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

CHAPTER 501 AGED AND DISABLED WAIVER (ADW)

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BACKGROUND

The West Virginia Medicaid program is the 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 license, utilizing professionally accepted standards of care, and in accordance with all state and federal requirements. Enrolled providers are subject to review of services provided to people enrolled in Medicaid by the BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible, and completed documentation to justify medical necessity of services provided to each person 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 at:
http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/ADWProgram/Pages/ADW-Policy-and-Forms.aspx

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

PROGRAM DESCRIPTION

The 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. The goals and objectives of the program are focused on providing services that are person-centered to promote choice, independence, respect, dignity and community integration. All members receiving services are offered, and have a right to freedom of choice of providers for services, 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 person 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 to avoid institutionalization. Individuals may not be enrolled in the ADW for the sole purpose of obtaining Medicaid eligibility.

Services are person-centered and ensures health and welfare, reasonable, and identify a person's strengths and goals. They are not to be provided for the convenience of the household or others. Although informal supports are not mandatory in the ADW program, the program is designed to provide formal support services to supplement, rather than replace the person's existing informal support system.

ADW services include:

- Case Management
- Personal Attendant Services
- Skilled Nursing, and
- Non-Medical Transportation Services.

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 their service levels. In *Personal Options*, members are able to 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 on a monthly basis, unless temporarily in a nursing home, hospital, or other inpatient medical facility.

TAKE ME HOME, WEST VIRGINIA (TMH) OVERVIEW

Individuals wishing to transition from long-term facilities to the community often face numerous obstacles including lack of basic household items (including furniture), 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 the 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 Network (ADRN);
- 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 participant 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 resident'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
There are two services available to assist individuals in transitioning back to the community beginning on January 1, 2019. The two new services include:

1. Pre-Transition Case Management (Section 501.20.1): 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 501.20.2): 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 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 OA, in collaboration with the BMS, will provide answers to policy questions which will serve as policy clarifications. These policy clarifications will be posted on the BMS website at: http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/ADWProgram/Pages/Provider-Communications-and-QA's.aspx

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 person'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 persons wishing to self-direct services with employer functions; perform payroll, information, and resource functions.

The BMS contracts with ADW providers for the provision of services for people receiving ADW services. All ADW providers must be certified by the OA and enrolled as a Medicaid provider.

Please refer to the BMS website for the OA, UM, and *Personal Options* Model contact information at: http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/ADWProgram/Pages/default.aspx

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 BMS website for program contact information.

An agency may provide both case management and personal attendant services provided they maintain the following:

- A separate certification and National Provider Identifier (NPI) or each service;
- Separate staffing, for example, an agency Registered Nurse may not provide both Skilled Nursing and Case Management services for the same person; and
- Separate files must be maintained for case management and personal attendant agency services.

Conflicts of Interest

Conflicts of interest are prohibited. A conflict of interest is when the case manager who represents the person who receives services has competing interests due to affiliation with a provider agency, combined with some other action. “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.

A case manager representing the person and being affiliated with a provider agency is not by itself a conflict. However, if a case manager affiliated with a provider agency takes action on behalf of the person they represent to obtain services for the person from the company(s) with which the case manager is affiliated, or influences the Freedom of Choice of the person by steering them towards receiving services from the company(s) with which the case manager is affiliated, then a conflict of interest occurs. Case managers must always ensure any affiliation with a provider agency does not influence their actions with regard to seeking services for the person they represent. Failure to abide by this conflict of interest policy will 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 Service Coordination 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 person’s “Right to Choose (transfer).” The BMS notes that whether any action is taken would be within the sole discretion of the particular 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.

To be certified as an ADW provider, applicants must meet and maintain the following requirements:

- A business license issued by the State of West Virginia.
- 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 persons receiving ADW services, that:
    - Addresses the process for submitting a complaint.

  - Provides steps for remediation of the complaint including who will be involved in the process.
  - Steps include the process for notifying the person of the findings and recommendations.
  - Provides steps for advancing the complaint if the person/staff does not feel the complaint has been resolved.
  - Ensures that a person receiving ADW services 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;
  - 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 person's services.
- 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 person receiving ADW services.
- An Agency Emergency Plan (for people 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 person receiving ADW services is not discharged unless a viable discharge/transfer plan is in place that effectively transfers all services that the person needs to another provider(s) and is agreed upon by the person 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 mandatory training sessions.

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 Certification 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.

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 at all times 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 501.3 Agency Staff Qualifications.

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.

501.2.1.3 Employment Fitness Determination

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

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

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

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

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

501.2.1.4 Provisional Employees

Provisional basis employment for no more than 60 days may occur when:

1. An applicant does not have a negative finding on a required registry or licensure database and the employment fitness determination is pending the criminal history record information; or
2. An applicant has requested a variance of the employment fitness determination and a decision is pending.

All provisional employees shall receive direct on-site supervision by the hiring entity until an eligible fitness determination is received.

The provisional employee, pending the employment fitness determination, must affirm in a signed statement, that he or she has not committed a disqualifying offense, and acknowledge that a disqualifying offense shall constitute good cause for termination. Provisional employees who have requested a variance shall not be required to sign such a statement.

501.2.1.5 Variance

The applicant, or the hiring entity on the applicant's behalf, may file a written request for a variance of the fitness determination with WV CARES within 30 days of notification of an ineligible fitness determination.

A variance may be granted if mitigating circumstances surrounding the negative finding or disqualifying offense is provided, and it is determined that the individual will not pose a danger or threat to residents or their property.

Mitigating circumstances may include:

- The passage of time;
- Extenuating circumstances such as the applicant's age at the time of conviction, substance abuse, or mental health issues;
- A demonstration of rehabilitation such as character references, employment history, education, and training; and
- The relevancy of the particular disqualifying information with respect to the type of employment sought.

The applicant and the hiring entity will receive written notification of the variance decision within 60 days of receipt of the request.

501.2.1.6 Appeals

If the applicant believes that his or her criminal history record information within the State of West Virginia is incorrect or incomplete, he or she may challenge the accuracy of such information by writing to the State Police for a personal review.

If the applicant believes that his or her criminal history record information from outside the State of West Virginia is incorrect or incomplete, he or she may appeal the accuracy of such information by contacting the Federal Bureau of Investigation (FBI) for instructions.

If the purported discrepancies are at the charge or final disposition level, the applicant must address this with the court or arresting agency that submitted the record to the State Police.

The applicant shall not be employed during the appeal process.

