CHAPTER 502 CHILDREN WITH SERIOUS EMOTIONAL DISORDER WAIVER (CSEDW)

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BACKGROUND

The Bureau for Medical Services (BMS, hereafter also referenced as WV, the State) in the West Virginia Department of Health and Human Resources (DHHR) is the single state agency responsible for administering the Medicaid Program. The West Virginia Medicaid Program is administered pursuant to provisions of Title XIX of the Social Security Act and *Chapter 9 of the West Virginia Code*.

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 Medicaid members 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 Medicaid member and made available to the BMS or its designee upon request.

This chapter sets forth requirements for payment of services provided under the Children with Serious Emotional Disorder Waiver (CSEDW) program to eligible West Virginia Medicaid members. These members may or may not be eligible for other Medicaid covered services found in other chapters of the BMS Provider Manual. Any service, procedure, item, or situation not discussed in this chapter must be presumed non-covered under the waiver.

All Medicaid enrolled providers should coordinate care if a Medicaid member receives different Medicaid services at different locations with other providers to help ensure that quality care is taking place and that safety is the forefront of the member's treatment.

PROGRAM DESCRIPTION

The CSEDW is a Medicaid Home and Community-Based Services (HCBS) waiver program authorized under §1915(c) of the Social Security Act. The CSEDW provides services that are additions to Medicaid State Plan coverage for members ages three (3) to 21 who are enrolled in the CSEDW program. The CSEDW permits West Virginia to provide an array of HCBS that enables children who would otherwise require institutionalization to remain in their homes and communities.

This waiver prioritizes children/youth with serious emotional disorder (SED) who are:

1. In Psychiatric Residential Treatment Facilities (PRTFs) or other residential treatment providers either out-of-state or in-state; and
2. Other Medicaid-eligible children with SED who are at risk of institutionalization.

It is anticipated that this waiver will reduce the number of children placed both in-state and out-of-state in PRTFs and shorten the lengths of stay for children who require acute care.

West Virginia defines the term "children with a serious emotional disorder" (CSED) as children with an SED who are ages three (3) to 21 and who currently have or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM) (or International

Classification of Disease (ICD) equivalent) that is current at the date of evaluation and results in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, and/or community activities.

The CSEDW provides services to children with serious emotional disorders based upon the National Wraparound Initiative model. This model is strengths-based, meaning it uses the strengths of families and individuals as a starting point for growth and change, with a goal of helping waiver members and their families develop skills to cope with challenges and stabilize children in their homes. The model is also centered around the needs of the child and their family in that the child experiencing challenging behaviors is central to the process and engaged in a plan to help develop the skills necessary to achieve stability and improve coping strategies, ideally enabling the child to achieve their personal goals. There are 10 principles of the wraparound process, they are:

1) **Family voice and choice.** Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.
2) **Team based.** The wraparound team consists of individuals agreed upon by the family and committed to the family through informal, formal, and community support and service relationships.
3) **Natural supports.** The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.
4) **Collaboration.** Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.
5) **Community based.** The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.
6) **Culturally competent.** The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/ youth and family, and their community.
7) **Individualized.** To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.
8) **Strengths based.** The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.
9) **Unconditional.** A wraparound team does not give up on, blame, or reject children, youth, and their families. When faced with challenges or setbacks, the team continues working towards meeting the needs of the youth and family and towards achieving the goals in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer necessary.
10) **Outcome based.** The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. (Bruns, 2008)

Members enrolled in the CSEDW may not receive services simultaneously through another West Virginia §1915(c) waiver though they may be on a waiting list for another waiver. Medicaid members who are not willing to enroll with the identified Managed Care Organization (MCO) are not eligible to enroll in the CSEDW program.

All required documentation forms and links to CSEDW required trainings are available on the CSEDW website.

POLICY

502.1 BMS CONTRACTUAL RELATIONSHIPS

BMS operates the CSEDW in conjunction with the West Virginia Specialized Youth in Foster Care §1915(b) managed care program and utilization management will be managed by one identified MCO.

BMS contracts with an Administrative Service Organization (ASO) that acts as an agent of BMS and administers the operation of the CSEDW program. The ASO screens potential waiver applicants during the initial eligibility determination process and provides data to the Medical Eligibility Contracted Agent (MECA) to facilitate both initial evaluations and annual re-determinations of medical eligibility. The ASO conducts education for CSEDW providers, persons, advocacy groups, and DHHR. At times, the ASO, in collaboration with BMS, will provide answers to policy questions, which will serve as policy clarifications. These policy clarifications will be posted on the CSEDW website.

In order to facilitate coordination of care, the ASO will notify the MCO administering the CSEDW when a new waiver member is determined eligible so that the member may begin receiving services within three business days of the eligibility determination for waiver enrollment as long as there is not a waitlist for services. If there is a waiting list, the member will be notified that they are approved for services, but they have been placed on the list until an opening is available. Members can receive other Medicaid services while they are on the waiting list. Members are added to the CSEDW program on a first-come, first-served basis. Medicaid members who are not willing to enroll with the identified MCO are not eligible to enroll in the CSEDW program.

The BMS contracts with a MECA to determine initial and re-determination eligibility of prospective and active persons and to recruit and train licensed clinicians to participate in the Independent Evaluator Network (IEN). The ASO and the MECA work together to process initial applications and re-determination packets.

The West Virginia Medicaid Management Information System (MMIS) contractor is responsible for enrollment of all Medicaid providers that then must contract with the identified MCO to provide CSEDW services. All Medicaid providers must contract with the identified MCO prior to initiating CSEDW services with enrolled members.

Please refer to the CSEDW website for ASO and MECA contact information.

502.2 MEDICAL NECESSITY

All CSEDW services covered in this chapter are subject to a determination of medical necessity defined as services and supplies that are:

- Appropriate and medically necessary for the symptoms, diagnosis, or treatment of an illness
- Provided for the diagnosis or direct care of an illness
- Within the standards of good practice
- Not primarily for the convenience of the plan member or provider
- The most appropriate level of care that can be safely provided

Medical necessity must be demonstrated throughout the provision of services. For these types of services, the following five factors will be included as part of this determination:

1. Diagnosis (as determined by a physician or licensed psychologist)
2. Level of functioning
3. Evidence of clinical stability
4. Available support system
5. Appropriate level of care

Consideration of these factors in the service planning process must be documented and reevaluated at regular service plan updates. Evidence-based diagnostic and standardized instruments may be administered at the initial evaluation and as clinically indicated. The results of these measures must be available as part of the clinical record, as part of the documentation of the need for the service, and as justification for the level and type of service provided.

Providers rendering services that require prior authorization must receive authorization before rendering all services. Prior authorization does not guarantee payment for services rendered. See Section 502.29, Prior Authorization.

502.3 PROVIDER ENROLLMENT AND PARTICIPATION REQUIREMENTS

All Medicaid providers must meet the provider enrollment requirements in *Chapter 300, Provider Participation Requirements*.

To become a CSEDW provider agency, an agency must also apply for a Certificate of Need (CON) through an expedited Summary Review process and be approved by the West Virginia Health Care Authority. Then, the agency must obtain a Behavioral Health License through the Office of Health Facility Licensure and Certification (OHFLAC).

CSEDW waiver service providers must also enroll with the MCO who manages the West Virginia Specialized Youth in Foster Care §1915(b) managed care program. See *Chapter 527, Section 527.9 Mountain Health Trust (Managed Care)*.

502.3.1 Enrollment Requirements: Comprehensive Behavioral Health Centers (CBHC) and Licensed Behavioral Health Centers (LBHC) Administration

CBHC and LBHC must develop and maintain a Credentialing Committee composed of the clinical supervisor and/or certified staff representative of the disciplines or practitioners within the agency. See *Chapter 503, Licensed Behavioral Health Centers* for duties and responsibilities of the committee.

502.3.2 Enrollment Requirements: CSEDW Medical Eligibility Evaluators – Staff Qualifications

Independent evaluators, including psychologists, supervised psychologists, licensed independent clinical social workers, and licensed professional counselors must be licensed to practice independently and must follow the internal regulations of their accrediting body, licensing board, and/or certification board, enrolled in West Virginia Medicaid. The MECA is responsible to ensure that these providers are qualified.

Psychologists who are on the West Virginia Board of Examiners of Psychologists approved list of supervisors may only bill for up to four supervised psychologists. Board Approved Supervisors may not "trade" supervisees for billing Medicaid services.

502.3.3 Enrollment Requirements: CSEDW Providers – Staff Qualifications

These requirements apply to all employees of CSEDW providers. The employing provider shall ensure that all new staff receive an orientation within the first 10 days of employment and shall document that orientation in each individual's personnel record. The orientation shall include an introduction to the staff person's primary job responsibilities and requirements. Staff must be over the age of 18, and able to perform the job tasks as mandated by OHFLAC and the BMS and have acceptable fingerprint-based checks, and have an acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check upon hire. Documentation including required licenses; certifications; proof of completion of training; collaborative agreements for prescriptive authority, if applicable; proof of psychiatric certification, as applicable; and any other materials substantiating an individual's eligibility to perform as a practitioner must be kept on file at the agency location where the services are provided.

CSEDW providers must receive orientation and training on the following within one month of employment:

- The provider agency's mission, philosophy, and goals,
- The provider agency's services, policies, and procedures,
- The provider agency's organizational structure, including lines of accountability and authority related to the employee,
- Universal precautions;
- Documentation procedures;
- Fire drills and evacuation procedures (if applicable),
- Procedures for medical and other emergencies,
- Person-specific needs of waiver members based on their Plan of Care (POC),
- Psychiatric emergency procedures and management including systematic de-escalation;

- Copies of current Cardiopulmonary Resuscitation (CPR) and First Aid cards from DHHR-approved training providers that include manual demonstration, relevant to the age of the population served under the waiver,*
- Crisis intervention and restraint,*
- Recognition and reporting suspected abuse, neglect, and exploitation;*
- Training on member rights;*
- Crisis planning;*
- Emergency and disaster preparedness,*
- Infectious disease/infection control;*
- Member-specific needs, including health/welfare, medical, and habilitation needs;*
- Trauma-informed care and practice*
- Cultural competency,*
- Confidentiality;* and,
- Direct-care ethics.*

*The trainings above with an asterisk are verified annually and include a competency component (i.e., post-test with a score of 80% or above).

