member's needs. They must communicate, and share information/documentation included in the assessments. All providers are to maintain a copy of the entire Assessment in the member's record.

The member in the *Personal Options* model will be contacted by the case manager to schedule a home visit within seven calendar days to complete the case manager assessment. The resource consultant will assist with the PPL assessment with information from the PAS. The case manager will coordinate with the resource consultant to ensure that the assessment information has been forwarded prior to the Service Plan meeting.

A new assessment must be completed when a member's needs change. Changes in a member's needs are to be incorporated into the Service Plan. Any changes in needs will be reported to the case manager. Case managers are to share any final changes, from those reported to the case manager or those determined by the case manager in a member's assessment with the personal attendant agency or the *Personal Options* staff, if applicable.

A copy of all Person-Centered assessments must be provided to the member (or legal representative).

501.15 SERVICE PLAN DEVELOPMENT

The case manager is responsible for development of the Service Plan in collaboration with the member (or legal representative). The meeting must be scheduled within seven calendar days however, the case manager has up to 14 days to hold the appointment. It is the case manager's responsibility to ensure that all assessments are reviewed with the member and considered in the development of the Service Plan. If agreed upon by the member and the case manager, the case manager assessment and the Service Plan meeting may take place at the same time however, consideration must be given for personal attendant agency RNs and resource consultants to also have time to complete their assessments. The case manager assessment and Service Plan meeting cannot exceed the total timeframe of 14 calendar days without prior adequate documentation noting the delay (i.e., member is in the hospital). Conflict of interest guidelines must be adhered to. If a conflictual relationship must exist (not enough providers in the area etc.) then the Conflict-of-Interest Safeguards in ADW manual Section 501.2, Provider Agency Certification must be followed.

Participation in the development of the initial Service Plan meeting is mandatory for the member (or legal representative), case manager and personal attendant agency RN in the Traditional Model. For those choosing *Personal Options*, the resource consultant may or may not be present however, they will forward the PAL information to the case manager if they are not able to attend. The member (or legal representative) may choose to have whomever else they wish to participate in the process (other service providers, informal supports, etc.). The resource consultant will conduct the assessment, complete the FEIN forms, and develop the budget and PAL in a separate meeting however the PAL will be forwarded to the case manager within 14 days if the Resource Consultant is unable to attend.

The Service Plan must detail all services (service type, provider of service, amount, frequency, and duration) the member is receiving, including any informal supports that provide assistance (family, friends, etc.), dual services if applicable, and any other agency services such as VA, Home Health, and Hospice, regardless of the source of payment. The Service Plan must include all needs and risks identified in the PAS, the case manager assessment , and address the member's preferences, goals, home and community-based living arrangements, personal strengths, emergency back-up plan(s) and outcomes. The Service Plan must include a risk plan, service(s) plan (service, amount, frequency, and duration) and resource plan with referral source. It is the case manager's responsibility to ensure that all assessments are reviewed with the member and considered in the development of the Service Plan.

It is the case manager's responsibility to send a copy of all Service Plans to the member (or legal representative), the personal attendant agency and resource consultant, if applicable within seven business days from the Service Plan meeting. The case management agency must have the original document in the member's file.

When the member has a change in needs, the PAL can be changed and attached to the current Service Plan to document any permanent Plan changes. (i.e., change in service hours, types of assistance with the activity, frequency of the activity, destination for community activity or essential errands, etc.). The case manager is required to document the member's approval of the change in the plan by telephone or in person on the changed PAL under the comment section.

Approved minor daily changes (i.e., worker arrived at 8:00 A.M.to get the member ready for a doctor appointment) in a member's needs such as hours of service, may be documented on the PAL and does not constitute the need for a change. However, if a change becomes permanent, a new PAL must be completed.

For those choosing *Personal Options*, the Resource Consultant is responsible for all duties related to the PAL.

An ADW agency that provides private pay services to a member must ensure that documentation is maintained separately, and no duplication of services occurs between the private pay and ADW services.

Service Plan Disagreement

The member may disagree with the Service Plan. Resolution of Service Plan disagreements occur within the Service Planning meeting. The case manager must document the disagreement on the Service Plan and the resolution when the member disagrees with the Service Plan. When there is a disagreement with the Service Plan, the member is to continue to receive services throughout the resolution process. A resolution to a disagreement must not override any ADW policy or other Medicaid policy. Disagreements not resolved in the planning meeting must be referred to the agency's grievance process.

Risk Analysis and Mitigation Plan

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 ADW Provider approved Risk Analysis and Mitigation Plan must be used and be a part of the Person- Centered Service Plan.

24-hour Emergency Back- up Plan

The purpose of the 24-hour emergency back up plans is to ensure that critical services and supports are provided to safeguard members health and safety whenever there is a breakdown in the delivery of planned services. The ADW provider agency approved twenty-four-hour emergency back- up plan must be used and be part of the Person-Centered Service Plan

Responsibility Agreement

A Responsibility Agreement is between the ADW 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 non-attendance for required Service Planning Meetings, refusal to allow the Case Manager to conduct required home visits in the member's residence, not permitting Personal Attendant staff to perform services or asking Personal Attendant staff to perform services not outlined in the member's Service Plan. Safety concerns in the member's home should be addressed promptly when first displayed or noticed and addressed in a Responsibility Agreement. The Case Manager will develop the Responsibility Agreement.

501.15.1 Six-Month and Ongoing Service Plan Development

Participation in the six-month and Annual Service Plan development are mandatory for the member (or legal representative), the case manager, the RN (Traditional Model) and/or the resource consultant (*Personal Options*) as applicable. The member (or legal representative) may choose to have whomever else they wish to participate in the process (direct-care staff, family members, other service providers, informal supports, etc.).

Service Plan Addendum

A Service Plan Addendum is completed to document a change in the member's needs. These changes would include such things as an additional service needed after release from a hospital, a member wants to change frequency or times they receive services, or an informal support is going to provide the service for the member as opposed to the personal attendant. A service plan addendum does not take the place of required six-month or annual Service Plan meeting.

An addendum should also be used if a Responsibility Agreement needs to be implemented. The addendum should discuss the reasons that lead to the need for the Responsibility Agreement.

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

501.15.2 Interim Service Plan Development

To begin services immediately to address any health and safety concerns, an Interim Service Plan may be developed and implemented upon the completion of ADW enrollment. The Interim Service Plan can be in effect up to 21 calendar days from the date of ADW Enrollment Confirmation to allow time for assessments to be completed, the Service Plan meeting to be scheduled, and the Service Plan to be developed.

If the case management agency develops an Interim Service Plan, the personal attendant agency must initiate services within three business days.

This is only available through the Traditional Service Model and the TMH program.

All ADW Service Plans must be developed using a person-centered approach as required by CMS. These regulatory requirements can be found at:

- Requirements for the person-centered planning process can be found at 42 CFR 441.301(c)(1)(ix)
- Requirements for the person-centered service plan can be found at 42 CFR 441.301(c)(2)(xiii A through H)
- Requirements for review of the person-centered plan can be found at 42 CFR 441.301(c)(3)

501.15.3 Spending Plan

People choosing *Personal Options* will develop a spending plan based on the services outlined in the Service Plan. The spending plan helps people determine how their budget will be used.