501.2.1.7 Responsibility of the Hiring Entity

The WV CARES system will provide monthly rechecks of all current employees against the required registries. The hiring entity will receive notification of any potential negative findings. The hiring entity is required to research each finding to determine whether or not the potential match is a negative finding for the employee. The hiring entity must maintain documentation establishing no negative findings for current employees. **NOTE:** This includes the Office of Inspector General List of Excluded Individuals and Entities (OIG LEIE) check.

501.2.1.8 Record Retention

Documents related to the background checks for all direct-access personnel must be maintained by the hiring entity for the duration of their employment. These documents include:

- Documents establishing that an applicant has no negative findings on registries and licensure databases;
- The employee's eligible employment fitness determination;
- Any variance granted by the Secretary, if applicable; and
- For provisional employees, the hiring entity shall maintain documentation that establishes that the individual meets the qualifications for provisional employment.

Failure of the hiring entity to maintain state and federal background check documentation that all direct-access personnel are eligible to work, or employing an applicant or engaging an independent contractor who is ineligible to work may subject the hiring entity to civil money penalties.

501.2.1.9 Change in Employment

If an individual applies for employment at another long-term care provider, the applicant is not required to submit to fingerprinting and a criminal background check if:

- The individual previously submitted to fingerprinting and a full state and federal criminal background check as required by this policy;

- The prior criminal background check confirmed that the individual did not have a disqualifying offense;
- The individual received prior approval from the Secretary to work for or with the healthcare facility or independent health contractor, if applicable; and
- No new criminal activity that constitutes a disqualifying offense has been reported.

The WV CARES system retains all fitness determinations made for individuals.

501.2.2 Office Criteria

ADW providers must designate and staff at least one physical office location within West Virginia. 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 make a determination on the request and inform the provider in writing. No changes in counties served can be made unless approved by the OA.
- Providers may only add counties served two times per year - effective June 30 and December 31. Providers may discontinue serving a county at any time pending transfer of any current persons 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 call lights and 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.
- 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 (personal attendant agencies only).
- 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.

501.2.3 Quality Improvement System

The Quality Improvement System (QIS) is designed to:

- Collect data necessary to provide evidence to the Centers for Medicare and Medicaid Services (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 participant's level of care consistent with level of care provided in a hospital, nursing facility, or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).
- Qualified Providers: The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.
- Service Plan: The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.
- Health and Welfare: The state demonstrates it has designed and implemented an effective system for assuring waiver participant 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, incident management system, complaints/grievances, abuse and neglect reports,

administrative reports, the West Virginia Participant Experience Survey (PES), oversight of delegated administrative functions, and the Quality Improvement Advisory 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;
- 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 people 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 person'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 Incident Management System WVIMS *(*Refer to Section 501.4, 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 reviews 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 BMS will request reimbursement for paid claims that occurred where employee certification requirements were not met. If a lapse occurs for any checks within the WV CARES, the BMS will request reimbursement for paid claims, should any disqualifying offenses during the lapse be found. The provider must remove employees who do not meet requirements from provision of services until certification standards are met and required documentation is approved by the OA. 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.

NOTE: Continuing Certification Review Reports are not subject to document/desk reviews. All information entered into the OA web portal is entered by the provider, attested to by the provider to be complete and accurate and becomes final once submitted.

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

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 at: http://www.wvseniorservices.gov/HelpatHome/MedicaidAgedandDisabledWaiver/tabid/77/Default.aspx 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 exit summation with the agency director. Following the exit summation, the OA will make available to the provider a draft report and Plan of Correction 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 overpayment; 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 overpayment; 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, but scheduled repayments will not begin until after the document/desk review decision. 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:

Commissioner
Bureau for Medical Services
350 Capital 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.

Plan of Correction

In addition to the draft report sent to the ADW providers, the OA will also send a draft Plan of Correction (POC). The ADW providers are required to complete the POC 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 POC 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 in writing detailing the reason for the request. The POC 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 Plan of Correction will be completed; and
- Any provider-specific training requests related to the deficiencies

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.

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. ADW providers must use the approved format for submitting self-audits to the Office of Program Integrity (OPI). Failure to submit self-audits may jeopardize the future status of the ADW provider as a West Virginia Medicaid provider. ADW providers are required to send all completed forms in an electronic format to the Office of Program Integrity along with the original Excel spreadsheet and repayment forms.

For more information on self-audits and sanctions refer to *Chapter 800, Quality and Program Integrity(B).*

501.2.4 Record Requirements

Providers must fully complete all required ADW forms and follow published forms instructions. Forms and instructions can be found on the ADW website at:
http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/ADWProgram/Pages/ADW-Policy-and-Forms.aspx

Providers must meet the following record requirements:

Program Records:

- The provider must keep a file on each person they serve.
- Files must contain all original and required documentation for services provided to the person by the provider responsible for development of the document including the Service Plan, Pre-Admission Screening (PAS), the complete Person-Centered Assessment, contact notes, personal attendant worksheets, enrollment confirmation, etc.
- Original documentation on each person must be kept by the Medicaid provider for five years or three years after audits, with any and all exceptions having been declared resolved by the BMS, in the designated office that represents the county where services were provided.

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 (Registered Nurse (RN), Social Worker, 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 in the designated office that represents the county where services were provided.

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 any 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 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. Those choosing *Personal Options* and their direct care employees may access a resource consultant for OA training materials and assistance.

501.3.1 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. Documentation that covers all of 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, transcripts, 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.

501.3.2 Case Management Initial and Annual Training Requirements

- *Conflict free case management training (including a signed Conflict of Interest Statement)
- *Training on Personal Options Service Delivery Model
- *Abuse/Neglect/Exploitation identification training
- *HIPAA training
- *Person-Centered planning and Service Plan development
- 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.

501.3.3 Personal Attendant Qualifications

A personal attendant is an individual paid to provide the day-to-day care to people on 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 (PA), Health Care Surrogate or any other legal representative may provide services. However, if an MPOA, PA, Health Care Surrogate, or any other legal representative is providing services they must:

- Work for an ADW provider agency, or
- If the person self-directs, they must have a program representative that is not the MPOA, PA, Health Care Surrogate, or any other legal representative.

Personal attendants must be at least 18 years of age and have the ability to perform the tasks required for the person receiving ADW services. In addition, they must have completed the following competency based initial training before providing service and annually 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.