CPR and First Aid training must be renewed subsequently as required by the expiration date on the card supplied by the approved agency. Until the above training is completed, the provider staff shall not work unless accompanied at all times by another staff member who is experienced and knowledgeable in these areas.

Approved trainings, including Direct Care Ethics, First Aid and CPR training resources, are posted on the DHHR's website for the CSED waiver.

See Section 502.4 Criminal Background Checks of this manual for specific information related to fingerprint-based background check requirements.

All further staff qualifications will be indicated under the service codes. All documentation for staff, including college transcripts, certifications, credentials, background checks, and trainings should be kept in the staff's personnel file, and the BMS, its contractors, or state and federal auditors may review them at any time.

Electronic Visit Verification

As required by the Cures Act, BMS will implement an Electronic Visit Verification (EVV) system to verify in-home visits for Personal Care Services (Participant-Directed Support) providers by March 1, 2021, and Home Health Care Services (HHCS) providers by January 1, 2023. The EVV system will verify:

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

For services requiring EVV, direct-care staff and wraparound facilitators will use the system to check-in at the beginning of the visit. After the visit, the member or authorized representative will use the system to verify the correct visit has been provided. BMS will ensure the EVV solution is secure, minimally burdensome, and does not constrain member selection of a caregiver or the manner of care delivery. BMS will provide training and an EVV guide that will be available when the system is implemented.

The services that are subject to EVV in CSEDW are the following:

- Wraparound facilitation
- In-home respite
- Independent living/skills building

502.4 CRIMINAL BACKGROUND CHECKS

Please see *Chapter 700, West Virginia Clearance for Access: Registry & Employment Screening (WV CARES)* for fingerprint-based background check requirements.

502.5 CLINICAL SUPERVISION

Clinical supervision's purpose for CBHCs and LBHCs is to improve the quality of services for every member while helping to ensure adherence to West Virginia Medicaid policy; therefore, the provider must have a policy for clinical supervision. See *Chapter 503, Licensed Behavioral Health Centers* for clinical supervision requirements.

502.6 METHODS OF VERIFYING MEDICAID REQUIREMENTS

Enrollment requirements, as well as provision of services, are subject to review by the BMS and/or its contracted agents. The BMS-contracted agents may promulgate and update utilization management guidelines that the BMS has reviewed and approved. These approved guidelines function as policy. Additional information governing the surveillance and utilization control program may be found in *Chapter 100, General Administration and Information* and are subject to review by State and federal auditors.

502.7 PROVIDER REVIEWS

The primary means of monitoring the quality of the CSEDW services is through provider reviews conducted by the OHFLAC and the ASO as determined by a defined 12-month review cycle.

The ASO performs on-site and desk documentation provider reviews, staff interviews, telephone satisfaction surveys with members who receive services and/or their parent/legal representative, and day service visits to validate certification documentation and address CMS quality assurance standards. Targeted on-site CSEDW provider reviews and/or desk reviews may be conducted by OHFLAC and/or the ASO in follow-up to incident management reporting, complaint data, corrective action plan, etc.

Prior to beginning the provider reviews, the ASO will identify the time frame for review for each provider based upon the time frame elapsed since the last review. The ASO will request a universe of members served (and employees providing CSEDW services) over the sample time period from the provider. The ASO will request CSEDW claims data reports from the MCO for the 10% representative sample selected

of employees and waiver members. During the review, the ASO will compare the claims data to the provider and employee records and include any discrepancies between provider records and claims in their findings.

Upon completion of each provider review, the ASO conducts a face-to-face exit summation with staff as chosen by the provider to attend. Within two weeks of the exit summation, the ASO will make available to the provider a draft exit report and a Corrective Action Plan (CAP) to be completed by the CSEDW provider. If there are no potential disallowances identified, then a CAP is not necessary. If potential disallowances are identified, the CSEDW provider will have 30 calendar days from receipt of the draft exit report to send any necessary information/documentation, comments related to disallowances, and the completed CAP back to the ASO. If a CAP is not submitted within the 30-day comment period, BMS may place a hold on payments for services. After the 30-day comment period has ended, BMS will review the draft report and any comments submitted by the CSEDW provider and issue a final report to the CSEDW provider's Executive Director. The final report reflects the provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of CSEDW services. A cover letter to the CSEDW provider's Executive Director will outline the following options to effectuate repayment:

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

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

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

If no potential disallowances are identified during the ASO review, then the CSEDW provider will receive a final letter and a final report from the BMS.

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

CAP: In addition to the draft exit report sent to the CSEDW providers, the ASO will also send a draft CAP electronically. CSEDW providers are required to complete the CAP and electronically submit a CAP to the ASO for approval within 30 calendar days of receipt of the draft CAP from the ASO. BMS may place a

hold on claims if an approved CAP is not received by the ASO within the specified time frame. The CAP must include:

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

502.8 TRAINING AND TECHNICAL ASSISTANCE

The BMS contracted agent, the MCO for waiver providers and the MECA for independent evaluators, develops and conducts training for CSEDW providers and other interested parties as necessary to improve systemic and provider-specific quality of care and regulatory compliance. The ASO provides training and technical assistance for providers based on the retrospective record reviews. Trainings are approved by the BMS and available through both face-to-face and web-based venues.

502.9 OTHER ADMINISTRATIVE REQUIREMENTS

The provider must assure implementation of BMS policies and procedures pertaining to documentation and case record review, as well as the following:

- All documentation completed on a member must be recorded and maintained in the member's individual record, whether electronic or written, and must be legible.
- Staff must use uniform guidelines for case record organization, so similar information will be found in the same place from case record to case record and can be quickly and easily accessed. Copies of completed release of information forms and consent forms must be filed in the case record.
- Records must contain completed member identifying information. The waiver member's POC must comply with all child and family team planning requirements and must contain service goals and objectives, which are derived from a comprehensive member assessment and must stipulate the planned service activities and how they will assist in goal attainment. Discharge reports must be filed upon case closure.
- Prior to the retrospective review, all records requested must be presented to the reviewers completing the retrospective review.
- If requested, the providers must provide copies of Medicaid member records within one business day of the request.
- Providers must facilitate the records access that is requested as well as equipment that may need to be utilized to complete the Comprehensive Retrospective Review Process.
- Providers must provide a point of contact throughout the Comprehensive Retrospective Review Process.
- In addition to the documentation requirements described in this chapter, CSEDW service providers must comply with the documentation and maintenance of records requirements described in *Chapter 100, General Administration and Information, Chapter 300, Provider Participation Requirements* and *64 CSR 11 Behavioral Health Centers Licensure*.

- Documentation of the services provided in this manual must demonstrate only one staff person's time is billed for any specific activity provided to the member.
- Electronic signature is an acceptable form of submission as long as it contains a time and date stamp.
- Reimbursement is not available for a telephone conversation, electronic mail message (email), or facsimile transmission (fax) between a provider and a member except for wraparound facilitation services.
- Reimbursement for training, coordination, and case contacts between CSEDW providers is included as an administrative cost in the provider rate and is not billable as a medical service provided to the waiver member.
- Mandatory CSEDW program training for all agency staff must be documented on the Certificate of Training Form (WV-BMS-CSED-06) unless an agency has a system for tracking training that includes all information on the WV-BMS-CSED-06 form. The system must be available for review by BMS or its designee upon request.
- Providers must subcontract with licensed individual or group practices of the behavioral health profession as defined by the OHFLAC, if contracting occurs.
- Providers must maintain evidence of implementing a utilization review and quality improvement process, which includes verification that services have been provided and the quality of those services meets the standards of the CSEDW program and all other applicable licensing and certification bodies.
- Providers must provide an assigned agency CSEDW contact person whose duties include:
    - Oversight of agency staff implementing the POCs of all members in the CSEDW program,
    - Monitoring service utilization throughout the service year,
    - Verifying that services delivered are reflected both in the POC and CSED agency electronic records/reporting systems and are not being over- or under-utilized based on the current juncture in the service year for all waiver members served, and,
    - Communicating with BMS, the MCO, and the ASO.
- Providers must implement the CSEDW Quality Improvement System (QIS) as further defined under Section 502.13 Quality Improvement System.
- Providers must maintain written policies and procedures to avoid conflict of interest (if agency is providing wraparound facilitation and other services) that must include at a minimum:
    - Education of wraparound facilitators on general conflict of interest/professional ethics with verification
    - Annual signed conflict of interest statements for all wraparound facilitators and the wraparound facilitation agency director
    - Process for investigating reports on conflict of interest
    - Process for reporting to the BMS
    - Process for complaint to professional licensing boards for ethics violations
- Staff training documentation must include training topic, date, the beginning time of the training, the ending time of the training, the location of the training, the signature of the instructor, and the signature of the trainee. Internet training must include the person's name, the name of the online training provider, and a certificate of completion or other documentation showing successful completion. All documented evidence of training for all staff persons who deliver CSEDW services must be kept on file and available upon request.

- Prior to using an online training provider to meet training requirements, the name, web address, and course names must be submitted to the ASO for review. The ASO will respond in writing whether the training meets training criteria.
- Wraparound facilitators are also required to receive initial and annual training in Conflict-Free wraparound facilitation.
- In addition, the agency must maintain documentation that any staff person who provides transportation services via personal vehicle abides by local, state, and federal laws regarding maintaining current vehicle licensing, insurance, registration, and inspections.

502.10 TELEHEALTH SERVICES

West Virginia Medicaid encourages providers that have the capability to render services through Telehealth to allow easier access to services for Medicaid members. To utilize Telehealth, providers will need to document that the service was rendered under that modality. When filing a claim, the provider will bill the service code and add 02 as the place of service. Each service in this manual is identified as "Available" or "Not Available" for Telehealth. Some services codes give additional instruction and/or restriction for Telehealth as appropriate. Services provided through Telehealth must align with requirements in *Chapter 519.17, Telehealth Services*.