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

501.16 ASSISTED LIVING RESIDENCES AND GROUP RESIDENTIAL FACILITIES

ADW services may not be provided in assisted living residences or in group residential facilities. Qualified residences for ADW recipients, including ADW TMH members, is defined as:

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

All settings where ADW services are provided must be integrated into the community per the CMS Final Rule on Home and Community-Based Settings.

501.17 INITIATION OF PERSONAL ATTENDANT SERVICES

Once the Service Plan is developed, the agency providing personal attendant services will begin providing services within 10 calendar days, using the PAL to document all services provided.

If the current agency providing personal attendant services is unable to meet this timeline, they must request an emergency transfer unless the member has informal supports in place to safely wait for provider staffing. When a member is placed in a health and safety risk due to the lack of service provision, a referral to APS for neglect must be made.

ADW services not provided as scheduled on the Service Plan cannot be made up on a different day. (Traditional Model) Any changes in scheduled services must be approved in advance by the RN who then notifies the Case Manager in the traditional model. In the *Personal Options*, services not provided as

planned, may not be carried over into a new month. The resource consultant will need to inform the case manager.

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

501.18 COVERED SERVICES

The following services are available to people receiving ADW services if they are deemed necessary and appropriate during the development of and listed on their Service Plan:

- Case management
- Personal attendant
- Skilled nursing – assessment and ongoing assessment/supervision
- Non-medical transportation
- PERS

501.19 CASE MANAGEMENT

Case management activities are indirect services that assist the member in obtaining access to needed ADW services, other State Plan services, as well as medical, social, educational, and other services, regardless of the funding source. Case management responsibilities include the development of the Service Plan, monthly phone calls, quarterly home visits, the completion of the assessment, the ongoing monitoring of the provision of services included in the Service Plan, quality of services provided, monitoring continued eligibility, health, safety welfare, requested and needed transfers, and advocacy.

Case management includes the coordination of services that are individually planned and arranged for people whose needs may be lifelong. 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. This involves collaboration with the member, family members, friends, informal supports, and health care and social service providers as warranted.

Case management services are provided to all members on the ADW program. The cost of the service does not reduce the amount of personal attendant services in either the Traditional Model or *Personal Options*.

501.19.1 Case Management Services

Procedure Code: G9002 U1
Service Unit: All Case Management services provided within one calendar month.
Service Limit: **One Unit per month.**
Reimbursed at a monthly rate.

Prior Authorization Required: No

Documentation Requirements: All contacts with, or on behalf of a member, must be legibly documented within the member's record, including date and time of contact, a description of the contact, and the

signature of the case manager. The case manager must contact the member (or legal representative if the member is unable to respond to questions), once per month via call, face to face visit quarterly, and document the contact on the Case Management Monthly Contact Form. Case management agencies may not bill for transportation services. The case manager must complete the Initial Contact form for a member new to the program and the Monthly Contact Form for documentation of required monthly contact with the member. The case manager may utilize the Case Management Recording Log for documentation of contact needed outside of the Initial Contact form and the Monthly Contact form.

Resource consultants working for the F/EA are not case managers.

Case managers will also participate in the use of EVV for quarterly home visit verification.

501.19.2 Case Management Case Loads

Each provider must assure that there is an adequate number of qualified case managers for the number of people served. All ADW provider agencies will determine case load totals based on the member's geographic location and level of member need. Case load amounts will be reviewed by BMS through reports from KEPRO and claims reporting. If it appears that case load amounts are too large, the ADW agency may be contacted and requested to adjust current case- loads.

501.19.3 Case Management Responsibilities

The case manager is responsible for follow-up with the member to ensure that services are being provided as described in the Service Plan. Initial contact, via telephone or face-to-face, must be made within seven calendar days after Personal Attendant Services have begun. At a minimum, a monthly telephone contact and a quarterly home visit (verified by EVV) must be conducted to ensure services are being provided and to identify any potential issues. Monthly telephone contacts must be documented on the Case Management Monthly Contact Form and include detailed information on the status of the member in the comment section.

If a member (or legal representative) cannot be reached by telephone for the monthly contact, the case manager must attempt to reach the member's individual (s) listed on the member's 24-hour emergency back- up plan within one business day of not being able to reach the member. In addition, the case manager will contact the personal attendant provider agency or the F/EA resource consultant to see if there has been any disruption of services. Within 48 hours from the initial attempt to contact the member, if no contact has been received from the member or their contact person, a 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 and documented. 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. Monthly contact should at a minimum, confirm that the member is receiving services as required by his/her Service Plan and ensure the member's health and safety. In addition to quarterly face to face visits and monthly contacts, the case manager must complete a six-month Person-Centered Assessment and Service Plan. These must also be a face-to-face home visit with the member.

Case managers will also participate in the use of EVV for quarterly home visit verification.
Specific activities to assure that needs are being met also include:

- Assure financial eligibility remains current.

- Assure the health and welfare of the member.
- Annually submit the MNER to the UMC in accordance with policy timelines.
- Address changing needs of the member as reported by them (or legal representative), Personal Attendant staff and/or RN, resource consultant, if applicable or informal supports.
- Address changing needs determined by the monthly contact and/or quarterly face to face visit.
- Refer and procure any additional services or resources needed.
- 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 (or legal representative), the case manager, the RN, and the resource consultant when applicable be present at the 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, including TMH transition navigators if applicable and *Personal options* resource consultant if applicable within seven business days.
- Provide copies of all necessary documents to the member. and the Personal Attendant service provider agency or *Personal Options* Resource Consultant.
- Coordinate and process all requested, required due to agency closure, and/or emergency transfers. This includes coordination of the transfer to include arranging for agencies to provide services and determine transfer effective date.
- Submit West Virginia Personal Care Request for Dual Services as needed.
- At a minimum, upload the following documents into the UMC web portal: MNER, Service Plans, assessments, legal representative information, WV Personal Care Dual Services Request Form (if applicable) and any other pertinent information.
- Assist with filing grievances, complaints, fair hearing request.
- Make fraud and abuse/neglect referrals as needed.
- Assist with obtaining legal representation when needed, such as medical power of attorney, health care surrogate, etc.
- Ensure services were provided in accordance with the Service Plan.
- Evaluate social, environmental, service, risks, and support need of the individual.
- Develop and write an individualized Service Plan which details all services that are to be provided including both formal, informal (if available) and State Plan or other agency services that will assist the member to achieve optimum function.
- Ensure no duplication of services.
- 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 facilities and resources, and accessibility to services.
- Ensure that a member's (or legal representative) wishes, and preferences are reflected in the development of the Service Plan by working directly with the member (or legal representative) and all service providers.
- Assure that a member's legal and human rights are protected.
- Follows up on all service delivery concerns within two business days and document in the WV IMS.
- Monitor the member's risk management, safety, and welfare. Notify the OA, personal attendant agency, and resource consultant if applicable of concerns.

- Explain person centered planning along with the roles and supports that will be available through each service delivery model.
- Ensure that the member knows how and when to notify the case manager about any operational and support concerns or questions.
- Notify the personal attendant agency, resource consultant (if applicable) of concerns regarding potential issues which could lead to a member disenrollment.

501.19.4 Case Management Reporting

The case management agency will complete and submit all required administrative and program reports as requested by either the BMS or the OA.