501.3.4 Personal Attendant Initial Training Requirements

- Cardiopulmonary Resuscitation (CPR) training – a certified trainer from the American Heart Association, American Red Cross, American Health and Safety Institute, or American CPR. Additional CPR courses may be approved by the OA. Please refer to the http://www.wvseniorservices.gov/LinkClick.aspx?fileticket=Hq0e%2fRbD%2b9w%3d&tabid=77 and ADW Program website for information.
- First Aid Training – must be provided by the agency nurse, a certified trainer or a qualified internet provider.
- Universal Precautions training.
- Personal Attendant Skills – training on assisting people with Activities of Daily Living (ADL's) – must be provided by the agency RN.
- * Abuse/Neglect/Exploitation identification training
- * HIPAA training
- 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.
- Health and Welfare for Person Receiving Services – training must be provided by the agency nurse and must include emergency plan response, fall prevention, home safety and risk management.
- * Person-Centered Planning and Service Plan Development

*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.

501.3.5 Personal attendant Annual Training Requirements

Cardiopulmonary Resuscitation (CPR), First Aid, Occupational Safety and Health Administration (OSHA), Abuse/Neglect/Exploitation Identification, and HIPAA training must be kept current.

- CPR is current as defined by the terms of the 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, 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, 2010, it will be valid through May 31, 2011).
- OSHA, 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. Specific on-the-job-training can be counted toward this requirement.

501.3.6 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 covers all of the employee's 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, transcripts, 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.

501.3.7 Registered Nurse Training Requirements

1. *Person-Centered Planning and Service Plan Development
2. 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.

501.3.8 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 person receiving services (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 at:
http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/ADWProgram/Pages/ADW-Manuals-and-Forms.aspx

501.3.9 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.

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

501.4 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.

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 person receiving ADW services and/or the staff) during the investigation. In addition, all required entities must be notified as applicable Adult Protective Services (APS), law enforcement, fraud, etc.)

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

Anyone providing services to a person on the ADW 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. You may also report suspected sexual assault and/or sexual abuse, serious physical abuse or exploitation to your 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 person receiving ADW services is considered to be neglect and must be reported to APS 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 person receiving ADW services or incidents which have caused harm or injury. It could also include any type of suspected criminal activity. For the purpose of 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 person receiving ADW services, person's families, health care providers, concerned citizens, and public agencies that compromise the health or safety of the person.
- 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 person's residence that compromises the health or safety of the person.
- Environmental/structural problems with the person's home, including inadequate sanitation or structural damage that compromises the health or safety of the person.
- Fire in the home resulting in relocation or property loss that compromises the health or safety of the person.
- 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 person receiving ADW services and/or others residing in the person's home that compromises the health or safety of the person.

- Medication errors by a person or his/her family caregiver that compromises the health or safety of the person, such as medication taken that was not prescribed or ordered for the person, 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 person receiving ADW services, including failure of person's emergency backup plan.
- Any other incident judged to be significant and potentially having a serious negative impact on the person receiving ADW services.
- Any incident attributable to the failure of ADW provider staff to perform his/her responsibilities that compromises the person's health or safety is considered to be neglect and must be reported to APS.

Simple Incidents

Simple incidents are any unusual events occurring to a person receiving ADW services 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.

501.4.1 Reporting Requirements, Incident Management Documentation and Investigation Procedures

Any incidents involving a person receiving ADW services must be entered into the West Virginia Incident Management System (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 abuse, neglect and/or exploitation 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, in addition to reporting in the WV IMS, the case manager must complete the Notification of Death form within the next business day of learning of the death of a person on the ADW, and send the form to the OA. For unexplained deaths, the case manager must report on the Notification of Death the cause of the death, source of report of the death, any action taken or not taken on behalf of the person. (i.e. CPR performed, called 911, etc.)

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 applicable. If a case manager becomes aware of an incident before the resource consultant, the agency must enter it in the WV IMS and also 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 criteria utilized for a thorough investigation include:

- 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.
- Person 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.

Unanticipated/unexplained deaths must be reported in the WV IMS within one business day of learning of the incident. This would include deaths that occur in the person's home that are not anticipated, unexplained and not medically or age related. Example: Personal attendant arrives at the person's home and finds the person deceased with no known reason.

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.

501.4.2 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.

501.5 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.
- 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 any and all exceptions having been declared resolved by the BMS, in the person's receiving ADW services 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 person 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).
- 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 Service Plan or monthly summary (visit) are to be maintained in the case management provider record.
- In the course of monitoring of the Service Plan and services, the case manager may review or request specific day to day documentation. All documentation provided must meet the criteria for documentation as indicated in the policy manual such as date, actual time of service and number of units claimed.
- Required on-site documentation may be maintained in an electronic format as long as the documentation is accessible to individuals who may need to access it.
- Electronic health record and electronic signature requirements described in *Chapter 100, General Administration and Information* of the BMS Provider Manual.

PROGRAM ELIGIBILITY AND ENROLLMENT

501.6 ADW PROGRAM ELIGIBILITY

Applicants for the ADW program must meet all of 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, as long as 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 SSI (Supplemental Security Income) 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.

Even if an individual is medically and financially eligible, a slot must be available for him/her to participate in the program.

501.7 FINANCIAL ELIGIBILITY - PRE-MEDICAL ELIGIBILITY

The financial eligibility process starts once an applicant applies to the ADW program. Within two business days after receiving a fully completed Medical Necessity Evaluation Request (MNER), the Utilization Management Contractor (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 offer assistance 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.

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. 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.

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

If the applicant has been placed on the Managed Enrollment List (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 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 sixty 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 Managed Enrollment List.

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 501.10 Enrollment) If the person has been on another waiver program, no services may be charged prior to an applicant's discharge from the other waiver program. 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: (1)Advance notice for termination is dated January 27, Medicaid would end February 28. (2) Advance notice is dated January 16, Medicaid ends January 31. This is true regardless of when ADW services end.

501.9 MEDICAL ELIGIBILITY

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

- New applicants and existing people on the ADW program are medically eligible based on current and accurate evaluations.
- Each applicant/person 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.

501.9.1 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 preparation)
b.	Bathing	Level 2 or higher (physical assistance or more)
c.	Dressing	Level 2 or higher (physical assistance or more)
d.	Grooming	Level 2 or higher (physical assistance or more)
e. f.	Continence, Bowel Continence, Bladder	Level 3 or higher; must be incontinent
g.	Orientation	Level 3 or higher (totally disoriented, comatose).
h.	Transfer	Level 3 or higher (one-person or two-person assistance in the home)
i.	Walking	Level 3 or higher (one-person assistance in the home)
j.	Wheeling	Level 3 or higher (must be Level 3 or 4 on walking in the home to use Level 3 or 4 for wheeling in the home. Do not count outside the home)
#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	

501.9.1.1 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 in order 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.

Section	Description of Points
#28	Medication Administration - 1 point for **b.** or **c.**
#34	Dementia - 1 point if Alzheimer's or other dementia
#35	Prognosis – 1 point if Terminal

Total number of points possible is 44.