502.11 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

Documentation and record retention requirements governing the provision of all WV Medicaid services will apply pursuant to *Chapter 100, General Administration and Information* and *Chapter 300, Provider Participation Requirements* of BMS Provider Manual. Providers must also comply, at a minimum, with the following documentation requirements:

- Providers must maintain a specific record for all services received for each eligible member including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current POC signed by the provider, signature, in ink or in an electronic documentation system, and credentials of staff providing the service, designation of what service was provided, documentation of services provided, the dates the services were provided, and the actual time spent providing the service by listing the start-and-stop times as required by service.
- All required documentation must be maintained for at least five years in the provider's file subject to review by authorized BMS personnel or BMS' contracted agent. 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.
- Failure to maintain all required documentation may result in the disallowance and recovery by BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to the BMS upon request.
- Providers must also comply with the specific documentation requirements for the program or service procedure, as described in this manual.
- The BMS recognizes that some providers use an electronic system to create and store documentation while other providers choose to use a hard copy-based system. Regardless of the system the provider is using, providers using an electronic-based system will require an electronic signature with a time date stamped on the documentation. Each service code in this manual describes the required documentation. All requirements must be met no matter the modality of system choice. Any document that is printed must have a handwritten signature and be dated.

502.11.1 Confidentiality

An appropriate release of information form must be obtained and approved prior to sharing information in any situation other than those described here. Access to medical records is limited to the member, parent/legal representative, authorized facility personnel, and others outside the facility whose request for information access is permitted by law and is covered by assurances of confidentiality and whose access is necessary for administration of the facility and/or services and reimbursement.

A member may review their medical record in the presence of professional personnel of the facility and on the facility premises. Such review is carried out in a manner that protects the confidentiality of other family members and other individuals whose contacts may be contained in the record. Access to medical records is limited and should be available on a medical need-to-know basis and as permitted under federal and state law and any relevant court rulings.

Pictures of Medicaid members may be used for identification purposes only (contained in the member medical record and medication administration record). Usage for any other purposes, including public displays, social media posts, or for promotional materials, are prohibited. All Medicaid member information must be kept locked in a secure place.

502.11.2 Health Insurance Portability and Accountability Act (HIPAA) Regulations

Providers must comply with all requirements of the HIPAA and all corresponding federal regulations and rules. The enrolled provider will provide, upon request of the BMS, timely evidence and documentation that they are in compliance with HIPAA. The form of the evidence and documentation to be produced is at the sole discretion of the BMS. Additional information on HIPAA may be found in *Chapter 300, Provider Participation Requirements*.

502.12 INCIDENT REPORTING REQUIREMENTS

All incident reporting requirements for the CSEDW are adherent to state and federal guidelines and subject to change. The comprehensive and up-to-date incident reporting guidelines for this waiver are available on the CSEDW website. The CSEDW provider must also comply with any other reporting required for mandatory reporters or as part of their behavioral health license.

Anyone providing CSEDW services who suspects an incidence of abuse or neglect is mandated by Behavioral Health Centers Licensure Legislative Rules (Title 64 Series 11), WV State Code§ 9-6-1, § 9-6-9, and § 49-2-803 to report the incident. Reports of abuse and/or neglect may be made anonymously by calling 1-800-352-6513, seven days a week, 24 hours a day.

The CSEDW provider must also report suspected incidence of abuse and neglect to OHFLAC by telephone at 304-558-0050 or reports may be faxed to 304-558-2515. OHFLAC may assist with referring the report to the proper authorities.

The CSEDW providers must report critical incidents to the MCO immediately and within 24 hours of the provider becoming aware of the occurrence so that the MCO may enter them into Incident Management System (IMS) to track the types of incidents listed below for anyone the agency provides services to:

- **Non-critical Incidents:** Incidents that do not create an immediate risk of serious consequence or harm for waiver members requiring immediate response from CPS/APS, law enforcement or emergency medical personnel. Non-critical incidents are divided into two sub-categories: reportable events and non-reportable events.
    - **Reportable events:** These non-critical incidents are any unusual event or injury of unknown origin involving a waiver member that needs to be recorded and analyzed for risk management or quality improvement purposes but does not meet the definition of abuse, neglect, or critical incident. Reportable events do not require an immediate response by law enforcement, CPS/APS, or emergency medical personnel.
    - **Non-reportable events:** These non-critical incidents do not have the potential to impact the waiver member's health, safety, or welfare and do **not** need to be reported. Mandated reporters and family members should use good judgement when considering whether an event rises to the level of being reportable. If a mandated reporter is unsure whether the incident is reportable, they should complete a report. However, events where there is no need for medical attention or investigation are screened out.
- **Critical Incidents:** Incidents that are serious in nature and pose immediate risk to health, safety, or welfare of the waiver member or others. These incidents require in-depth investigation, an expedited timeline, and possibly additional resources. Critical incidents include instances of suspected abuse, neglect and exploitation.
    - **Abuse, Neglect, and Exploitation Incidents:** Incidents which meet the following definitions of abuse, neglect, or exploitation:
        - Abuse means any physical motion or action (hitting, slapping, punching, kicking, pinching, etc.) by which bodily harm or trauma occurs. It includes use of corporal punishment as well as the use of any restrictive intrusive procedure to control inappropriate behavior for purposes of punishment.
        - Abuse also includes psychological abuse which means humiliation, harassment, and threats of punishment or deprivation, sexual coercion, intimidation, whereby individuals suffer psychological harm or trauma.
        - Abuse also includes verbal abuse which means use of oral, written, or gestured language by which abuse occurs. This includes demeaning and derogatory terms to describe persons with disabilities. Verbal abuse includes, but is not limited to yelling or using demeaning, derogatory, vulgar, profane, or threatening language; threatening tones in speaking; teasing, pestering, molesting, deriding, harassing, mimicking, or humiliating a person in any way; and making sexual innuendo.
        - Neglect means a negligent act or pattern of actions or events that caused or may have caused injury or death to person, or may have placed a person at risk of injury or death that was committed by an individual responsible for providing services. Neglect includes, but is not limited to a pattern of failure to establish or carry out a person's individualized program plan or treatment plan that placed or may have placed a person at risk of injury or death; a pattern of failure to provide adequate nutrition, clothing, or health care; failure to provide a safe environment; and failure to maintain sufficient, appropriately trained staff.
        - Exploitation means the unlawful expenditure or willful dissipation of the funds or assets the benefit of an incapacitated individual.

The wraparound facilitation provider must submit a Mortality Notification (WV-BMS-CSED-11) to OHFLAC within 24 hours, to the ASO within seven calendar days, and to the MCO within 14 calendar days of the member's death occurring or when the CSEDW provider becomes aware of the member's death.

WV Code requires a report to the medical examiner or coroner when there is probable cause to believe that a CSEDW member has died as a result of abuse or neglect.

If the wraparound facilitation provider is forced to exceed the maximum caseload cap of 15 members due to staff vacancy, the wraparound facilitation provider must notify the ASO within 48 hours of learning of the need to exceed the maximum by providing the following in writing to the ASO:

- The number of members per each wraparound facilitator whose caseload exceeds 15 members (e.g., wraparound facilitator name, # of members)
- The agency plan, including time lines for hiring and training new wraparound facilitators
- The agency's back-up plan to cover emergencies that occur due to exceeding the maximum case load cap.

The wraparound facilitator is responsible for submitting and maintaining accurate and current data including name, address, telephone numbers, wraparound facilitation provider, parent/legal representative name, and contact information, etc., of all individuals served.

The wraparound facilitator is required to notify the MCO of a member's transfer to another wraparound facilitation provider or if the member chooses another service delivery system within two business days:

- The transferring agency is responsible for the notification by submitting the Person Transfer/Discharge Form (WV-BMS-CSED-10). This form must include the last date of service provided.
- Lack of notification of the transfer will affect the prior authorization for service or registration of services to the correct service provider(s) and subsequent payment of claims for services.

Documentation: Evidence that incident reporting to MCO occurred within required timelines and to all applicable entities (OHFLAC and Protective Services have 24 hours to submit written report for Abuse / Neglect / Exploitation to the MCO) and that the incident report is in the waiver member's record for each reported incident. Case notes showing that the wraparound facilitator followed up with law enforcement and other entities as needed to maintain safety and keep the waiver member and legal guardian updated on the investigation, as appropriate, when there is an investigation by law enforcement. For each incident that is recorded in the MCO's IMS, there is a copy of the incident report in the waiver member's file and correspondingly, for each incident in the waiver member's file, there is documentation recorded in the MCO's IMS of the incident.

502.13 QUALITY IMPROVEMENT SYSTEM (QIS)

The BMS is responsible for building and maintaining the CSEDW QIS. The CSEDW provider is responsible for participating in all activities related to the QIS. The CSEDW QIS is used by BMS and the ASO as a continuous system that measures system performance, tracks remediation activities, and identifies opportunities for system improvement. Achieving and maintaining program quality is an ongoing process that includes collecting and examining information about program operations and outcomes for

members receiving services, and then using the information to identify strengths and weaknesses in program performance. This information is used to form the basis of remediation and improvement strategies.

The QIS is designed to collect the data necessary to provide evidence that the CMS Quality Assurances are being met, and help ensure the active involvement of interested parties in the quality improvement process.

502.13.1 Centers for Medicare & Medicaid Services (CMS) Quality Assurances

The CMS mandates the CSEDW program guarantee the following six Quality Assurances:

1. **CSEDW Administration and Oversight:** The State Medicaid agency is actively involved in the oversight of the CSEDW, and is ultimately responsible for all facets of the CSEDW program
2. **Level of Care:** Members enrolled in the CSEDW have needs consistent with an institutional level of care
3. **Provider Qualifications:** CSEDW providers are qualified to deliver services/supports
4. **Plan of Care:** A member has a POC that is appropriate to their needs and preferences and receives the services/supports specified in the service plan
5. **Health and Welfare:** A member's health and welfare are safeguarded
6. **Financial Accountability:** Claims for CSEDW services are paid according to state payment methodologies specified in the approved waiver.

Data is collected and analyzed for all the Quality Assurances and sub-assurances based on West Virginia's Quality Performance Indicators, as approved by CMS. The primary sources of discovery include CSEDW provider reviews, Incident Management Reports, complaints and/or grievances of members who receive services or the parent/legal representative OHFLAC reviews, abuse and neglect reports, administrative reports, oversight of delegated administrative functions and interested party input.