501.20 PERSONAL ATTENDANT

Personal attendant services are defined as long-term direct care and support services that are necessary 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 direct care services to a member. However, per Section 501.2.3.3 Initial/Continuing Certification of Providers, providers are to provide staffing in the evenings and weekends, based on the member's needs. Therefore, before a second personal attendant agency is contacted to provide services, the personal attendant agency must contact the OA to explain why a second agency is necessary. The OA must approve the second personal attendant agency before the process continues. The agency the member 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. The primary agency must coordinate the billable nursing units. There cannot be a duplication of services.

501.20.1 Personal Attendant Services

Traditional Model Procedure Code

Personal attendant not living in home with member:	S5130
Personal attendant living in home with member:	S5130 UK

***Personal Options Model* Procedure Code**

Personal attendant not living in home with member**:**	S5130 U1
Personal attendant living in home with member:	S5130 U1 UK

Ratio: 1:1
Service Unit: 15 minutes
Service Limits: Determined by Service Level Criteria and Service Level Limits
Prior Authorization Required: Yes

Documentation Requirements: All services provided to a member must be legibly documented on the Service Plan and maintained in the member's record.

Personal Attendants will also participate in EVV requirements.

501.20.2 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 such as changing linens, meal preparation and light housekeeping such as sweeping, mopping, dishes, and dusting. All incidental services are intended to maintain the member in his/her home. The scope of personal attendant service may include performing incidental services however, such activities may not comprise the entirety of the service. personal attendants may also assist the member to complete essential errands, community activities, and supervision of health and welfare risk factors in the home and community. The member must accompany the personal attendant on all community activities. When able and if available, informal supports may be utilized to assist with essential errands and community outings. If the informal support is also the personal attendant, they may bill ADW transportation for the provision of these services if completed during plan hours. The same guidelines regarding the provision of these services would be the same for the informal supports. All services provided must appear on the Service Plan and must be fully documented on required forms and comply with the BMS documentation standards, including form instructions. The personal attendant must inform the RN of any changes in the member's health, safety, or welfare. Personal attendants must complete all required ADW training per the BMS policy.

Personal attendant services can be provided on the day of admission and 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 ADL:

- Bathing
- Grooming
- Dressing
- Eating/meal preparation
- Toileting
- Transferring
- Mobility
- Supervision

Personal attendants may provide supervision to the member if she/her requires prompting and observation for safety reasons for ADLs/Instrumental Activities of Daily Living (IADLs). Supervision may also cover communication and cognitive exercises.

Essential Errands: Essential errands are activities that are essential for the member to live as independently as possible and remain in his/her own home. Essential errands involve going outside of the member's home for the purpose of conducting the errand with the member or on behalf of the member (when the member is unable to travel outside the home). Examples of essential errands include grocery shopping, banking, picking up prescriptions, going to the laundromat. The case manager must document on the Service Plan 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 supports, family, friends, or other resources are available, these resources must be utilized before personal attendant services. The informal support availability must be addressed in the service plan. Special caution is advised for those people 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 member's immediate community unless a need is otherwise identified and documented on the Service Plan. The essential errand must be fully documented per the PAL.

Activities include, but are not limited to, the following types of IADL for essential errands for the benefit of the member:

- 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 send/receive mail.
- Assistance with DHHR for benefits or financial eligibility

Family-paid personal attendants will not be able to take the member 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 attendants could not bill to take the member to visit their parent in their own residence/nursing home/hospital. However, a non-family member paid personal attendant could 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).

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 the member to have the opportunity to interact with others in their immediate community and utilize community resources where other individuals without a disability or aging might go and engage in community life. The member's immediate community is a 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 supports, family friends or other resources are available, these resources must be utilized before personal attendant services. The Service Plan should address informal support availability for such activities. Special caution is advised for those people 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. Community activities may not exceed 20 hours per month. The community activity must be fully documented per the PAL.

Activities may include but are not limited to, the following:

- 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 needs as outlined on the Service Plan must take place before essential errands or community activities can occur.

The personal attendant must also document on the PAL the time the services were provided. Personal attendant staff cannot perform any service that is considered a professional skilled service or any service that is not on the Service Plan.

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.
- Injection of any medication including insulin.
- Administer any medications - prescribed over the counter. This would include placing medication in the member's mouth (this would exclude the use/administration of an epi-pen as this would be allowed).
- Perform catheterizations, apply external (condom type) catheter.
- Tube feedings of any kind.
- Make judgments or give medical advice.
- Application of heat or cold
- Nail trimming if the member is a diabetic.

If at any time a personal attendant is witnessed to be, or suspected of, performing any prohibited tasks, the personal attendant RN, ADW case manager, and the *Personal Options* vendor (if applicable) must be notified immediately.

501.21 SKILLED NURSING

Skilled nursing care is health care given when a member needs skilled nursing staff (RN) to manage, observe, and evaluate care. Skilled nursing care requires the involvement of skilled nursing staff to be given safely and effectively.

501.21.1 Skilled Nursing Annual Assessment

Traditional Model Procedure Code: T1001-UD
Service Limits: One event per calendar year (January - December)
Prior Authorization Required: No

Documentation Requirements: The RN Initial and Annual Person-Centered Assessment.

501.21.2 Skilled Nursing Services

Traditional Model Procedure Code: T1002-UD
Service Unit: 15 minutes
Service Level: Six units per month (One of the six units per month can be utilized for review/ approval of the PAL and all other units billed must be from the RN responsibilities and billable activities list in in this section).
Prior Authorization Required: No

Documentation Requirements: All contacts (except for the six month and annual visits) with, or on behalf of, a member receiving ADW services must be documented using the RN Contact Log and maintained in the member's record.

One unit of nursing services per month can be utilized for review of the PALs to assure services were provided as planned, signed, and dated by the personal attendant and the member, certifying the reported information is complete and accurate.

One-time changes to planned activities must have prior approval by the RN and noted in the comment section of the PAL. Example: The member requires service to begin at 9:00 am due to an appointment. The plan is for the member's service to begin at 10:00 am. The request is made by the ADW recipient. The RN informs the personal attendant of the planned schedule change and a notation is made by the RN or personal attendant in the comment section of the PAL.

The RN responsibilities and billable activities are as follows:

- Attend the Initial, six-month and Annual Service Plan meeting.
- If requested by the member (or legal representative), attend the member's ADW medical eligibility appointments with the UMC.
- Initiate services within three business days if the case management agency develops an Interim Service Plan.
- Make a home visit with the ADW recipient and personal attendant within 30 calendar days after personal attendant services begin.
- Complete a RN Assessment within six months from the date of the Initial or Annual RN Assessment.
- Based on discharge orders from an acute care hospital, nursing facility, or other residential setting indicating a change in member's condition, complete a RN Assessment, to determine the needed changes to address the discharge orders in the Service Plan. The RN must notify the case manager if additional services or changes in services are needed (notification of the case manager is an administrative duty and is not billable) so the case manager can amend the plan if necessary.
- Review and approval of the PALs to assure services were provided as described in the Service Plan and completed per policy before submitting billing under approved personal attendant allowable codes list in ADW manual section 501.20.1
- Provide member-specific training to personal attendants. This training may be counted under the additional four hours of training requirement. Refer to Section 501.5.4, Personal Attendant Initial

Training Requirements and Section 501.5.5, Personal Attendant Annual Training Requirements of this Chapter.