501.9.1.2 Service Level Limits

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 Person-Centered 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 person reports formal personal attendant services to assist with ADLs are not needed, a request for closure must be submitted.

For persons new to *Personal Options*, the first month's budget must be prorated by the Fiscal Employer/Agent (F/EA) to reflect the actual start date of services.

501.9.2 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 (MD or DO), 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. The UMC will not process any MNER form if the referent's signature is more than 60 days old. If the MNER form is incomplete, it will be returned for completion and resubmission, 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 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 individual 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 will be notified and the UMC will issue a potential referral closure letter to the applicant (or legal representative) and the referent. If no contact is made with the UMC within 10 business days, the referral will be closed. If the applicant chooses to have the evaluation after the referral is closed, a new referral is required if the 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.

501.9.2.1 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 person may receive and a copy of the PAS, is sent to the applicant and/or legal representative/designated contact and the referent. 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 OA will be notified.

The applicant must be enrolled within 60 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 given.

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 (or legal representative) and the referring entity 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 and/or the 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 OA will be notified.

Denial

If it is determined that the applicant does not meet medical eligibility, the applicant (or legal representative) and referent 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, (or legal representative) and the referent 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.

501.9.3 Medical Re-Evaluation

Annual reevaluations for medical eligibility for each person on the ADW must be conducted. The process is as follows (as predominantly directed in 2005 Cyrus decree):

- A MNER form must be submitted to the UMC after being signed and dated by the person (or legal representative) 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 person's file. 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 person'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 person (or legal representative) 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 person.
- If the UMC makes the contact, a letter is sent to the person (or legal representative) 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 person (or legal representative) within three attempts, a Potential Closure letter will be sent to the member (or legal representative). 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 person (or legal representative). The OA, case management agency, *Personal Options* vendor, and the TMH office, as applicable will be notified. The OA will close the case.

501.9.3.1 Results of Medical Re-Evaluation

Approval

If the person meets the medical eligibility criteria, a Notice of Approved Continued Medical Eligibility is sent to the person (or legal representative). The case management agency, if applicable, the TMH office, and *Personal Options* vendor will be notified. 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.

Denial

If it is determined that the person does not meet medical eligibility the person (or legal representative) and the referent 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 person 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 person (or legal representative), and the referent 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 person wishes to contest the decision.

If the person 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 person 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 person will be notified in writing. The level change will occur on the person'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 person of the results of the medical re-evaluation, services will continue at the previous level until a decision is made.

501.10 ENROLLMENT

Once an applicant has been determined both financially and medically eligible, the case manager, if applicable, must request program enrollment from the OA by completing an Enrollment Request Form. The OA will complete the enrollment and provide a confirmation notice to the case management agency and the personal attendant agency. If the person chose *Personal Options*, the *Personal Options* program manager at the OA will be notified by the case management agency, if applicable.

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

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

The *Personal Options* vendor must maintain a file which contains the Enrollment Confirmation Notice for people choosing *Personal Options*. Initial phone contact with the person must occur within three business days of the date of the Enrollment Confirmation notice.

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

501.11 DESCRIPTION OF SERVICE OPTIONS

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

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

501.11.1 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 person's individual wishes and needs. Providers must try to match personal attendants with criteria set forth by the person receiving ADW services, i.e. person requests non-smoker. Services are provided when the person needs them, not at the convenience of the provider.

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

The Financial Management Service (FMS) Model available to persons to support their use of participant-directed services is *Personal Options*. Under *Personal Options*, the person is the Common Law Employer of the personal attendants they hire directly. The person may appoint a representative to assist with these functions, but the person remains the common law employer.

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

All personal attendants hired by the person must meet the requirements listed in Section 501.3.3, 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 persons and their representatives as appropriate.

Under *Personal Options* Fiscal Management Services (FMS) option, the person is the Common Law Employer of the
Personal attendants they hire directly. The Common Law Employer is responsible to:

- Elect the participant-directed option.
- Work with their resource consultant to become oriented and enrolled in the Participant-Directed Option, enroll personal attendants, develop a spending plan for the participant-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 person-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 attendants' daily activities.
- Evaluate their personal attendant's performance.
- Review, sign, and submit personal attendants' 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/or 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 person's budget funds (received, disbursed and any balances);
- Monitoring persons' spending of budget funds in accordance with persons' approved spending plans;
- Submitting claims to the state's claim processing agent on behalf of the person/employer;
- Processing and paying invoices for transportation and services in the person's approved participant-directed spending plan
- Assisting persons exercising employer authority;
- Assisting the person 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 support service worker the person employs);
- Assisting in submitting criminal background checks of prospective personal attendants;
- Collecting and processing support worker's timesheets;
- Operating a payroll service, (including withholding taxes from workers' pay, filing and paying Federal (e.g., income tax withholding, Federal Insurance Contributions Act (FICA), and Federal

Unemployment Tax Act (FUTA)), state (e.g., income tax withholding and State Unemployment Tax Act (SUTA)), and, when applicable, local employment taxes and insurance premiums);
- Distributing payroll checks on the person's behalf;
- Executing simplified Medicaid provider agreements on behalf of the Medicaid agency;
- Providing orientation/skills training to persons about their responsibilities when they function as the employer of record of their direct support workers;
- 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* participant.

The *Personal Options* F/EA is not the common law employer of the person's personal attendant(s). Rather, the *Personal Options* Fiscal/Employer Agent assists the person/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 participant-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 person chooses to use participant-directed services and enrolls with *Personal Options*, and,
- Skills training to assist common law employers to effectively use participant-directed services and FMS and perform the required tasks of an employer of record of personal attendants' 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 participant-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 person would stop using participant-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 persons and their representatives (when applicable) who wish to function as common law employers. The educational presentations provide interested persons with information on the role and responsibilities of *Personal Options* and each of the other interested parties (i.e., person, representative, personal attendant, and the BMS) and what is

required of the person to be a common law employer to his or her personal attendant(s). These presentations provide the venue through which a person may enroll in the participant-directed option. *Personal Options* makes available I&A supports to persons and their representatives (when applicable), to implement and support their use of participant-directed services and performing as an employer of record.

If *Personal Options* is selected by the person, *Personal Options*, rather than the case manager 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 participant-directed budget with the common law employer.
- Presenting the common law employer with the *Personal Options* F/EA's role in regards to payment for services.
- Assisting common law employers with determining participant-directed budget expenditures.
- Assisting with the development of an individualized spending plan based upon the person's annual participant-directed budget.
- Making available to the person/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 person's utilization of the participant-directed budget to the person, representative, case manager and BMS.
- Explaining all costs/fees associated with the person directing their own services.

With regard to 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* persons 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.