502.13.2 Quality Improvement Advisory (QIA) Council

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

- Recommend policy changes
- Recommend waiver priorities and quality initiatives
- Monitor and evaluate policy changes
- Monitor and evaluate the implementation of waiver priorities and quality initiatives
- Serve as a liaison between the waiver and interested parties
- Establish committees and work groups consistent with the QIA Council's purpose and guidelines

The QIA Council membership is comprised of members who formerly utilized CSEDW services, members who currently are utilizing CSEDW services or the parent/legal representative, service providers,

advocates and other interested parties of people with SEDs. The MCO facilitates the creation and convening of the Quality Council. The ASO provides information for the Council based upon annual reviews.

ELIGIBILITY AND ENROLLMENT

502.14 APPLICANT ELIGIBILITY AND ENROLLMENT PROCESS

In order for an applicant to be found eligible for the CSEDW program, they must:

- Be an eligible West Virginia Medicaid member- Medicaid eligibility is independent of medical eligibility for the CSEDW and is not impacted by enrollment in the CSEDW
- Choose HCBS over services in an institutional setting
- Choose to enroll with the identified MCO
- Meet CSEDW medical eligibility
- Be at least three (3) years of age and not yet 21
- Be a resident of West Virginia, even if presently living out of state in a PRTF, and be able to provide proof of residency upon waiver application

Enrollment in the CSEDW program is dependent upon the availability of a funded CSEDW slot.

Initial medical eligibility is determined by the MECA through review of an Independent Evaluation (IE) report completed by a member of the Independent Evaluation Network (IEN), which must include background information, a mental status examination, functional behavior, achievement, and any other documentation deemed appropriate.

If a slot is not available, the applicant is placed on a Managed Enrollment List (MEL) in the chronological order in which they were determined eligible. When a slot becomes available, the applicant is informed and may proceed with the enrollment process for the CSEDW program.

In the event that an individual is assigned to an MCO other than the Specialized Foster Care/CSEDW MCO while they are on the MEL, they are required to transfer to the Specialized Foster Care/CSEDW MCO when a funded slot becomes available.

502.14.1 Application Process: Initial Eligibility Determination Process

Each new applicant must follow the eligibility process listed below for medical eligibility, which is determined by an IE. The evaluation includes assessments which support the diagnostic impressions offered and relevant measures of functioning. The IE is utilized by the MECA to make a medical eligibility determination. Evaluators in the IEN are identified and placed on an IEN list following documented training by the MECA. An applicant may obtain an Application Form (WV-BMS-CSED-1) from the MCO, CSEDW providers, local/county DHHR Offices, the ASO and on the CSEDW website.

1. The process begins with the applicant contacting the ASO or submission of the application from the applicant to the ASO (information is located on the application).

a. The ASO screens the waiver applicant for medical eligibility for waiver services and assists with the waiver application, if needed.
b. Upon receipt of the WV-BMS-CSED-1, the ASO time and date stamps the application.
c. If the applicant mails the application, the ASO contacts the applicant within one business day upon receipt of the WV-BMS-CSED-1.
    i. The ASO provides the applicant with a copy of the Freedom of Choice (FOC) form. The initial FOC offers the child/family the election between institutional and HCBS.
    ii. If the applicant child/family elects HCBS, the ASO immediately asks the family to select a provider from the IEN and contacts the IE at once to schedule an evaluation.
        1. If the IE is unable to schedule and complete a report within 14 days, then the ASO will work with the family to choose another IE who has sooner availability for an appointment.
        2. The ASO helps the applicant child/family select an IE within the applicant's geographical area or otherwise convenient for the member and their family.

2. Once the child/family has scheduled the IE, the ASO will obtain a signed FOC form for the applicant child/family's selected IE provider.
    a. The ASO will provide information about the CSEDW. The ASO will also offer the family the option to select a preferred wraparound facilitation agency and complete an FOC for CSEDW services. This will help ensure that services will be ready to begin as soon as possible, if the child is found eligible.
    b. The ASO will also inform the family that the ASO will refer the family to appropriate alternative behavioral health services if the child is not eligible for CSEDW services.
3. The IEN provider completes the IE and sends it to the MECA within 14 calendar days of the kept IE appointment .
4. The MECA makes a final medical eligibility determination within seven calendar days of receipt of the completed IE using the current approved diagnostic tool, which is the Child and Adolescent Functional Assessment Scales (CAFAS) / Preschool and Early Childhood Functional Assessment Scale (PECFAS), if one of these tools has not been completed within the last 90 days. The Independent Evaluator will also complete the most recent version of the Behavioral Assessment System for Children (BASC) unless the child is currently receiving PRTF services.
5. The MECA notifies the ASO of the medical eligibility determination.
6. If an applicant is Medicaid-eligible and approved for medical eligibility by the MECA and a funded CSEDW slot is available, then the applicant is enrolled into the CSEDW program.
    a. If a slot is not available, then the applicant will be placed on a MEL until a funded slot allocation is available.
7. The ASO notifies the applicant child/family of the medical eligibility determination and waitlist status, if applicable.
    a. A written copy of the decision is also mailed to the applicant and/or their parent/legal representative by the ASO.
8. When a member is determined eligible, the ASO also notifies the MCO of the determination. The ASO also notifies the MCO of the preferred wraparound facilitation agency.
    a. If a funded waiver slot is available, the MCO then contacts the wraparound facilitation agency selected by the waiver enrollee to assign a wraparound facilitator.

i. If the waiver member is already receiving wraparound services, the ASO will contact the current wraparound facilitation agency to inform the agency that the child has been approved for CSEDW services.

The applicant's right to a medical eligibility determination within 90 calendar days may be forfeited if the applicant fails to schedule and keep a timely appointment or does not submit follow-up information needed to complete the IE to the IEN provider within a reasonable timeframe specified by the IEN provider. Examples of follow-up documentation requested by the Independent Evaluator may include, but may not be limited to:

- Individualized Education Program (IEP) plan for school aged children (if applicable);
- Psychiatric and psychological evaluations;
- Outpatient therapy notes and progress notes;
- Records from inpatient psychiatric hospitalizations, partial hospitalizations, or residential placements; and
- Any other additional documentation deemed necessary by the IEN provider or MECA to complete the IE.

502.14.2 Right to Appeal

If an applicant is determined to not meet medical eligibility criteria by the MECA, a written Notice of Decision, a Request for Medicaid Fair Hearing form, and a copy of the IE is sent by certified mail by the ASO to the applicant or the parent/legal representative. This denial of medical eligibility may be appealed by the applicant or the parent/legal representative through the Medicaid Fair Hearing process by submitting the Request for Medicaid Fair Hearing form to the Board of Review within 90 calendar days of receipt of the Notice of Decision. The Notice of Decision letter also allows the applicant or the parent/legal representative to request a second medical evaluation. Unless the CSEDW member's medical eligibility determination is appealed by the family or a second evaluation is requested, CSEDW services will end within 14 calendar days of the termination letter.

If a second medical evaluation is requested, then it must be completed by a different member of the IEN within 60 calendar days of the request. Requests for a second evaluation received by the ASO are date stamped upon receipt. The ASO will assist the applicant and family by providing options available with a different IEN provider and scheduling the second evaluation.

If an applicant is determined to be medically eligible following the second medical evaluation and a slot is available, then the applicant is enrolled into the CSEDW program. If an applicant is determined to be medically eligible, but a slot is not available, then the applicant will be placed on a MEL until a funded slot is available.

If the applicant is again determined by the MECA to not meet medical eligibility criteria following the second medical evaluation, then the applicant or their parent/legal representative of the applicant will receive a written Notice of Decision, a Request for Medicaid Fair Hearing form and a copy of the second IE by certified mail by the ASO. This second denial of medical eligibility may be appealed through the Medicaid Fair Hearing process by submitting the Request for Medicaid Fair Hearing form to the Board of

Review within 90 calendar days of receipt of the Notice of Decision and a Medicaid Fair Hearing will be scheduled. See Section 502.16.4 Medical Redetermination Eligibility Appeals.

The applicant or parent/legal representative may request a pre-hearing conference at any time prior to the Medicaid Fair Hearing. At the pre-hearing conference, the applicant and/or the parent/legal representative and a representative from the MECA will review the information submitted for the medical eligibility determination and the basis for the denial.

The applicant shall have the right to access their IE used by the MECA in making the eligibility decision and copies shall be provided free of charge by BMS.

If the denial of initial medical eligibility is reversed by the Hearing Officer, the applicant will be placed on the MEL based on the date of the Hearing Officer's decision. When a slot is available, the applicant will be enrolled in the program.

Any applicant denied medical eligibility may re-apply to the CSEDW program at any time.

502.14.3 Initial Medical Eligibility

To be medically eligible, the applicant must require the level of care and services provided within a PRTF settings as evidenced by required evaluations and other information requested by the IE or the MECA and corroborated by narrative descriptions of functioning and reported history.

In order to be eligible for CSEDW, an applicant must have:

- Eligible diagnosis;
- Functional impairment; and
- Require PRTF Level of Care.

502.14.3.1 Level of Care Instruments

The applicant must have an IE completed by an enrolled psychologist, supervised psychologist, licensed independent clinical social worker, or licensed professional counselor who is licensed to practice independently that includes a PECFAS/CAFAS and the most recent version of the Behavioral Assessment System for Children (BASC) for children living at home or in a community setting. A BASC is not required for medical eligibility for individuals already placed in a PRTF setting.

Children presently placed in a PRTF may have their CAFAS/PECFAS evaluation completed by the PRTF. The evaluation must be completed within 90 calendar days of submission of application for CSEDW in order to be considered current. Payment for the out-of-state CAFAS/PECFAS evaluation is considered a part of the PRTF per diem.

502.14.3.2 Diagnosis

An eligible diagnosis is defined as a diagnosable mental, behavioral, or emotional disorder that meets the current DSM diagnostic criteria. These disorders include any mental disorders listed in the DSM with the

exception of "V" codes, substance use, and developmental disorders, which are excluded unless they co-occur with another diagnosable SED.