- Pre-fill the member's medication box monthly if ordered by an MD, PA, or Adult Nurse Practitioner (ANP) per written prescription. Documentation to support the need for this service must be included in the Service Plan and Assessment to substantiate the need. Example: The ADW recipient has Rheumatoid Arthritis in left and right hand/fingers and unable to open a medication bottle. No pharmacy prepackaging services available. No family, friends, or other informal support to assist.
- The RN must attend the initial, six-month, and annual dual services planning meetings with the case manager and the personal care RN. (Refer to Section 501.28, Dual Provision of ADW and Personal Care (PC) Services).
- Compile, prepare, and submit material that can be used to assess an ADW recipient's need for an increase in their Service Level. Service level changes can only be requested for members at Service Level A, B, or C, and only when there is a substantial change in the member's medical condition. A Request for Service Level Change must be completed and submitted to the UMC with clinical documentation sufficient to support the request, which may include applicable test results from the physician, PA, ANP, or hospital discharge summary. These documents must be on the professional's letterhead and/or dated no later than one month prior to, or one month following, the request for an increased service level. Any verbal or telephonic statements; or letters from family, neighbors, friends, or Case Management and Personal Attendant staff will not be considered without attached physician's documentation or a facility discharge summary. The Service Level Request form must be signed by both the RN and the ADW recipient (or legal representative). Original signatures are required, i.e., "signature of member on file" is not acceptable. This request may or may not result in a change in the Service Level.
  Notice of the determination will be sent to the ADW recipient (or legal representative), Case Manager and RN if applicable.
- People receiving ADW services who are appealing a denial of medical eligibility will remain at their current Service Level pending a Fair Hearing decision if the request was made within 13 days of the denial letter date. The UMC will not review a request for an increased Service Level for ADW recipients appealing a denial of medical eligibility.

The following skilled nursing services are not approved billable services. These include but are not limited to:

- IV Therapy
- Venipuncture
- Dressing changes
- Suctioning.
- Insertion of any catheter.

Administrative duties are not billable. These include but are not limited to:

- Sending copies of any assessments to the people receiving ADW services (or legal representative) or the case management agency.
- Notifying the case management agency if an ADW recipient has been admitted to or discharged from an acute care hospital, nursing home, or other residential facility.
- Being available to the Personal Attendant for consultation and assistance at any time when the personal attendant is providing services.

- Completing and submitting required program reports to the BMS, the OA, or the UMC.
- Telephone calls.

501.22 NON-MEDICAL TRANSPORTATION

Non-medical transportation provides reimbursement for Personal Attendants that perform essential errands and/or community activities for/or with a member. (See Section 501.20.2, Personal Attendant Responsibilities 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 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. Essential errands should be completed before mileage is used for community activities to ensure the member's needs are met.

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

The case manager must document on the Service Plan the availability of the member's family, friends, or other community agencies to provide transportation first. Special caution is advised for those people 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 to people residing in a county bordering another state.

Non-medical transportation services can be used to transport members to health care appointments not covered by Medicaid. If there is another funding source that can be billed for transportation such as VA, then VA funding must be used to pay for the transportation first.

NEMT service is available through the Medicaid State Plan for transportation to and from Medicaid paid medical appointment and must be utilized.

Non-medical transportation cannot be used to transport people on the ADW program to any Medicaid paid medical appointment.

501.22.1 Non-Medical Transportation Services

Traditional Model Procedure Code:	A0160 U5
***Personal Options Model* Procedure Code:**	A0160 U4
Service Unit:	One unit - One mile
Service Limit:	300 units per calendar month
Prior Authorization:	Not Required

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 and PAL must document the purpose of the travel and the destination. The personal attendant must document on the PAL accurate miles traveled, exact location of the destination and reason for the travel. Those using *Personal Options* will submit and invoice the *Personal Options* vendor.

501.23 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

Any ADW member wanting a PERS unit will be given the opportunity to be provided this service. The ADW personal attendant agency and the F/EA when applicable will provide the service at the request of the member. Any member that it is felt would benefit from the service, will also be approached by the case manager, personal attendant agency, or F/EA to see if they would be interested in having this service provided.

The PERS vendor 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, 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 U6
***Personal Options Model* Procedure Code**:	S5161 U6 UK
Service Unit:	1 unit – 1 per month
Service Limit:	12 Month Calendar Year
Prior Authorization:	Not Required

Documentation Requirements: The ADW personal attendant or the F/EA when applicable will chose the PERS vendor(s) to provide the service for the member that has indicated or needs the service to remain safe in the community. The service provision will be documented in the service plan by the case manager and the personal attendant and F/EA when applicable will submit billing. This fee is up to $50/month and the agency should only bill the actual costs.

501.24 TRANSITION SERVICES

Transition services support individuals transitioning from nursing facilities, hospitals, and Institutions for Mental Diseases (IMDs) to their own home or apartment in the community. The provision of transition services is individualized, based on a comprehensive transition needs assessment conducted by a transition coordinator in collaboration with the individual, nursing facility staff, and other individuals identified by the member to participate in the transition process. Transition services and other waiver, as well as non-waiver services and supports, are incorporated into a transition plan, and approved by the transition manager.

These services include:

- Pre-Transition Case Management: To develop a Waiver Participant Interim Service Plan and ensure that the needed community services and supports are in place the first day the participant returns to the community; and

- Community Transition Services: One-time expenses that address identified barriers to a safe and successful transition from facility-based living to the community.

501.24.1 Pre-Transition Case Management

Procedure Code: T1016 U1
Service Unit: 15 minutes
Service Limit: 24 units
Prior Authorization: Required

Service Definition: The purpose of the pre-transition case management service is to ensure that waiver services are in place the first day of the participant's transition to the community. Prior to the participant'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 supports needs are thoroughly considered in transition planning,
- Conduct the assessments 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 ADW 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 direct-care services are in place the first day the resident returns home,
- Enroll the participant 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.

Limits

Individuals eligible to receive this service:

- Live in a nursing facility, hospital, IMD (within the allowable age guidelines), or a combination of any of the three for at least 60 consecutive days; and
- Have been determined medically and financially eligible for the ADW 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 transition to community living safely and successfully; 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 the TMH 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 501.5.1, Case Manager Qualifications.

501.24.2 Community Transition Services

Procedure Code: T20208 U1
Service Unit: Unit = $1.00
Service Limit: 4000 units
Prior Authorization: Required

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 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 expense; 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

The total expenditures 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.
- Travel
- Vehicle expense including 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.), or
- Discretionary cash
- Assistive technology
- PERS
- Equipment
- Specialized Medical Supplies
- Transportation

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.

For individuals ages 22-64 transitioning from an Institution for Mental Disease (IMD), the individuals will not receive community transition services because Federal Financial Participation (FFP) is not permitted for services rendered to individuals in this age range while they are in an IMD.

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.

501.25 BILLING PROCEDURES

Claims must not 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 one claim 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 service initially and then monthly.

501.26 PAYMENTS AND PAYMENT LIMITATIONS

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

No ADW services may be charged while an individual is inpatient in a nursing home, hospital, rehabilitation facility or other inpatient medical facility, except for personal attendant services. Personal Attendant services may be provided 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-TMH members.