501.12 PERSON-CENTERED ASSESSMENT

Assessment is the structured process of interviews which is used to identify the person'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 person a good understanding of the program, services, and expectations. There are two sections to the Person-Centered Assessment: Case Management (Section 1) and RN Assessment (Section 2).

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 Person-Centered Assessment (T1001).

The Person-Centered Assessment (Section 1 and 2) must be completed at least every 6 months from the date of the initial Assessment and annually thereafter.

The case manager and RN must work together to ensure that the program meets the person's needs. They must communicate, and share information/documentation included in the Person-Centered Assessment (Section 1 and 2). Both providers are to maintain a copy of the entire Person-Centered Assessment in the person's record.

The person receiving ADW services in the Personal Option model will be contacted by the case manager, if applicable, to schedule a home visit within seven calendar days to complete the Initial Person-Centered Assessment (Section 1). If the person does not have a case manager, this does not apply.

For those choosing *Personal Options*, they may choose to use part of their budget to purchase an RN assessment, but it is not required. If they do not choose to have a nursing assessment, the resource consultant will complete the *Personal Options* Assessments in conjunction with the Case Manager, if applicable, at the initial visit.

A new assessment must be completed when a person's needs change. Changes in a person's needs are to be incorporated into the Service Plan. Case managers are to share any changes in a person'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 person (or legal representative).

501.13 SERVICE PLAN DEVELOPMENT

The case manager is responsible for development of the Service Plan in collaboration with the person (or legal representative). The meeting must be scheduled within seven calendar days of the Person-Centered Assessment (Section 1 and 2) if applicable. It is the case manager's responsibility to ensure that all assessments are reviewed with the person receiving ADW services and considered in the development of the Service Plan. If agreed upon by the person receiving services and the case manager, the Person-Centered Assessment and the Service Plan meeting may take place at the same time or sooner. The Person-Centered Assessment and Service Plan meeting cannot exceed the total timeframe of 14 calendar days without prior adequate documentation noting the delay (i.e. person is in the hospital).

Participation in the development of the initial Service Plan meeting is mandatory for the person (or legal representative), case manager and RN in the Traditional Model. For those choosing *Personal Options*, the resource consultant must be present along with the case manager, if applicable. The person (or legal representative) may choose to have whomever else they wish to participate in the process (other service providers, informal supports, etc.).

The Service Plan must detail all services (service type, provider of service, amount, frequency and duration) the person is receiving, including any informal supports that provide assistance (family, friends, etc.) regardless of the source of payment. The Service Plan must include all needs and risks identified in the PAS, the Person-Centered Assessment (Section 1 and 2) if applicable, and address the person'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 person and considered in the development of the Service Plan.

It is the Case Manager's responsibility to send a copy of the Service Plan to the person and/or their legal representative (if applicable) within seven business days from the meeting.

A copy of all Service Plans must be provided to the person (or legal representative) and the personal attendant agency and resource consultant, if applicable. The case management agency must have the original document in the person's file.

When the person receiving ADW services has a change in needs, the personal attendant Log 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, days of the week, destination for community activity or essential errands, etc.). The case manager is required to document the person's approval of the change in the plan by telephone or in person on the changed Personal attendant Log (PAL) under the comment section.

Approved minor daily changes (i.e. worker arrived at 8:00 A.M.to get the person ready for a doctor appt.) in a person'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*, if they do not have a case manager, the resource consultant is responsible for all duties related to the Service Plan.

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

Service Plan Disagreement: The person 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 person disagrees with the Service Plan. When there is a disagreement with the Service Plan, the person 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.

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

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)

501.13.1 Six-Month and Ongoing Service Plan Development

Participation in the six-month and Annual Service Plan development are mandatory for the person (or legal representative), the case manager, the RN (Traditional Model) and/or the resource consultant (*Personal Options*) as applicable. The person (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.).

501.13.2 Interim Service Plan Development

In order 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.

501.13.3 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.

501.14 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 (page 3 and 4 of the Service Plan) 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 person has informal supports in place to safely wait for provider staffing. When a person 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 in the traditional model. In the *Personal Options*, services not provided as planned, may not be carried over into a new month.

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

POLICY

501.15 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

501.16 CASE MANAGEMENT

Case management activities are indirect services that assist the person 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 also include the development of the Service Plan, 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, and advocacy.

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

Case management services are available to anyone 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*.

501.16.1 Case Management Services

Procedure Code: G9002
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 person receiving ADW services, must be legibly documented within the person's record, including date and time of contact, a description of the contact, and the signature of the case manager. At a minimum, the case manager must make contact with the person (or legal representative if the person is unable to respond to questions), once per month 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 person new to the program and the Monthly Contact form for documentation of required monthly contact with the person. 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.

501.16.2 Case Management Case Loads

Each provider must assure that there is an adequate number of qualified case managers for the number of people served. A full-time-equivalent case manager can serve no more than 75 active people on the ADW; however, in situations where a provider has a vacancy due to staff turnover, a higher case load may not be sustained for more than three months.

501.16.3 Case Management Responsibilities

The case manager is responsible for follow-up with the person receiving ADW services 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 home visit every six months must be conducted to ensure services are being provided and to identify any potential issues. Monthly telephone contact must be documented on the Case Management Monthly Contact Form and include detailed information on the status of the person in the comment section.

If a person (or legal representative) cannot be reached by telephone for the monthly contact, a home visit must be made. Monthly contact should at a minimum, confirm that the person is receiving services as required by his/her Service Plan and ensure the person's health and safety. At a minimum, the case manager must complete a six-month Person-Centered Assessment and Service Plan. This must be a face-to-face home visit with the person.

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

- Assure financial eligibility remains current.
- Submit the MNER in accordance with policy.
- Address changing needs of the person 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.
- 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 person (or legal representative), the case manager and the RN be present at the six-month Service Plan meeting and the Annual Service Plan meeting.
- Provide the Service Plan to all applicable service providers including TMH transition navigators that are providing services to the person.
- Provide copies of all necessary documents to the person receiving ADW services.
- Annually submit a MNER to the UMC.
- Submit West Virginia Personal Care Request for Dual Services as needed.
- At a minimum, upload the following documents into the UMC web portal: Enrollment Request, MNER, Service Plans, Person-Centered Assessment, 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 needs of the individual.
- Develop and write an individualized Service Plan which details all services that are to be provided including both formal and informal (if available) services that will assist the person to achieve optimum function.
- Coordinate the delivery of care, eliminate fragmentation of services, and assure appropriate use of resources.
- Proactively identify problems and coordinate services that provide appropriate high-quality care to meet the individualized and often complex needs of the person.
- Provide advocacy on behalf of the person to ensure continuity of services, system flexibility, integrated services, proper utilization of facilities and resources, and accessibility to services.
- Ensure that a person's (or legal representative) wishes and preferences are reflected in the development of the Service Plan by working directly with the person (or legal representative) and all service providers.
- Assure that a person's legal and human rights are protected.
- Follows up on all service delivery concerns within two business days and documents in the WV IMS.