The applicant must also demonstrate an impairment in functioning that is due to an eligible diagnosis to meet eligibility requirements.

502.14.3.3 Functionality

The applicant must have a substantial impairment in functioning that is defined as a Youth Total score of 90 or above on the PECFAS/CAFAS. The applicant must demonstrate an ability to engage in activities of daily living but lack adequate emotional or behavioral stability to meet the demands of daily living. The PECFAS/CAFAS must reflect elevated scores as noted above. The presence of substantial impairment must be supported not only by relevant test scores, but also the narrative descriptions contained in the documentation submitted for review and other relevant information (i.e., previous psychological testing, the IEP, treatment records, discharge summaries, etc.).

The following PECFAS/CAFAS subscales must equal a total score of 90:

- School/day care/work role performance
- Home role performance
- Community role performance
- Behavior toward others
- Moods/emotions
- Self-harmful behavior
- Substance use (CAFAS only)
- Thinking/communication

Additionally, ratings on the most current BASC must reflect T-scores greater than 60 in two or more of the Clinical Scales. The criteria must be supported by additional documentation provided (i.e., previous psychological evaluations, IEP, facility records, etc.).

502.14.3.4 PRTF Level of Care

The applicant must require a PRTF level of care and specifically has either resided in a PRTF within the past six months, or through evaluations and documentation submitted to the MECA it is determined that there is a reasonable indication that the applicant is in danger of being placed in a PRTF.

The purpose of a PRTF is to provide full-time psychiatric treatment for children under age 21 with mental/emotional/behavioral problems who do not require emergency or acute psychiatric care but whose symptoms are severe enough to require supervision/intervention on a 24-hour basis.

PRTF care is the most restrictive type of care for children. A secure facility is used for treatment of children who have been clearly diagnosed as having a psychiatric, emotional, or behavioral disorder that is so severe the child is a danger to himself or others. All services must be delivered under the direction and orders of a physician and psychiatrist. Educational services for the child must be provided on the grounds of the facility. The ultimate goal of the PRTF services is to promote a successful return of the

child or adolescent into the community. Please refer to *Chapter 531, Psychiatric Residential Treatment Facility Services* for more information.

502.14.4 Slot Allocation Referral and Selection Process

The MCO will keep the ASO apprised of CSEDW providers by service type and their capacity to accept new enrollees by region. Wraparound facilitation agency providers that reject referrals due to service capacity may not receive future referrals until the capacity/service issues are resolved.

Provided a funded CSEDW slot is available, the allocation process is based on:

- The chronological order by date of the ASO's receipt of the fully completed initial application (WV-BMS-CSED-1) and approval of eligibility from the MECA; or
- The date medical eligibility is established as a result of a Medicaid Fair Hearing decision.

Once a funded slot becomes available, the waitlisted enrollee will be contacted by the ASO and assisted to complete a FOC form (WV-BMS-CSED-2) on which the enrollee must indicate the choice to receive HCBS as opposed to services in an institution. The waitlisted enrollee will also select a preferred wraparound facilitation provider and then return the FOCs to the ASO in order to begin receiving services.

Upon receipt of the complete and signed FOC form, which may be sent electronically, the ASO will notify the MCO of the selection of the wraparound facilitation agency within one business day. The MCO will notify the chosen wraparound facilitation provider. The wraparound facilitation provider may reject the referral only if:

- It appears to have been received in error; or
- The wraparound facilitation provider is at maximum service capacity and unable to accept referrals until additional wraparound facilitators are hired; or
- The wraparound facilitation provider is unable to meet the referred member's medical and/or behavioral needs.

For waitlisted enrollees residing in a PRTF setting, the enrollee must access CSEDW direct care services within 180 calendar days of when the funded slot becomes available or the enrollee will be discharged from the program. For current enrollees receiving waiver services, BMS may approve a pause in receiving waiver services due to family and waiver member needs, such as medical treatment or visits to extended family. Members are only required to receive one waiver service per month to remain enrolled as long as they remain eligible.

502.15 ANNUAL REDETERMINATION OF WAIVER ELIGIBILITY PROCESS

In order for a member to be redetermined eligible for CSEDW services, the member must continue to meet all eligibility criteria as previously defined. This waiver determination is independent of the financial eligibility process for Medicaid coverage.

All members presently receiving CSEDW services will be evaluated annually utilizing a CAFAS/PECFAS and the Child and Adolescent Needs and Strengths (CANS). In order to be found eligible, the member must have an eligible diagnosis of SED as described above.

To be redetermined and to continue to meet medical eligibility, the member must have a substantial impairment as described in Section 502.14.2.3 Functionality of this manual. Functionality for the annual redetermination will be determined by the CAFAS/PECFAS and the CANS.

The ASO will conduct the CAFAS/PECFAS for medical eligibility redetermination up to 90 calendar days prior to each member's anchor date. The anchor date is assigned by the ASO and is defined as the annual date by which the member's medical eligibility must be recertified and is determined by the anniversary date that is the first day of the month following the date when initial medical eligibility was established by the MECA.

At the time of the annual reassessment by the ASO, each member or parent/legal representative must complete the FOC Form (WV-BMS-CSED-2) indicating their choice of level of care settings, wraparound facilitation agency, and other providers of CSEDW services. If the member has a legal representative that did not attend the annual reassessment and complete the FOC Form (WV-BMS-CSED-2), then it is the responsibility of the wraparound facilitator to obtain the signature, in ink or in an electronic documentation system, of the legal representative prior to or at the Child and Family Team (CFT) meeting.
The Needs Domains of the CANS completed by the wraparound facilitator and the CAFAS/PECFAS will be reviewed by the MECA. Members who show "no evidence of need/no need for action" as defined by the CANS may not require continued eligibility for the CSEDW program, and eligibility for the CSEDW program may be terminated, if the CAFAS/PECFAS total score is also less than 90 overall.

The ASO, the member, the parent/legal representative, and any other members of the CFT that the member wishes to be present may attend the annual reassessment, but may not be reimbursed for attending the meeting. The member and/or parent/legal representative shall sign an acknowledgment that they participated in the assessment and were given the opportunity to review and concur with the answers recorded during the assessment. If the member or parent/legal representative declines to sign the acknowledgment for any reason (e.g., he or she does not believe the answers were recorded accurately), the member or their parent/legal representative shall notify the ASO through their wraparound facilitator within five calendar days of the assessment date, and the ASO shall resolve the issue by conferring with the member and/or parent/legal representative to come to an agreement on the answers on the assessment. If the member or parent/legal representative still disputes the answers on the assessment, then the issue can be appealed through a Medicaid Fair Hearing. The Assessment Data Modification Request (WV-BMS-CSED-13) form must be fully completed must cite the items in question.

502.16 RIGHTS, RESPONSIBILITIES, GRIEVANCES, AND APPEALS

The member retains all rights afforded to them under the law and the lists below are intended to be limited to their rights and responsibilities as a member participating in the CSEDW program. Each member is informed of these rights by their CSEDW wraparound facilitation agency upon enrollment and at least annually thereafter.

502.16.1 Rights

Members and/or their legal representatives have the right to:

- Choose between HCBS as an alternative to institutional care by the ASO through the completion of a FOC form (WV-BMS-CSED-2) upon enrollment in the program and at least annually thereafter.
- Choose their CSEDW providers.
- Address dissatisfaction with services through the CSEDW provider's grievance procedure.
- Access the Medicaid Fair Hearing process consistent with state and federal law.
- Be free from abuse, neglect, and financial exploitation.
- Be notified and attend any and all of their CFT meetings, including significant life event meetings.
- Choose who they wish to attend their CFT meetings, in addition to those attendees required by regulations.
- Obtain advocacy if they choose to do so.
- File a complaint with the ASO regarding the results of their reassessment.
- Have all assessments, evaluations, medical treatments, and POCs explained to them in a format they can understand, even if they have a legal representative making the final decisions in regard to their health care.
- Make decisions regarding their services.
- Receive reasonable accommodations afforded to them under the American with Disabilities Act (ADA).

502.16.2 Responsibilities

The member and/or their legal representative (if applicable) have the following responsibilities:

- To be present during CFT meetings. In extremely extenuating circumstances, the legal representative or other team members may participate by teleconferencing, if permitted by policy or the MCO. The member must be present and stay for the entire meeting if they do not have a legal representative.
- To understand that this is an optional program and that not all needs may be able to be met through the services available within this program.
- To participate and supply correct information in the annual assessments for determination of medical eligibility.
- To comply with all CSEDW policies including monthly home visits by the wraparound facilitator.
- To implement the portions of the POC for which they have accepted responsibility.
- To maintain a safe home environment for all service providers.
- To notify their wraparound facilitator immediately if the member's living arrangements change, the member's needs change, the member is hospitalized, or if the member needs to have a significant life event meeting.

Failure to comply with these responsibilities may jeopardize the member's continuation of CSEDW services. If the waiver member's behaviors continue to escalate or put the member at risk of harm to themselves or others, or the waiver member is not participating in services, then a referral may be made for further evaluation and consideration for other services. As long as the waiver member continues to meet medical and financial eligibility and participates in treatment, waiver services can continue.

502.16.3 Grievances and Complaints

A member receiving services has the right to obtain oral and written information on the CSEDW provider agency's complaints and grievance policies. If the member or the parent/legal representative is dissatisfied with the quality of services or the provider of service, it is recommended that they follow the CSEDW provider agency's grievance process. If the issue is not resolved at this level, the member or the parent/legal representative may file provider complaints directly to the Secretary's office (DHHR) and OHFLAC outlines the process within the behavioral health regulations in Section 4.7, Complaint Investigations.

In regard to the MCO, a complaint is defined as an expression of dissatisfaction made about an MCO decision or services received from the MCO when an informal grievance is filed; some complaints may be subject to appeal. Complaints are handled through the MCO Provider Services Department and reported to BMS quarterly, though reporting can be more frequent if necessary. Grievance is defined as an expression of dissatisfaction, either in writing (formal) or orally (informal), regarding any aspect of service delivery provided or paid for by the MCO, other than those MCO actions that are subject to appeal. The term grievance also refers to the overall system that includes grievances and appeals handled at the MCO level and access to the State Fair Hearing process.