501.27 SERVICE LIMITATIONS AND SERVICE EXCLUSIONS

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 ADW program services described in this chapter.

ADW services are made available with the following limitations:

- The member must live in West Virginia and be available for planned services.
- All ADW regulations and policies must be followed in the provision of the services. This includes the requirement that all ADW providers be certified by the OA in the State of West Virginia and enrolled in the West Virginia Medicaid program.
- The services provided must conform with the stated goals and objectives on the member's Service Plan; and
- Member's budgets (*Personal Options*) and limitations described in this manual must be followed.
- No duplication of services assisting members with ADL's or ancillary tasks that are being provided by another program such as but not limited to Medicare, Medicaid, VA, Worker's Compensation, some private long-term care insurances, 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.
- ADW members cannot be a paid caregiver in another waiver program or the Personal Care Services program for another program participant or family member.

- Any setting where the provider of the HCBS also owns and operates an individual's residential setting is considered a conflict of interest and therefore not in compliance with the CMS HCBS setting rule unless the provider operating the residential setting can produce a signed agreement indicating that the member can maintain their freedom of choice in regard to personal attendant services.
- Adult family care, group home, and assisted living facilities are not approved settings for ADW services.

Restrictive Intervention

ADW 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 kind, 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.

Emergency Safety Intervention

The BMS allows limited interventions of emergency safety in predictable environments for only where the member may be confused or agitated and has one or more of the following diagnoses: dementia, Alzheimer's, stroke, Parkinson's, traumatic brain injury (TBI), 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 may include alarms for doors, 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 Person-Centered Assessment and the Risk Mitigation Plan the rationale for the use of an emergency safety intervention. The OA monitoring staff will review the use of emergency safety interventions during the provider on site review.

Reimbursement for ADW 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; and
- Services that exceed service limits.

501.28 REQUESTS FOR DUAL SERVICES WITH WAIVER

Individuals who are receiving ADW services may also receive PC services if they have unmet direct support needs (above what can be provided through waiver) and meet PC criteria. The PC member must meet the maximum waiver limit criteria required to apply for dual services. This is a Level D utilizing the full 155 hours.

The use of PC services as a dual service is not intended to provide direct-care coverage 24 hours a day, seven days a week.

Though a dual PC request will include a prior authorization starting with the waiver anchor date, PC services must not be provided until medical eligibility for PC services has been approved by the UMC.

For members who access their waiver services through *Personal Options* (self-directed model) the hours of daily service must be documented on the ADW PAL. There cannot be a duplication of services. While Waiver *Personal Options* (self-directed model) services offer flexibility in scheduling, the PC Plan of Care must still meet all program criteria.
Combined Waiver/PC schedule must:

- Specify days and times each program will be used during each week.
- Specify tasks during the time they are to be completed.

Any changes to the dual services schedule requested by a member requires agreement to the changes indicated by the signatures of all waiver and PC parties on a revised dual services schedule and uploaded into the UMC web portal by the PC RN. The dual service schedule cannot be changed for the convenience of a provider agency. Please refer to the appropriate "sample dual service schedule" for the corresponding waiver program (See the BMS Personal Care Website). Any duplication/conflict of schedules will be subject to retro review monitoring.

501.28.1 Dual Service Requests for Participants Receiving ADW Services

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

- For initial PC requests, the PC applicant, ADW case manager or referent will submit an Initial PC-MNER to the UMC via fax or mail. The Case Manager will verify the ADW member is authorized to receive Level D and a Personal Attendant Log for a 155 hours per month of ADW services exists. If Waiver requirements are met, the UMC will key the ADW PAS previously completed (by the UMC) into the PC web portal and will reach out to the PC applicant to acquire their choice of PC agency in 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 member may reapply for PC if/when the member meets the Waiver requirements.
- For reevaluation requests of PC services, the PC agency will submit the Reevaluation PC-MNER and attach the PC-MNER and a copy of the ADW PAS Summary into the UMC's PC web-based PC system. The Case Manager will verify the ADW requirements are met. If Waiver requirements are met, the UMC will key the ADW PAS previously completed (by the UMC) into the PC web portal for determination of PC eligibility. If waiver requirements are not met, the request will be closed.
- If an existing PC member becomes eligible for ADW and is offered a slot but does not meet ADW requirements (Service Level D) for dual services, the member must choose between ADW or PC services. PC services are to remain in place until the ADW service begin.

Once Dual Services are approved for an ADW/PC member, the ADW Person-Centered Assessment and the ADW PAL must be used to determine the member's need for PC services. For members who receive

ADW services through *Personal Options*, the *Personal Options* Assessment and Service Plan must be used to determine a member's need for PC services. A PC RN Assessment is not required for ADW members but can be done if necessary.

- For members who receive ADW services through an ADW provider agency, the ADW case manager is responsible to coordinate and attend the service plan meeting(s) which includes the ADW Personal Attendant RN, the PC RN and the member.
- For members who receive ADW services through *Personal Options*, the PC RN is responsible to coordinate and attend the service plan meeting(s) with the member receiving ADW services, the case manager, resource consultant, and the PC RN.
- A service plan meeting between the resource consultant, if applicable, the PC RN and the case manager, must be held with the member in the member's residence.
- The PC RN is responsible to develop the PC Plan of Care. The ADW Service Plan must include the Plan of Care and a combined ADW/PC schedule as an attachment. The PC RN, ADW case manager, ADW RN, and member must agree to and sign the ADW Service Plan and attached PC POC. The ADW Service Plan, PC POC and combined ADW/PC schedule must be attached to the UMC's web portal and disseminated to all meeting attendees within 14 calendar days of the meeting.
- The combined schedule must outline when all direct support services (PC and waiver) are expected to be delivered. The PC and ADW agencies are responsible to monitor and assure that the two programs are being administered according to the member's needs including evenings and weekends, as needed.

If the ADW agency is unable to provide an ADW personal attendant for a 155 hours per month due to staffing issues, PC services can continue to allow the ADW Agency time to hire/train new staff for 30 days, so the case manager can process a transfer.

501.28.2 Dual Provision of ADW and Home Health Agency Services

Members who have been determined eligible for and are enrolled in the ADW program may receive services from a Home Health agency that do not duplicate ADW services. Home Health agency services provided to the ADW member must be coordinated by the ADW Case Manager 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 member's Service Plan. Documentation of the referral from the member's attending physician must be maintained in the member's record of both the ADW agency and the Home Health agency. Please refer to Chapter 508, Home Health Services for additional information.

501.29 VOLUNTARY AGENCY CLOSURE

A provider may terminate participation in the ADW Program with 60 calendar day's written notification of voluntary termination. The written termination notification must be submitted to the BMS claims agent and to the OA. The provider must provide the OA with a complete list of all current people and their case management agency receiving ADW services that will need to be transferred. The OA will notify the case management agencies.

The case management agency will provide selection forms to each of the agency's people receiving ADW services and explain to the member that that agency will no longer be providing ADW services.

If possible, a joint visit with the member will be made by both the agency ceasing participation and the new one selected to explain the transfer process. Services must continue to be provided until all transfers are completed by the case management agencies involved. 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.