501.16.4 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.

501.17 PERSONAL ATTENDANT

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

More than one personal attendant agency can provide direct care services to a person receiving services on the ADW. 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 person'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 person 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.

501.17.1 Personal Attendant Services

Traditional Model Procedure Code: S5130
Personal Options Model Procedure Code: S5130 U1
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 person on the ADW must be legibly documented on the Service Plan and maintained in the person's record.

501.17.2 Personal Attendant Responsibilities

The personal attendant's primary function is to provide hands-on personal care assistance outlined 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 person in his/her home. At no time, may the time spent on incidental services exceed the amount of time spent on hands-on personal care assistance. Personal attendants may also assist the person to complete essential errands and community activities. The person receiving ADW services must accompany the personal attendant on all community activities. 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 person's health, safety or welfare and document the person's wellness response on the ADW Wellness Scale. 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

Essential Errands: Essential errands are activities that are essential for the person who receives ADW services to live as independently as possible and remain in his/her own home. Essential errands involve going outside of the person's home for the purpose of conducting the errand with the person or on behalf of the person (when the person 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 person is unable to travel outside the home for any given period of time. 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. 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 person to avoid disallowances. Travel must be conducted in the person'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 the following types of Instrumental Activities of Daily Living (IADL) for essential errands for the benefit of the person receiving ADW services:

- 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

Community Activities: Community activities are those that offer the person receiving ADW services an opportunity to participate and integrate into their local communities and neighborhoods. The purpose of community activities is for the person 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 person's immediate community is a reasonably close proximity to the person's home. The person 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. 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 person. 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 or CD's 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.

Personal attendants shall note the condition of the person on the PAL by documenting the person's wellness response on the ADW Wellness Scale (located in the PAL). The personal attendant must also document in the PAL that a staffing ratio of 1:1 was provided (one worker to one person receiving ADW services) and the time the services were provided. Personal attendant staff cannot perform any service that is considered to be 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.
- Perform catheterizations, apply external (condom type) catheter.
- Tube feedings of any kind.
- Make judgments or give medical advice.
- Application of heat.
- Nail trimming, if the person is a diabetic.

If at any time a personal attendant is witnessed to be, or suspected of, performing any prohibited tasks, the RN or *Personal Options* vendor must be notified immediately.

501.18 SKILLED NURSING

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

501.18.1 Skilled Nursing Annual Assessment

Traditional Model Procedure Code: T1001-UD
Personal Options Model Procedure Code: T1001-U2
Service Limits: One event per calendar year (January - December)
Prior Authorization Required: No

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

501.18.2 Skilled Nursing Services

Traditional Model Procedure Code: T1002-UD
Personal Options Model Procedure Code: T1002-U1
Service Unit: 15 minutes
Service Level: Six units per month (One of the six units per month can be utilized for review and approval of the PAL
Prior Authorization Required: No

Documentation Requirements: All contacts (except for the six month and annual visits) with, or on behalf of, a person receiving ADW services must be documented using the RN Contact Log and maintained in the person'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 person receiving the services, 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 person requires service to begin at 9:00 am due to an appointment. The plan is for the person'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 person receiving services (or legal representative), attend the person'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 clinical judgment, complete a Person-Centered Assessment Section Two, to determine the need for changes in the Service Plan such as a person's change in condition following discharge from an acute care hospital, nursing facility, or other residential setting. 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).
- 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 code S5130.
- Provide member-specific training to personal attendants. This training may be counted under the additional four hours of training requirement. Refer to Section 501.3.4 and Section 501.3.5 of this Chapter.
- Pre-fill the person'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 501.24, 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.

501.19 Non-Medical Transportation

Non-Medical Transportation provides reimbursement for personal attendants that perform essential errands for/or with a person receiving ADW services or community activities with a person. (See Section 501.17.2 Personal Attendant Responsibilities for more information on essential errands and community activities).

Non-Medical Transportation must be utilized for the person’s needs and cannot be for the benefit the personal attendant, person’s family or person’s friends. Family, neighbors, friends, or community agencies that can provide this service, without charge, must be utilized first. The person may be transported by the personal attendant in order to gain access to incidental services and activities as specified in the Service Plan. Mileage can be charged for essential errands and community activities related to the Service Plan. Essential errands should be completed before mileage is used for community activities to ensure the person’s needs are met.
Non-Medical Transportation must occur in the person’s local home community unless otherwise stated in the Service Plan and must be the closest location to the person’s home.

The case manager must document on the Service Plan the availability of the person'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 person 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.

Activities that are incidental to the delivery of personal attendant Services are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for the provision.

Non-Medical Transportation cannot be used to transport people on the ADW program to any medical appointment.

501.19.1 Non-Medical Transportation Services

Traditional Model Procedure Code: A0160
Personal Options Model Procedure Code: A0160 U4
Service Unit: One unit - One mile
Service Limit: 300 units per calendar month
Prior Authorization: Over 300 units (Provided that criteria has been met and approved by the OA.)

Documentation Requirements: All transportation with, or on behalf of, the person receiving ADW services 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 to the *Personal Options* vendor.

501.20 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 person 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.

The two new services include:

1. 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
2. Community Transition Services: One-time expenses that address identified barriers to a safe and successful transition from facility-based living to the community.

501.20.1 PRE-TRANSITION CASE MANAGEMENT

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

Service Definition: This service is not available until January 1, 2019.

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 person-centered assessment as required by waiver policy;
- Complete the required waiver interim service plan;
- Facilitate the development of the assessment for those eligible for and planning to enroll in the 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, or a combination of any of the three for at least 90 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 safely and successfully transition to community living; and
- Can reasonably be expected to transition safely to the community within 180 days of initial date of transition service.

The pre-transition case management service may be billed up to 24 units (a unit is 15 minutes) only one-time following transition to the community. This service is not available once the resident transitions to the community and enrolls in the waiver. The case management agency will receive authorization for this service via the Pre-Transition Case Management Services Authorization Letter that will be sent from 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 501.3.1 with the exception that the case manager must be fully licensed as a social worker, therapist, or registered nurse.

501.20.2 COMMUNITY TRANSITION SERVICES

Procedure Code: T2028 U1
Service Unit: Unit = $1.00
Service Limit: 4000 units
Prior Authorization Required: Yes

Service Definition: This service is not available until January 1, 2019.