The MCO will complete an investigation for all grievances received and report the results to the BMS and to the member receiving services or the parent/legal representative.

502.16.4 Medical Redetermination Eligibility Appeals

If a member is determined not to be medically eligible, then the ASO sends by certified mail to the member or parent/legal representative: a written Notice of Decision (termination), a Request for Hearing form that includes free legal resources, and the results of the reassessment. This notice is also sent to the member's wraparound facilitator and MCO. 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 90 calendar days of receipt of the Notice of Decision. If the member or parent/legal representative wishes to continue existing services throughout the appeal process, the Request for Hearing form must be submitted within 13 calendar days of the member or the parent/legal representative receipt of the Notice of Decision. If the Request for Hearing form is not submitted within 13 calendar days of the member or the parent/legal representative receipt of the Notice of Decision, reimbursement for all CSEDW services will cease.

After filing a request for a Medicaid Fair Hearing, the member receiving services, or their legal representative may also request a second medical evaluation (IE). The second medical evaluation must be completed within 60 calendar days by a member of the IEN. The wraparound facilitator, upon notification of the eligibility decision, must begin the discharge process by arranging for a Transfer/Discharge CFT meeting to develop a backup plan for transition because reimbursement for CSEDW services will cease on the 13th day after receipt of the written Notice of Decision letter if the member or their parent/legal representative does not submit a Request for Hearing form.

If the member is again denied medical eligibility based on the second medical evaluation, the member or the parent/legal representative will receive a written Notice of Decision, a Request for a Fair Hearing

Form and a copy of the second medical evaluation by certified mail from the ASO. The member's wraparound facilitator and MCO will also receive a notice. The member or their legal representative may appeal this decision through the Medicaid Fair Hearing process if the Request for Hearing form is submitted to the Board of Review within 90 calendar days of receipt of the Notice of Decision.

A pre-hearing conference may be requested by the member or the parent/legal representative any time prior to the Medicaid Fair Hearing and the ASO will schedule. If the member or the legal representative has obtained legal counsel, the BMS legal counsel will conduct the pre-hearing. At the pre-hearing conference, the member and/or their legal representative and a representative from the MECA will review the information submitted for the medical eligibility determination and the basis for the termination.

If the denial of medical eligibility is upheld by the Hearing Officer who is a member of the Department's Board of Review authorized to conduct hearings and render decisions on behalf of the Board of Review, services that were continued during the appeal process must cease on the date of the hearing decision. If the member is eligible financially for Medicaid services without the CSEDW Program, other services may be available for the individual. If the termination based on medical eligibility is reversed by the Hearing Officer, the individual's services will continue with no interruption.

The member and/or parent/legal representative shall have the right to access their medical evaluation (IPE) used by the MECA in making the eligibility decision and copies shall be provided free of charge.

502.17 TRANSFER AND DISCHARGE

The member has the right to transfer or discharge wraparound facilitation and other services from the existing provider to another chosen provider at any time for any reason. Transfers and discharges must be addressed on the POC and approved by the member or parent/legal representative and a representative from the receiving provider as evidenced by their signatures on the POC signature sheet, in ink or in an electronic documentation system. During the transition from one provider to another, the POC must be developed and must specifically address the responsibilities and associated time frames of the "transfer-from" and the "transfer-to" providers. The wraparound facilitator must complete and submit the Person Transfer/Discharge Form (WV-BMS-CSED-10) within seven calendar days to the MCO. If a transfer POC is found not to be valid, then the authorizations for services may be rolled back to the transfer-from provider until a valid CFT meeting is held. A CSEDW provider may not terminate services unless a viable POC is in place that effectively transfers needed services from one CSEDW provider to another provider and is agreed upon by the member and/or their parent/legal representative and the receiving provider. Providers are prohibited from discriminating in any way against a member or parent/legal representative wishing to transfer services to another provider agency.

502.18 POC REQUIREMENTS

Participation in wraparound Services is a collaborative process led by the CFT. The CFT should ideally be composed of people who have a strong commitment to the family's well-being, and choices about who is invited to participate in the CFT should be driven by the waiver member and family member's perspectives (Bruns, 2008). Ideally, the team should primarily include the natural supports identified by the waiver member and family.

The POC development process is rooted in what is most important to the member and involves them directly with their community, network of connections, and close personal relationships in order to look at the innovative ways to attain specific life goals. The focus is entirely on the needs of the member, never the formal supports participating in the team. Numerous mainstream resources are unearthed, considered, researched, and used. These resources are only considered in relationship to how they will support the member in achieving the member's goals. Team members are invited to attend and often times do not have a professional relationship with the member (e.g., coworkers, family, and community members). Meetings typically do not occur at a provider office, rather the member's home or private community setting. These meetings are meant to be interactive and can involve nontraditional means of visualizing goals and the various steps to achieve them, beyond clinical record keeping.

The wraparound services agency will initiate services within 72 hours of the referral. The initial service plan must be completed within seven calendar days of waiver enrollment CSEDW wraparound services once the waiver member has been found eligible for the waiver. If the waiver member has already been receiving services from the wraparound facilitation agency, the existing POC is reviewed to consider any additional CSEDW services that would be beneficial to the member and revised within this time frame. The plan must be completed by the wraparound facilitator and the member and/or parent/legal representative.

Development of the POC is not a billable service, but is an administrative cost that is included in the rate for the service, except for the role of the wraparound facilitator. See Section 502.18.2 POC Development for clarification and description of exceptions. The initial POC describes the services and/or supports the member is to receive until the assessment process is complete and the master POC is developed. This Initial POC must consist of the following at a minimum:

- Description of any further assessments or referrals that may need to be performed
- A listing of immediate interventions to be provided along with objectives for the interventions
- A date for development of a master POC. The designated date must be appropriate for the planned length of service but at no time will that exceed 30 calendar days from the date of waiver enrollment
- The signature of the member and/or parent/legal representative, wraparound facilitator, and other persons participating in the development of the initial plan, each person's credentials, and start/stop times, in ink or in an electronic documentation system

The POC goals and objectives must be based on problems identified in the initial assessment or in subsequent reassessment(s) during the treatment process. The master POC is developed within 30 calendar days of waiver enrollment and must include:

- A statement or statements of the member-centered positive and outcome-oriented goal(s) of services in general terms;
- A Therapy Plan;
- Any assessment-driven habilitation recommendations;
- A listing of specific objectives that the service providers and the member hope to achieve or complete. It is expected that objectives be specific, measurable, realistic, and capable of being achieved in the time available in the projected duration of the program or service;

- The measurable component objectives that provide steps toward achievement of specified outcomes, with realistic dates of achievement specified for each;
- The technique(s) and/or services (intervention) to be used in achieving the objective;
- Identification of the individuals (with their names and roles identified) responsible for implementing the services relating to the statement(s) of objectives and their frequency of intended delivery;
- The behaviors identified for intervention as well as the methods to address the person's assessed maladaptive behavioral need(s);
- Discharge criteria;
- A transition plans for members over 15;
- A date for review of the plan, timed in consideration of the expected duration of the program/service; and
- A signature page inclusive of credentials, the date, and start/stop times of attendance of all participants in the development of the plan, in ink or in an electronic documentation system.

Service plans must be flexible documents that are modified by the team as necessary and clinically appropriate. Service plans must be revisited at significant life events including changes in level of service to more intensive or less intensive types of care. When an intervention proves to be ineffective, the service plan must reflect consideration by the team of changes in the intervention strategy.

502.18.1 Child and Family Service Planning Team (CFT)

The CFT consists of the member and/or parent/legal representative, the member's wraparound facilitator, representatives of each professional discipline, provider and/or program providing services to that member (inter- and intra-agency), the MCO care coordinator (if requested) and anyone not listed who the member choses to participate. Ideally, natural supports and family will represent more than 50% of the CFT. The wraparound facilitator is ultimately responsible for facilitating the development of and subsequent updates to the POC document; the member’s wraparound facilitation agency cannot provide any additional CSEDW services, unless an exception is approved by the MCO due to a lack of providers available in the waiver member’s geographic area, a need for a provider who speaks the language of the child or family or who is closely aligned with the family’s culture. It is important to remember that, although coordination of the POC process is the responsibility of the wraparound facilitator, development of the POC is the responsibility of the CFT.

Although the POC is driven by the member’s needs, goals and preferences, the wraparound facilitator in conjunction with the CFT informs the member and the member’s parents/legal representatives of the available resources that may be included in the POC. CSEDW services will emphasize the importance of combining natural supports from the community with professionals to create a POC that supports the recovery of the member and the parents/legal representatives of the member. West Virginia utilizes a strengths model, which views the member and parent/legal representative as the expert on the strengths and needs of the member. These strengths and needs are then used to guide POC development in combination with the information gathered during enrollment. The POC captures the strengths, needs, preferences, and desired outcomes of the member and decides frequency and duration of services and supports.

502.18.2 POC Development

If a member is served by multiple behavioral health providers, all providers must be invited to participate in the initial CFT service-planning session. If a POC has already been completed, the CFT is convened to review the plan and consider whether any additional CSEDW services available through the waiver are needed. All members of the team must receive adequate notice, which is defined as at least seven calendar days prior to the treatment team meeting.

The wraparound facilitator is responsible for the scheduling and coordination of treatment team meetings, monitoring the implementation of the service plan, and for initiating treatment team meetings as the needs of the member dictates. Justification for the presence of each staff person participating in the meeting is the responsibility of the wraparound facilitator. Participation time by staff persons may vary depending on the nature of their involvement and contribution to the team process. Service planning meetings must be scheduled at times and places that facilitate the inclusion of the member. It is important to remember that, although coordination of the service planning process is the responsibility of the wraparound facilitator, development of the service plan is the responsibility of the child and family treatment team.

Only the wraparound facilitator can bill for case planning meetings. Other service providers may not bill for participation by any of their staff in the service planning process. The agency coordinating the service planning session also cannot bill for participation of staff from other agencies. Participation by family members is not billable.