If the provider sells their business, the members do not automatically transfer with the sale. Members must be provided freedom to choose from available ADW providers in their catchment area. Any effort to coerce a member to transfer to the purchasing ADW provider will be considered a conflict of interest. See section 501.2 (provider certification conflict of interest).

501.30 INVOLUNTARY AGENCY CLOSURE

The BMS may administratively terminate a provider from participation in the ADW 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 ADW program. After notice of intention to suspend or terminate enrollment under his/her authority, the provider may request a document/desk review. Refer to *Chapter 100, General Administration and Information*, for more information on this procedure.

Prior to closure, the provider will be required to provide the OA with a complete list of all people and the case management agencies currently on the ADW that will need to be transferred. The case manager will provide selection forms to each of the people on the agency's list that they are providing services to, along with a cover letter explaining the reason a new selection must be made. The case manager along with any needed assistance of the OA will ensure that the transfer of all people 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. 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.

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

501.31 ADDITIONAL SANCTIONS

If the BMS or the OA receives information that clearly indicates a provider is unable to serve new people due to staffing issues, health, and safety risk, etc., or has a demonstrated inability to meet recertification requirements, the BMS may remove the agency from the Provider Selection Forms and from the provider

information on the OA website until the issue(s) are addressed to the satisfaction of the BMS. Health and Safety deficiencies deemed critical may include other sanctions including involuntary agency closure. Failure to meet policy requirements will prompt the Bureau of Medical to issue a letter notifying the provider of the specific areas of noncompliance. A Corrective Action Plan will be requested from the provider to address each area of noncompliance. The provider will have fifteen days to develop a provisional Corrective Action Plan and submit to the OA and 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

Technical Assistance and Provisional Corrective Action Plan: The first step in the remediation is technical assistance which will be provided to the ADW agency by the OA and resulting in the agency developing a provisional Corrective Action Plan and implementation. Over the next 30 days targeted technical assistance will be provided to the agency and they must then submit a permanent Corrective Action Plan to the OA and BMS for approval before the end of the 30-day time frame.

- 30-Day Pay Hold: if the provider continues to be non- compliant, 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 non- compliant a census reduction up to 10% will be placed on the provider in addition to the thirty day pay hold and the census hold. The provider must submit an amended Corrective Action Plan to the OA and BMS.
- Termination of ADW Provider Status: BMS may either accept the amended Corrective Action Plan or issue a final noncompliance notification and termination of the ADW provider status.

501.32 MEMBER RIGHTS AND RESPONSIBILITIES

At a minimum, case management agencies along with resource consultants, as applicable, must communicate in writing including accessible format as requested to each member initially, upon admission to another agency (transfer), and annually the following:

Their right to:

- Transfer to a different provider agency or to *Personal Options*.
- Address dissatisfaction with services with the provider agency or the *Personal Options* agency.
- Access the West Virginia DHHR Fair Hearing process.
- Freedom from retribution when expressing dissatisfaction with services or appealing service decisions.
- Considerate and respectful care from their provider(s).
- Freedom from abuse, neglect, and exploitation.
- Participation in a person-centered planning and service delivery process.
- Confidentiality regarding ADW services.
- Access to all their files maintained by agency providers and/or the F/EA.
- Freedom from restrictive interventions including restraints and seclusion.

And their responsibility to:

- Notify the ADW personal attendant agency within 24 hours prior to the day services are to be provided if services are not needed.
- To notify case manager, personal attendant agency and/or resource consultant promptly of changes in Medicaid coverage.
- Comply with the agreed upon Person-Centered Service Plan and responsibility agreement (if applicable).
- Cooperate with all scheduled in-home visits.
- Notify the case manager, personal attendant agency, and/or resource consultant of a change in residence or an admission to a hospital, nursing home or other facility.
- Notify the case manager, personal attendant agency, and/or resource consultant of any change of medical status or direct-care need.
- Maintain a safe home environment for all service providers required to be in the home.
- Verify services were provided by initialing and signing the PAL.
- Communicate any problems with services to the case manager, personal attendant provider agency and/or the resource consultant for *Personal Options*.
- Report any suspected fraud to the case manager, personal attendant provider agency, resource consultant, or the Medicaid Fraud Unit at (304)558-1858.
- Report any incidents of abuse, neglect, or exploitation to the case manager, personal attendant provider agency, the resource consultant, or the WV Centralized Intake hotline at 1-800-352-6513.
- Report any suspected illegal activity of staff to their local police department or appropriate authority as well as the case manager, personal attendant provider agency and/or resource consultant.
- Notify case manager and resource consultant, if applicable, of any changes in their legal representation and/or guardianship and provide copies of the appropriate documentation.
- Utilize non-medical transportation support when available from family, friends, neighbors, and community agencies that can provide transportation.
- Not ask personal attendants to provide services that are excluded by policy or not on their Service Plan.
- Notify their resource consultant (if utilizing the *Personal Options* Model) within 24 hours when they terminate an employee.
- If a member is being investigated for or is in process of being closed by an agency for noncompliance or unsafe environment, they cannot transfer to another agency. If a member has had a closure due to an unsafe environment and reapplies for the ADW or other HCBS programs, the unsafe environment closure information will be shared with the selected providers.

501.33 GRIEVANCE PROCESS

Members who are dissatisfied with the services they receive from a provider agency have a right to file a grievance. All ADW agencies will have a written grievance procedure. The UMC RN will explain the grievance procedure to all applicants/people receiving ADW services at the time of initial application/reevaluation. Applicants/members will be provided with an ADW Grievance Form at that time. Service providers will only afford people 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 agency activities, nor will a personal attendant agency conduct a grievance procedure

for case management agency activities. ADW providers will also not conduct a grievance procedure for ADW contractor activities.,

A member may by-pass the level one grievance and file a level two grievance with the OA if he/she chooses especially if the grievance is related to service provision dissatisfaction for a particular ADW provider agency. 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: ADW Provider**
  - An ADW provider has ten business days from the date they receive an ADW 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 member. The agency has five business days from the date of the meeting to respond in writing to the grievance. If the member is dissatisfied with the agency decision, he/she may request that the grievance be submitted to the OA for a Level Two review and decision.
- **Level Two: Operating Agency (OA)**
  - If an ADW provider is not able to address the grievance in a manner satisfactory to the member and the member requests a Level Two review, the OA will, within ten business days of the receipt of the ADW Grievance form, contact the member and the ADW provider to review the Level One decision. Level Two decisions will be based on Medicaid policy and/or health and safety issues.

501.34 MEDICAL ELGIBILITY APPEALS

If a member/applicant is determined not to be medically eligible, a written Notice of Decision, a Request for Hearing Form and the results of the functional/medical assessment are sent by mail by the UMC to the member/applicant or their legal representative. A notice is also sent to the member's Case Manager via the UMC's web-based system. The termination may be appealed through the Medicaid Fair hearing process if the Request for Hearing form is submitted to the Board of Review within ninety days of receipt of the Notice of Decision.

If the member or legal representative 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 or their legal representative's receipt of the Notice of Decision letter. If the Request for Hearing form is not submitted within 13 days of the member or legal representative's receipt of the Notice of Decision, reimbursement for all ADW services will cease.