Community transition services are the primary waiver services available to support qualifying individuals' safe and successful transition from facility-based living to the community. Community transition services are one-time expenses necessary to support individuals 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 person 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 individuals 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 individuals 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 individual'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 participants with required utility deposits for a qualifying residence.
- Transition support: Provides assistance to help individuals with unique needs based on assessed needs and necessary for a successful transition.
- Personal Emergency Response System (PERS): One-time payment that includes initial installation upon transition to the community and service for the initial transition period (one year).
- Equipment: Items and services and necessary to enable individuals to interact more independently and/or reduce dependence on physical supports and enhance quality of life (e.g.

lift chairs, bathing aids such as handheld showers, shower chairs, transfer boards and portable showers). These items or services must be justified in the transition plan.
- Transportation: Assists participants with transportation service prior to transition in order to gain access to community activities, services and resources (i.e. food pantry). This service is used when other forms of transportation are not otherwise available. This service does not replace the Medicaid non-emergency transportation (for medical appointments) or emergency ambulance services.
- Specialized Medical Supplies: Includes purchases of various specialized medical supplies that enable individuals to maintain or improve independence, health, welfare, and safety and reduce dependence on the physical support needed from others. The service includes one-time purchases of incontinence items and food supplements needed as a bridge until Medicaid covers once the participant transitions home.

Services or supports that address an identified need in the transition plan, and decreases the need for other Medicaid services, or increase the person's safety in the home, or improves and maintains the individual's opportunities for full membership in the community may be considered.

Limits

The total expenditure for community transition services cannot exceed $4000 per transition period. community transition services cannot be used to cover the following items. **Note:** 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, spas, or any accessories, repairs or supplies for these items;
- Travel;
- Vehicle expense including routine maintenance and repairs, insurance, and fuel/gasoline;
- Internet service;
- Pet/Service/Support Care, including food and veterinary care;
- Experimental or prohibited treatments;
- Education;
- Personal hygiene services (manicures, pedicures, haircuts, etc.);
- Discretionary cash; or
- Assistive technology

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

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.

501.21 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. Billing cannot be rounded more than once within a calendar month. **The billing period cannot overlap calendar months.**

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.

501.22 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 person's discharge to ensure services are in place.

501.23 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 person receiving ADW services 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 licensed 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 person's Service Plan; and
- Person's budgets (*Personal Options*) and limitations described in this manual must be followed.

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.

501.24 DUAL PROVISION OF ADW AND PERSONAL CARE (PC) SERVICES

Approval of the provision of both ADW and PC services to the same person will be considered if the following criteria are met:

- Any PC services provided to a person receiving ADW services must be approved by the reviewing agencies (Refer to H below). The Dual Service Provision Request must be completed.
- A person must be receiving the maximum hours in Service Level D. (Otherwise, additional hours of personal attendant services may be requested through a Request for Service Level Change).
- All policy set forth in *Chapter 517, Personal Care Services*, must be followed. PC policy supersedes ADW policy for this request.
- The ADW RN requirements are not required for the ADW *Personal Options* model if not a purchased service.
- There must be a PC RN Plan of Care and an ADW Service Plan. These plans must be coordinated to ensure that services are not duplicated. PC and personal attendant services cannot be provided during the same hours on the same day. A service planning meeting between the case manager, the ADW RN, if applicable, and PC RN must be held with the person or the legal representative in the person's residence and documented on the Request for Dual Service Provision. For *Personal Options,* the meeting must include the F/EA and the participant.
- There must be a valid ADW PAS.
- In the Traditional Model, the ADW case manager is responsible for the coordination of the two services. For those using *Personal Options*, initiation of PC services is the responsibility of the resource coordinator. Coordination of the two services is the responsibility of the PC RN.
- Dual Service Provision Request Forms must be signed by the case manager, ADW RN, PC RN and the ADW recipient (or legal representative). Original signatures are required; i.e., "signature of person on file" is not acceptable. The case manager, ADW RN, PC RN must attend the initial, six-month and the annual planning meetings. Service Plans and Plans of Care copies must be provided to all parties (case manager, ADW RN and PC RN).
- All PC providers should submit requests to the UMC. Documentation submitted must include a copy of the ADW PAS and Service Plan a copy of the PC RN Plan of Care, current ADW assessment(s) and any documentation that substantiates the request. Additionally, a narrative describing how services will be utilized and verification that ADW and PC services will not be duplicated must be submitted. Approvals/denials will be based on the documentation submitted, appropriate program policy manuals, PC standards, and professional judgments. The PC RN, will receive notification of denial or approval from the reviewing agency through the UMC's web-based system. The person (or legal representative) will receive notification of denial via letter. If the request is denied or the hours approved are less than requested (or a service level change request), the notification will include Fair Hearing information.

- The BMS will conduct post-payment review of these combined services for duplication or inappropriate services. The OA and the BMS will review compliance during the agency monitoring process.

501.25 DUAL PROVISION OF ADW AND HOME HEALTH AGENCY SERVICES

People 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 person on the ADW must be coordinated by the ADW case management agency, and in general may only include skilled nursing care or therapy services for post-hospitalization stays or acute episodes of chronic conditions. The need for home health services must be documented in the person's Service Plan. Documentation of the referral from the person's attending physician must be maintained in the person's records of both the ADW provider agency and the home health agency. Please refer to *Chapter 508, Home Health Services* for additional information.

501.26 VOLUNTARY AGENCY CLOSURE

A provider may terminate participation in the ADW Program with 30 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 receiving ADW services that will need to be transferred.

The OA will provide selection forms to each of the agency's people receiving ADW services, along with a cover letter explaining the reason a new selection must be made.

If at all possible, a joint visit with the person will be made by both the agency ceasing participation and the new one selected in order to explain the transfer process. Services must continue to be provided until all transfers are completed by the OA. If a joint visit is not possible, both providers must document how contact was made with the person to explain the transfer process.

The agency terminating participation must ensure that the transfer of the person is accomplished as safely, orderly and expeditiously as possible. All program records must be made available to the BMS upon closing.

The agency must submit their final continuing certification for any part of the year they provided services prior to closing.

501.27 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 currently on the ADW that will need to be transferred. The OA will provide selection forms to each of the people on the agency's list, along with a cover letter explaining the reason a new selection must be made. 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.

All program records must be made available to the BMS upon closing.

501.28 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.

501.29 RIGHTS AND RESPONSIBILITIES

At a minimum, case management agencies or resource consultants, as applicable, must communicate in writing including accessible format as requested to each person (and/or their legal representative) receiving ADW services initially, upon admission to the 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 of their files maintained by agency providers and/or the F/EA.