CSEDW providers must make the proper distinction between service planning and other activities related to wraparound facilitation for the member. The wraparound facilitator may be involved in the development of individual program plans, such as residential plans, day treatment plans, work training plans, educational plans, etc. as called for by the member's master POC. These types of activities are included under wraparound facilitation services. Only wraparound facilitators may be reimbursed for the coordination and participation in the annual reassessment/redetermination meetings, as well as gathering all updates from each provider to present during this meeting.

Individual program plans for (i.e., day treatment, job development) and other organized programs are not billable as a separate activity, but are considered part of the services for which the plans were developed, and are covered under the definition of those services. The CFT relies on team member participation. A written service plan is a product of that process and serves as substantiation that the process took place.

Documentation: The following documentation is required for substantiation:

- The service plan must include: the cover sheet with member and family demographics, the waiver member’s goals and dreams, a summary of any assessments leading to qualification for waiver services and the results of those evaluations, any medications, identification of waiver services and non-waiver as well as natural supports assisting with the member’s goals, the therapy plan, behavior support plan, crisis plan, and signature page.
- The behavior support portion of the plan includes clinical opinions related to the behavior, other significant issues with documentation of follow-up and the clinical reason for and intended benefit of any direct observation.

- The service plan signature page must include original, dated signatures (with names, titles, and credentials) of all participating members of the treatment team, the member and/or parent/legal representative and must include the actual time all individuals listed participated by listing the start-and-stop times of their participation, in ink or in an electronic documentation system. The expectation is that the representative from each CSED service that is being provided to the member attend the meeting and sign the plan. For example, the in-home family therapist must attend when the service is requested or provided. Staff may participate for different lengths of time, depending on the nature of their involvement and contribution to the team process. The POC signature page along with the Rationale for disagreement (if applicable) is to be placed in the member's clinical record along with the completed service plan or service plan update and POC meeting minutes.
- Each staff person participating in the service planning session, must include the agency they are representing on the signature page.
- Separate documentation must also be included in their agency's clinical record in the form of an activity note that states the purpose for participating in the meeting, their signature, in ink or in an electronic documentation system, and credentials, the location, date, and the actual time spent participating in the session by listing their start-and-stop times.

If the waiver member and/or parent/legal representative is unable to attend the scheduled service planning meeting, the MCO may grant an exception to allow the meeting to proceed at the scheduled time without their participation. The reason for the member's absence must be documented in the clinical record. If the waiver member is unable to attend, the member and their parent/legal representative must review and sign the service plan within seven calendar days. Documentation of the MCO's approval for the member or legal representative's absence from the POC meeting must be included with the plan. The legal representative may also request an exception from the MCO. The wraparound facilitator must attend in person and sign the POC. If there is an emergency, for the wraparound facilitator or the in-home therapist necessitating a delay in the POC meeting, the wraparound facilitator should submit a request to the MCO for an extension of the time frame.

Many services, including CFT meetings, can be provided via telehealth (i.e., video conferencing). This delivery method is reimbursable, for the wraparound facilitator, as it is considered a face-to-face meeting. In extenuating circumstances, POC members may participate by teleconferencing (i.e., telephone). Team members may not bill for the time spent in the POC, and the wraparound facilitator must note on the signature sheet that they attended by phone. The wraparound facilitator must obtain signatures within 10 days for any POC member who attended the meeting via telehealth or teleconference and must forward copies of the POC to all participating CFT members and the MCO Care Manager within 14 days of the meeting. If the clinical record does not include a valid signature page with required signatures, in ink or in an electronic documentation system, the service plan will be invalid, and subsequently, no services provided under its auspices will be billable. Please see *Chapter 519.17, Telehealth Services* for more information on telehealth requirements.

502.18.2.1 Seven-Day CFT Meeting

This meeting is mandatory when a member receives a CSEDW slot. This is the initial meeting that occurs within the first seven calendar days of waiver enrollment and must include discussion of CSEDW services as well as other support services a member needs to live successfully in the community. This POC

document must reflect a full range of planned services: Medicaid, non-Medicaid, and natural supports. This meeting must be documented on the Initial POC (WV-BMS-CSED-4) by the member's wraparound facilitator. This meeting must be held prior to the initiation and billing of any CSEDW services included in the plan. If all CSED services can be finalized at this meeting and the full range of planned services are finalized and documented, then the 30-Day POC meeting is not necessary. Requirements for participation, notice, documentation requirements and billing requirements are the same for all CFT meetings. CFT members, including the member, legal representative, wraparound facilitator, and all CSED service providers are required to attend the and sign the POC for all formal CFT meetings. Exceptions for participation may be granted for waiver members or the legal guardian/representative by the MCO, if necessary.

502.18.2.2 30-Day CFT Meetings and 90-Day Review CFT Meetings

The Initial POC must be finalized within 30 calendar days of waiver enrollment. The resulting master POC (WV-BMS-CSED-5) completed by the wraparound facilitator identifies the comprehensive array of services necessary to fully support the member who receives CSEDW services. The goals in the POC are informally reviewed every 30 to 45 days by the CFT with the child and family to revisit the goals and progress on those goals that are being facilitated by each CSEDW provider. These reviews are documented in the SED-3 form for the visit and attached to the POC. A copy is also forwarded to the MCO Care Coordinator. The CFT must formally meet up to 30 calendar days prior to the member's annual anchor date to develop the annual POC. The effective date of the annual POC will remain the annual anchor date even if the POC was held 30 calendar days earlier. The anchor date sets the clock for scheduling all subsequent CFT meetings. The POC must be formally reviewed and approved by the CFT at least every 90 calendar days. The POC must be reviewed at significant life event meetings. Requirements for participation, notice, documentation requirements, and billing requirements are the same for all CFT meetings. CFT members, including the member, legal representative, wraparound facilitator, and all CSED service providers are required to attend the and sign the POC for all formal CFT meetings.

Since the population served under the waiver is at a PRTF level of care (LOC), at times stability would be considered an improvement for the waiver member. As long as the waiver member continues to meet medical and financial eligibility and participates in treatment, waiver services continue. If waiver members are hospitalized due to a crisis that puts themselves or others at imminent risk of harm, the member's waiver slot is suspended during that time so that they can return home with waiver supports, provided they access services within 180 days.

502.18.2.3 Transfer/Discharge CFT Meeting

This meeting is held when a member transfers from one CSEDW provider to another or when the member no longer meets medical eligibility or does not want to participate in the program. When the member transfers from one agency to another, the transfer-from agency is responsible for coordinating the meeting and documenting the transfer. The member or their parent/legal representative, as well as the transfer-to agency, must agree to the transfer. The transfer-from agency must send the resulting POC to the transfer-to agency within 14 calendar days. The transfer-from agency must also submit a transfer and attach Transfer/Discharge Form (WVBMS-CSED-10) to the MCO within seven calendar days. If the resulting POC is found to be invalid because necessary team members did not attend, or necessary

services were not addressed during the transfer, then the authorizations may be rolled back to the transfer-from agency until a valid CFT meeting is held.

The member may be discharged from the program for the following reasons including, but not limited to:

- Loss of financial or medical eligibility
- Direct-care services have not been provided for 180 continuous days. For example, the member is placed in psychiatric treatment for an extended period of time
- Unsafe environment: an unsafe environment is one in which the direct support worker and/or other agency staff are threatened or abused, and the staff's welfare is in jeopardy. This may include, but is not limited to the following circumstances:
    - The member or other household members repeatedly demonstrate sexually inappropriate behavior; display verbally and/or physically abusive behavior; and/or threaten the direct support staff or other agency staff with guns, knives, or other potentially dangerous weapons, including menacing animals or verbal threats to harm the direct-care staff and/or other agency staff
    - The member or other household members display abusive use of alcohol and/or drugs and/or other illegal activities in the home
- The member is persistently non-compliant with the POC
- The member no longer desires or requires services
- The member moves to another state
- The member can no longer be safely maintained in the community

CFT members, including the member, legal representative and wraparound facilitator are required to attend and sign the Transfer and Discharge POC. Exceptions for participation may be granted for waiver members or the legal guardian/representative by the MCO, if necessary. Transfer/Discharge POCs must be forwarded to the CFT and the MCO Care Manager within 14 calendar days.

502.18.2.4 Significant Life Event POC Meeting

This meeting is held within seven days when there is a significant change in the member's assessed needs and/or planned services. A significant life event may be the result of a change in the member's medical/physical status, behavioral status, or availability of natural supports. The wraparound facilitator and CFT can elect to convene a significant life event CFT meeting at any time and should do so whenever there is a concern about an incident or due to any obvious trend in escalation of behavior that is concerning. For example, if a child has escalating behaviors or is not taking needed medications. Conversely, there could be a circumstance where an event might be considered significant, like moving from elementary school to middle school or changing schools, but that event is anticipated and planned for in advance and does not create clinical concerns for the child or youth. In this circumstance, a CFT meeting may not be needed. Another example could be when a child is hospitalized. Once the child is admitted, they are put on hold for waiver services, the significant life event CFT meeting would be convened prior to discharge to update the team and plan for a transition home. The POC must be updated to include CFT recommendations, minutes, and signatures of all CFT members, in ink or in an electronic documentation system, indicating their attendance and agreement or disagreement.

A face-to-face meeting must be held under any of the following circumstances including but not limited to:

- All team members do not agree with services or service mix
- The member calls for a meeting
- A new goal will be implemented for the member
- The member changes residential setting (e.g., moves from natural family to a Licensed Group Home, foster care, or institutional setting or vice versa)
- The member goes into crisis placement
- The member has a change in legal representative status
- The primary caregiver changes or passes away
- The member receives a new service not previously received
- The member receiving services has had a documented change in need between the times the annual reassessment was conducted

The wraparound facilitator, in consultation with the member receiving services or their parent/legal representative and the CFT, should conduct a significant life event meeting whenever the need is identified. Requirements for participation, notice, documentation requirements and billing requirements are the same for significant life event CFT meetings as other CFT meetings. CFT members, including the member, legal representative, wraparound facilitator, and all CSED service providers are required to attend the and sign the POC as they are for any other CFT meeting. As with other CFT meetings, the MCO can grant an exception to participation for the member and the member's legal representative for this meeting, if needed.