ADW services will cease at close of business on the thirteenth day after date of the written Notice of Decision letter if the member or their legal guardian does not submit a Request for Hearing form.

A pre-hearing conference may be requested by the member or their legal representative any time prior to the Medicaid Fair Hearing and the OA will schedule. At the pre-hearing conference, the member and/or their legal representative, the OA, and BMS will review the information submitted for the medical eligibility determination and the basis for the termination. If the member and BMS come to an agreement during the pre-hearing conference, the OA will withdraw the member's hearing request from the Board of Review. All

parties will be notified by the OA 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 is eligible financially for Medicaid services without the ADW program, other services may be available. If the termination based on medical eligibility is reversed by the hearing officer, the member's services will continue with no interruption.

In addition, the WV DHHR 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, Member 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 501.36 Discontinuation of Services).

501.35 TRANSFER TO ANOTHER AGENCY OR TO *PERSONAL OPTIONS*

A member may request a transfer to another agency or to *Personal Options* and vice versa at any time. If a member wishes to transfer to a different agency, a Request to Transfer form must be completed and signed by the member or legal representative. The form may be obtained from the case manager, personal attendant provider, the new providers, the OA, or other interested parties. Once completed and signed by the member, the form must be submitted to and uploaded into the UMC's web portal by the case manager. The case manager notifies the OA that it was uploaded. The member's case manager will then coordinate the transfer with the receiving agency, including setting the effective date and entering the transfer into the CareConnecton web portal, with assistance from the OA if necessary. For case management transfers, the effective date of transfer will be the first date of the next month if the transfer is received by the 17th of the month.

At no time should the transfer take more than 45 calendar days from the date that the member's signed, correct, and complete transfer request is received by the case manager, unless there is an extended delay caused by the member in returning necessary documents and if it is a situation in which there is difficulty finding an ADW personal attendant agency able and willing to serve the member.

Transferring Agency Responsibilities:

- Continue providing services until notified that the transfer has been completed.
- If it is a case management transfer, the case management agency must provide the receiving agency, at a minimum of three business days prior to the effective date of the transfer, a copy of the current Service Plan, Person-Centered Assessment, a copy of the enrollment confirmation and any other pertinent documentation. This will be done by ensuring the documents are uploaded in the UMC's web portal.

- If it is a personal attendant agency transfer, the personal attendant agency must provide the receiving agency, at a minimum of three business days prior to the effective date of the transfer, with a copy of the current PAS, DHS-2, the Person-Centered Assessment, and any other pertinent documentation. This will be done by ensuring the documents are uploaded in the UMC's web portal.
- Maintain all original documents for monitoring purposes.

Receiving Agency Responsibilities:

- If it is a Personal Attendant Agency transfer, Section 2 of the Person-Centered Assessment must be conducted within seven business days of the transfer effective date. When a member transfers agency, the receiving personal attendant agency cannot bill for an Initial Assessment (billing code T1001, Modifier UD) if one has been completed within the calendar year). They can bill for a RN Assessment (T1002).
- Implement the Service Plan within seven business days of the transfer effective date.
- If it is a case management transfer, Section 1 of the Person-Centered Assessment must be conducted within seven business days of the transfer effective date.
- Provide a copy of the newly developed Service Plan to the member and/or legal representative, and upload copy into web portal within seven business days.

The existing Service Plan from the transferring agency must continue to be implemented until such time that the receiving agency can develop and implement a new plan to prevent a gap in services.
A provider may not request a transfer for unsafe or non-compliance. If there is an unsafe or noncompliant issue, the provider must follow the process outlined in Section 501.36 Discontinuation of Services.

501.35.1 Emergency Transfers to Another Agency Or to *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 OA, and the case manager will take appropriate action. The case management agency, the personal attendant agency that the member is transferring from or the *Personal Options* resource consultant must submit supporting documentation via the UMC's web portal notifying the OA that it has been uploaded, that explains why the member is in emergency status. The case manager will then expedite the request as necessary, coordinating with the member and agencies involved.

501.36 DISCONTINUATION OF SERVICES

The following require a Request for Discontinuation of Services Form:

- No personal attendant services have been provided for 180 continuous days – example, an extended placement in long-term care or rehabilitation facility.
- Unsafe Environment – an unsafe environment is one in which the personal attendant and/or other agency staff are threatened or abused, and the staff's welfare is in jeopardy. This may include, but is not limited to, the following circumstances:
    - The member or other household members 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 or verbal threats to harm the personal attendant and/or other agency staff.
    - The member or other household members display an abusive use of alcohol and/or drugs and/or illegal activities in the home.
    - The ADW provider agency has been forewarned by a mental health professional/law enforcement of harm or ideations of harm by the member.
    - The physical environment of the member's home is either hazardous or unsafe.

The provider must follow the steps in the ADW Procedural Guidelines for Non-Compliance and Unsafe Closures. This can be found on the ADW website.

- The member is non-compliant with the Service Plan, the responsibility agreement (if applicable), the program requirements by policy, the Member User Guide, the member rights and responsibilities, etc.
- The member no longer desires services.
- The member no longer requires services.
- The member can no longer be safely maintained in the community with ADW program services.

If an applicant/member has received an ADW slot but does not accept the required case management services and/or will not allow a service plan to be developed, the OA will make a request for discontinuation of services and submit it to BMS for approval.
The Request for Discontinuation of Services form must be uploaded into the UMC's web portal by the case manager and a notification is sent to the OA that it has been uploaded. The OA will review all requests for a discontinuation of services. If it is an appropriate request, and the OA approves the discontinuation, the OA will send notification of discontinuation of services to the person (or legal representative) with a copy to the case management agency or FE/A). Fair hearing rights will also be provided except if the member (or legal representative) no longer desires services. The effective date for the discontinuation of services is 13 calendar days after the date of the OA notification letter if the member (or legal representative) does not request a hearing.

If it is an unsafe environment, services may be discontinued immediately upon approval of the OA and BMS, and all applicable entities are notified, i.e., police, Adult Protective Services.

When the OA receives an unsafe closure request, they will review and make a recommendation to 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 ninety 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 OA at any time during the 90 days suspension to reinstate services.
- Immediate closure.

It is the case management agency's responsibility to monitor the health and safety of the member during any time that services are suspended. In all cases, the member must be provided their right to a Fair Hearing by the OA. However, due to the nature of unsafe environment closure, the member is not 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 to the OA and a discharge request in the UMC's web-based portal:

- Death
- Moved Out of State
- Medically Ineligible
- Financially Ineligible

501.37 HOW TO OBTAIN INFORMATION

For additional information, please refer to the WV BMS ADW program website where all forms, resources, policy clarifications, and the policy manual for this program can be found.

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: Means 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 bord-approved national certification examination. An advanced practice registered nurse shall meet all the requirements set forth by the board by rue for an advanced practice registered nurse that shall include, at 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.

Amount: As it relates to service planning, the amount refers to the number of hours in a day a service will be provided. Example: Four hours per day.

Anchor Date: The annual date by which the member's eligibility for ADW services requires recertification each year. Anchor Date will be the first day of the month following the date when initial medical eligibility was determined.

Board of Review: The agency under the West Virginia DHHR and the Office of Inspector General that provides impartial hearings to people receiving Medicaid services who are aggrieved by an adverse action including denial of eligibility, eligibility terminations or denial of a covered benefit or service.