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 providers and/or resource consultant promptly of changes in Medicaid coverage.
- Comply with the agreed upon Person-Centered Service Plan.
- Cooperate with all scheduled in-home visits
- Notify the ADW providers and/or resource consultant of a change in residence or an admission to a hospital, nursing home or other facility.
- Notify the ADW providers and/or resource consultant of any change of medical status or direct care need.

- Maintain a safe home environment for all service providers.
- Verify services were provided by initialing and signing the PAL.
- Communicate any problems with services to the provider agency and/or the resource consultant for *Personal Options*.
- Report any suspected fraud to the provider agency, resource consultant or the Medicaid Fraud Unit at (304)558-1858.
- Report any incidents of abuse, neglect, or exploitation to the 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 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 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.

501.30 GRIEVANCE PROCESS

People 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/people (or legal representative) 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 particular 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.

A person may by-pass the level one grievance and file a level two grievance with the OA if he/she chooses. 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 person (or legal representative). The agency has five business days from the date of the meeting to respond in writing to the grievance. If the person 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 person and the person requests a Level Two review, the OA will, within ten business days of the receipt of the ADW Grievance form, contact the person (or legal representative) 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.

501.31 MEDICAL ELGIBILITY APPEALS

If a person 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 person or their legal representative. A notice is also sent to the person'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 person 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 person 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 person 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 person or their legal guardian does not submit a Request for Hearing form.

A pre-hearing conference may be requested by the person or their legal representative any time prior to the Medicaid Fair Hearing and the OA will schedule. At the pre-hearing conference, the person 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 person and BMS come to an agreement during the pre-hearing conference, the OA will withdraw the person'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 person 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 person's services will continue with no interruption.

501.32 TRANSFER TO ANOTHER AGENCY OR TO *PERSONAL OPTIONS*

A person receiving ADW services may request a transfer to another agency or to *Personal Options* and vice versa at any time. If a person wishes to transfer to a different agency, a Request to Transfer form must be completed and signed by the person or legal representative. The form may be obtained from the current provider, the new providers, the OA or other interested parties. Once completed and signed by the person, the form must be uploaded into the UMC's web portal and the OA must be notified that it was uploaded. The OA will then coordinate the transfer and set the effective date based on when required

transfer documents are received. 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 person's signed transfer request is received at the OA, unless there is an extended delay caused by the person in returning necessary documents.

Transferring Agency Responsibilities:

- Continue providing services until the OA notifies them 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.

Note: Please refer to Section 501.2 Provider Agency Certification information on Conflict of Interest.

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 person transfers agencies, the receiving agency 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 person 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 501.34 Discontinuation of Services.

Traditional and *Personal Options* Service Model transfers are processed by the OA.

501.33 EMERGENCY TRANSFERS TO ANOTHER AGENCY OR TO *PERSONAL OPTIONS*

A request to transfer that is considered an emergency, such as when a person receiving ADW services suffers abuse, neglect, or harm, or a health and safety risk, including inability to provide services, will be reviewed by the OA, and the OA will take appropriate action. The case management agency, the personal attendant agency that the person 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 person is in emergency status. The OA will expedite the request as necessary, coordinating with the person and agencies involved.

501.34 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 person receiving ADW services or other household members repeatedly demonstrate sexually inappropriate behavior; display verbally and/or physically abusive behavior; and/or threaten a personal attendant or other agency staff with guns, knives, or other potentially dangerous weapons, including menacing animals or verbal threats to harm the personal attendant and/or other agency staff.
    - The person or other household members display an abusive use of alcohol and/or drugs and/or illegal activities in the home.

    The provider must follow the steps in the ADW Procedural Guidelines for Non-Compliance and Unsafe Closures. This can be found at: http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/ADWProgram/Pages/ADW-Manuals-and-Forms.aspx.
- The person is persistently non-compliant with the Service Plan.
- The person no longer desires services.
- The person no longer requires services.
- The person can no longer be safely maintained in the community.

The Request for Discontinuation of Services form must be uploaded into the UMC's web portal 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 person (or legal representative) no longer desires services. The effective date for the discontinuation of services is thirteen calendar days after the date of the OA notification letter, if the person (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 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 person receiving ADW services 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 person receiving services during any time that services are suspended. In all cases, the person receiving services must be provided their right to a Fair Hearing by the OA. However, due to the nature of unsafe environment closure, the person 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

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.

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.

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

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

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.

Days: Calendar days unless otherwise specified.

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

Dual Services: When a person receiving services is receiving Medicaid Waiver services and Personal Care services at the same time.

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.

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 persons 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 (LTCF).

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 person that needs to be recorded and investigated for risk management or quality improvement purposes.

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

Informal Support/Informals: Family, friends, neighbors or anyone who provides a service to a person 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)]

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.

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.

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 person’s Service Plan that results in negative outcome or places the person 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 person.

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 person 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 person receiving Medicaid services 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 person receiving ADW services 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 person by a specified provider before services can be rendered, billed, and payment made.

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

- A person's own home;
- A person's family's home;
- A person's own apartment, or
- Certain group homes with four or fewer people.

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. A 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 person receiving services 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 person with locating staff, helping to complete required paperwork for this service option; and helping the person select a representative to assist them, as needed.

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

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 at: http://www.wvsocialworkboard.org/Licensure/TypesofSocialWorkLicenses/RegularLicense.aspx#.VXHkM3fD98Q

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 person is receiving services to another provider or changing service delivery model from Traditional to *Personal Options* or vice versa

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

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

REPLACE	TITLE	CHANGE DATE	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

THE SECTIONS BELOW ARE TO BE REMOVED FROM THE PUBLISHED VERSION THEY ARE FOR INTERNAL BMS USE ONLY AND NOT FOR DISTRIBUTION

POLICY METADATA

Policy ID = 501
Policy Author = Home and Community Based Services (HCBS)
Policy Status = Published
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Initial Effective Date = Date.
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POLICY INTENT

COVERED SERVICES

CPT CODE	CPT CODE DESCRIPTION
A0160	Transportation case worker per mile
A0160-U4	Transportation case worker per mile PO
G9002	Case management, each 15 minutes
S5130	Personal attendant care services; per 15 minutes
S5130-U1	Personal attendant care services; per 15 minutes PO
T1001-UD	Skilled Nursing Assessment
T1001-U2	Skilled Nursing Assessment PO
T1002-UD	Skilled Nursing
T1002-U1	Skilled Nursing PO

CONFIGURATION OVERVIEW

The Policy Intent Worksheet for this policy is available here in the Policy Folder.

The Configuration Spreadsheet for this policy is available here in the Policy Folder.