Budget Authority: People choosing *Personal Options*, the Self-Directed Model for services, have choice in the types and amounts of services, wage rates (allowed by BMS) and of their employees to meet their needs and are within their monthly 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 public such as libraries, banks, stores, post offices, etc. within a justifiable proximity to the member's geographical area. **Competency-**

Based Curriculum: A training program which is designed to give people the skills they need to perform certain tasks and/or activities. The curriculum must 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 75%. If a staff fails to meet competency requirements, the PC agency must conduct additional training and retest the staff (must score at least 75%) before the staff can work with members.

Conflict Free Case Management: Conflict-free Case Management (CFCM) requires that assessment and coordination of services be 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.

Cultural Competence: means services, support 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 member is receiving Medicaid waiver services and PC services at the same time.

Duplication of services: ADW services are one to one staff to member ratio services. No single Personal attendant can bill for more than one member during a single fifteen-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 members or funding sources).

Duration: As it relates to service planning, the duration is the length of time a service will be provided. Example: six months, three months, one month.

Electronic Visit Verification (EVV): an electronic monitoring system used to verify a personal attendant and case manager for the following: type of service performed, member receiving service, date of service, location of service delivery, individual providing service, time 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 set 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*, which receives, disburses, and tracks funds based on a member approved service plans and budgets; assists people with completing *Personal Options* 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 ADW 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. Example: Monday-Friday, daily, etc.

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 his/her medical, financial, or personal affairs and through a legal process has been deemed to be incapacitated.

Incident: Any unusual event occurring to a member 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 house cleaning, making, and changing the bed, dishwashing, and laundry for the sole benefit of the member receiving services.

Informal Support: Family, friends, neighbors, or anyone who provides a service to a member but is not reimbursed.

Instrumental Activities of Daily Living (IADL): Skills necessary to live independently, such as abilities used to shop for groceries, handle finances, perform housekeeping tasks, prepare meals, and take 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 parent of a minor child (under the age of 18) that is legally responsible to provide supports that they are ordinarily obligated to provide.

Medicaid Fair Hearing: The formal process by which a member 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, eligibility terminations or when denied a covered benefit or service. This process is conducted by an impartial Board of Review Hearing Officer.

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

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 the lack of or inadequate medical care by the service provider and inadequate supervision resulting in injury or harm to the incapacitated person. Neglect also includes but is not limited to a pattern of failure to establish or carry out a member's Service 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 dietary errors resulting in a need for treatment for the member.

Operating Agency (OA): The BMS contracted vendor responsible for day-to-day operations and oversight of the program.

Personal Attendant: The individual who provides the day-to-day care to people on the ADW waiver including both Traditional and *Personal Options* Models.

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

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 member and/or legal representative 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 Medicaid Fair Hearing.

Program Representative: An individual selected by a member using the *Personal Options* Model, to assist them with the responsibilities of self-direction.

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

Qualified Residence: ADW and Take Me Home Transition Program (TMH), West Virginia defines a "Qualified Residence" as:

- A member's own home.
- A member's family's home.
- A member's own apartment.

Quality Management Plan: a written document which defines the acceptable level of quality for an 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 fault.

Registered Nurse: A person who has graduated from a college's nursing program or from a school of nursing, passed a national licensing exam, and is professionally licensed by the West Virginia State Board of Nursing as an RN. An RN's scope of practice is determined by each state's Nurse Practice Act, which outlines what is legal practice for RNs and what tasks they may or may not perform.

Representative Sample: a small quantity of a targeted group such as customers, data, people, products, whose characteristics represent (as accurately as possible) the entire batch, lot, population, or universe.

Resource Consultant: A representative from the F/EA's FMS who assists the member and/or their legal/non-legal representative who choose this Participant-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 member with locating staff, helping to complete required paperwork for this service option; and helping the member select a representative to assist them, as needed.

Responsibility agreement: Agreement between the ADW member and the provider agency. The agreement must address the specific actions/outcomes that are expected by the member for services to continue.

Room and Board: (BCF-SFCP policy definition 8/26/2015) Room and board services are defined as provision of food and shelter including private and common living space: linen, bedding, laundering, and laundry supplies, housekeeping duties and common lavatory supplies (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 member.

Sexual Abuse: Any act towards 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 his/her 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.

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

Social Worker: A social worker is a helping professional that focuses on both the individual and his or her environment. To work in the ADW program, a Social Worker must hold a Regular Social Work License. For more information please visit the WV Board of Social Work Licensure website

Spending Plan: The spending plan is a budgeting tool used in the *Personal Options* Model to help people accurately plan how, and when their budget will be used.

Transfer: Changing the provider from which a member is receiving services to another provider or changing service delivery model from Traditional to *Personal Options* 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.

Utilization Management Contractor (UMC): The UMC is authorized to grant prior authorization for services provided to people enrolled in the West Virginia Medicaid ADW program. The UMC utilizes nationally recognized medical appropriateness criteria established and approved by the BMS for medical necessity reviews.

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

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

CHANGE LOG

SECTION	DESCRIPTION	EFFECTIVE DATE
Entire Chapter	Aged and Disabled Waiver (ADW)	December 1, 2015
Take Me Home	ADW	January 1, 2019
Overview	ADW	January 1, 2019

Pre-Transition Case Management	ADW	January 1, 2019
Community Transition	ADW	January 1, 2019
501.4 and 501.5	Addition of Electronic Visit Verification (EVV) as required by 21st Century CURES Act.	April 1, 2021
501.2	Addition of requirement for Conflict-Free Case Management (CFCM)	April 1, 2021
501.23	Addition of Personal Emergency Response System service for Traditional and *Personal Options* members	April 1, 2021
501.22.1	Addition of modifier to Transportation service code	April 1, 2021
501.19.1	Addition of modifier to Case Management service code	April 1, 2021
501.19.2	Removal of Case Management caseload limit requirement	
501.20.1	Addition of Traditional and Personal Options service codes with UK Personal Attendant	April 1, 2021
501.27	Addition of limitation on restrictive interventions	April 1, 2021
Entire manual	Changed “person” to “member” throughout manual.	April 1, 2021
501.19.1	Addition of requirement for Case Manager to conduct quarterly visits in member’s home	April, 2021
501.21	Removal of Personal Options Skilled Nursing services	April 1, 2021
501.20.2	Addition of member supervision as a billable Personal Attendant service	April 1, 2021
501.31	Addition of progressive sanctions for agencies cited for failure to comply with policies	April 1, 2021
501.2	Clarification of requirements when a certified agency is sold.	April 1, 2021
501.14	Addition of Case Manager’s responsibility to coordinate development of member’s service plan and member transfers to new provider agencies	April 1, 2021
501.13.2	Addition of requirement for Personal Options members to receive Case Management services	April 1, 2021
501.32	Addition of member’s responsibility to provide a safe environment for workers	April 1, 2021

501.5.1	Addition of four-year degree in Human Services field as qualification for Case Manager	April 1, 2021
501.2	Addition of Conflict-Free Case Management safeguards	April 1, 2021
501.24	Addition of service limitations and restrictions for Community Transition Services	April 1, 2021
501.16	Addition of group homes and assisted living homes restriction to service locations	April 1, 2021