For situations where a CSEDW member does not appear to be improving with waiver services, the MCO tracks the incident reports by CSEDW member. If there is a single serious report or a number of incident reports made for the same member, the MCO Care Management team will confer with the wraparound facilitator and offer suggestions of additional services and supports available to help stabilize the member. The wraparound facilitator will convene the CFT to review the child's progress and recommend services to address the needs. The MCO will review these and generally approve additional services for the waiver member, based on the CFT's recommendations.

502.19 WRAPAROUND FACILITATION REQUIREMENTS

Wraparound facilitation providers must exhibit effective inter-agency coordination that demonstrates a working knowledge of other community agencies. This means the provider and its contracting agencies must be aware of the specific program goals of other human service agencies, and maintain current information regarding the types of services offered and limitations on these services. Similarly, providers must help ensure that other human service agencies are provided with accurate, up-to-date information regarding the provider's services, service limitations, and priorities within those services. The provider must be an enrolled as a West Virginia Medicaid provider and approved CSEDW provider. Independent wraparound facilitation agencies must be certified as independent wraparound facilitators by the BMS. The provider must have a contract with the identified MCO and must coordinate care between the MCO care manager and all other CSED providers for each waiver participant.

For children receiving wraparound services in a child placing agency setting under § 78-2-1 , wraparound facilitation providers must also maintain documentation that the home is in in compliance with the WV Statewide Transition Plan (STP) for individuals receiving HCBS by verifying the home meets the STP requirements. The child placing home agency home study includes completion of the HCBS settings

requirements checklist when initially licensing therapeutic foster homes to ensure the homes meet these requirements before they are licensed. For ongoing monitoring of these settings, the Wraparound Facilitator will complete the settings checklist monthly during one of their home visits each month. For all children receiving CSEDW services, the wraparound facilitator will use the checklist to review any potential new home or placement prior to the move to assure that it meets settings requirements. If there are any concerns identified, the wraparound facilitator will assist the member/family in locating other housing options prior to the move.

If there are any changes to a CSEDW member's home environment, who is receiving services while also receiving placement services through a child placing agency, the wraparound facilitator will complete a new HCBS settings checklist for the new setting. If there are any concerns or areas on the checklist indicating that the setting does not meet requirements, the wraparound facilitator will convene a significant life event CFT meeting to discuss the reasons for the change in the home environment within seven days. If modifications are identified either prior to or after the child is placed in a therapeutic foster home, then the modification must be in response to a specific addressed need and must be identified during a CFT meeting and justified in the member's POC. The justification for any accommodations recommended by the CFT must be forwarded to the MCO care coordinator for review and approval. If the change in settings does not stem from an accommodation in settings which are medically necessary for the member or the MCO does not believe that the change in settings is warranted, then the MCO will inform the wraparound facilitator that the setting issue must be resolved within 30 days. At the 30 day mark or before, if the child placing agency indicates that the issue is resolved, the wraparound facilitator will complete a new settings checklist and forward the checklist to the MCO care coordinator. Inability to resolve the issue within 30 days will result in the issue being escalated to BMS during a monthly contract meeting and BMS will work with the MCO and child placing agency provider to resolve the issue.

Wraparound facilitators must also be fully licensed (this does not include provisional or temporary license) in West Virginia as a social worker, professional counselor or registered nurse *or* may be an individual with a four year degree (Bachelor of Arts (BA) or Bachelor of Science (BS)) in a human service field with two years post-college work experience in this field and certification in the online wraparound facilitation training developed by BMS. Wraparound facilitators may have a Regents Bachelor of Arts (RBA) degree provided they have the concentration in social services documented on their transcript from the school granting the degree.

The wraparound facilitators must be certified to perform the CANS assessment, which is a comprehensive trauma-informed behavioral health evaluation and communication tool. CANS assessments help decision-making, drive service planning, facilitate quality improvement, and allow for outcomes monitoring. Wraparound facilitators will also be trained in providing wraparound services in alignment with the National Wraparound Initiative's (NWI) principles.

Providers must maintain documentation of staff qualifications in staff personnel files. Documented evidence includes, but is not limited to transcripts, licenses, and certificates. Wraparound facilitation providers must have a review process to ensure that employees providing wraparound facilitation services possess the minimum qualifications outlined above. The review process must occur upon hiring of new employees and on an annual basis to assure that credentials remain valid.

Wraparound facilitation providers must plan annual staff development and continuing education activities for its employees and contractors that broaden their existing knowledge in the field of mental health, substance abuse, and/or developmental disabilities and related areas.

Wraparound facilitation providers must have the following training requirements completed prior to serving members:

- State-sanctioned training to educate providers on providing wraparound facilitation services consistent with NWI
- Conflict-free wraparound facilitation training
- Be CANS-certified as a wraparound facilitator

Staff development and continuing education activities must be related to program goals and may include supporting staff by attendance at conferences, university courses, visits to other agencies, use of consultants, and educational presentations within the agency. Documentation of staff continuing education, staff development, and wraparound facilitation training must be maintained in staff personnel files. This documentation at a minimum must contain a description of the continuing education activities, and must be signed and dated by the wraparound facilitation trainer and the wraparound facilitator.

Conflicts of interest are prohibited. A conflict of interest is when the wraparound facilitator who represents the member who receives services has competing interests due to affiliation with a provider agency, combined with some other action. “Affiliated” means the wraparound facilitator has either an employment, contractual or other relationship with a provider agency such that the Wraparound facilitator receives financial gain or potential financial gain or job security when the provider agency receives business serving CSEDW members.

502.19.1 Member Choice of Single Wraparound Facilitation Provider

At the time of enrollment, the annual redetermination assessment, and at any time it is requested by the member or parent/legal guardian, each member or parent/legal representative will be provided a list of contact information for all Medicaid-enrolled providers rendering wraparound facilitation services. The member must be given an opportunity to choose one approved wraparound facilitation provider and must indicate this choice on BMS-approved CSED Waiver FOC form. A signed copy of this form must be retained in the member’s record and must serve as an enrollment, disenrollment, or re-enrollment of the member with the provider.

The BMS reimburses only for wraparound facilitation services provided by the Medicaid-enrolled provider chosen by the member.

A member may choose a new wraparound facilitation provider at any time. The effective date of the change of providers will be the first day of the month following the change.

If there are a lack of available providers to accommodate the waiver member’s need for services within 25 miles, or who speak the waiver member or family’s language or have a common cultural background to the waiver member and/or family, the State can waive the conflict-free wraparound facilitation requirement to allow a LBHC to provide wraparound facilitation services as well as other waiver services to that waiver member.

The Wraparound Facilitator is responsible for monitoring the implementation of the waiver member's POC, including:

- Reviewing the POC at least monthly or more frequently if needed and verifying with the CSEDW member and family that CSEDW and other services and supports are currently being delivered as outlined in the POC. If there are any unanticipated deviations from the plan, the Wraparound Facilitator will document them in the visit notes and follow up with the CSEDW service provider. Generally, the Wraparound Facilitator is expected to meet weekly with the CSEDW member and family, unless the CSEDW member is improving and the family has requested less frequent visits. However, at a minimum, the Wraparound Facilitator will meet with each CSEDW member and family at least monthly. The frequency of visits is driven by the progress of the member and family's preferences.
- When reviewing the POC, the Wraparound Facilitator will also review the Crisis Plan and any recent incidents. This review of the Crisis Plan should occur for both the informal monthly review of the POC as well as the formal CFT meetings held at least every 90 days.
- If the review of the Crisis Plan indicates updates are needed during the informal monthly review of the POC with the member and family, the Wraparound Facilitator will convene a Significant Life Event Team meeting to revise the Crisis Plan and POC.
- If the CSEDW member and family no longer want or need a particular CSEDW service, the Wraparound Facilitator will amend the POC with the CFT as appropriate and send the amendment to the MCO Care Manager. Any additional needed services to help ensure the health and safety of the CSEDW member will also be added to the POC at the CFT.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the member when a LBHC is authorized to deliver wraparound facilitation services and other CSEDW waiver services to the same member.

- The LBHC must have separate files for wraparound facilitation and for other CSEDW services. It is the responsibility of the LBHC to ensure separate file maintenance.
- The wraparound facilitation offices are in a separate location from the CSEDW service provider offices (may be in same building, but physically separated).
- There shall be no sharing of supervisory staff between the wraparound facilitation part of the agency and the CSEDW service provider.
- The wraparound facilitator may not provide any direct care services and other CSEDW service providers may not provide Wraparound Facilitation.
- The wraparound facilitator must have evidence of a written 25-mile radius, language or cultural background authorization issued by the MCO on behalf of BMS agency present in the member's file.

In addition, the MCO Care Manager tracks and reviews all POCs and amendments. The MCO Care Manager also reviews all critical and non-critical incidents to ensure that the POC and Crisis Plan are adequate to meet the needs of CSEDW participants. The MCO Care Manager will document these reviews and any discussions with the Wraparound Facilitator in the CSEDW member's record. Issues with the POC that are not resolved during the CFT meeting will be considered a complaint or grievance to the MCO and responded to according to that process.

In situations where the LBHC is providing wraparound facilitation services and other services, the MCO will review the POC and ensure that the individual providers of services in the Agency are distinct units within the Agency, supervised by separate Managers and that the roles of each individual provider and responsibilities for services under the POC are clearly defined. Once a single LBHC Agency is approved to provide both Wraparound Facilities (WF) and CSEDW services, the MCO will outreach to the CSEDW member and family to educate them regarding the option to have an independent WF or a choice of CSEDW service providers when one becomes available. This will give the CSEDW member/family the option to have a separate WF from CSEDW service providers whenever possible. The MCO Care Coordinator will contact each CSEDW legal guardian or family/CSEDW member quarterly to verify the frequency of services and offer additional providers if they are available. In addition to the separation of CSEDW services and Wraparound Facilitation services required above, the MCO conducts additional review of POCs to verify that the services in the plan are provided through claims data match for situations where a single LBHC is providing both WF and CSEDW services.

Waivers based on the above situations are awarded for one year, unless another appropriate willing and able provider becomes available, to provide agencies with sufficient program operation time before revisiting the continued need for a waiver of the conflict-free wraparound facilitation requirements becomes available. During the one-year waiver period, BMS or their designees have the right to review agency policies and operations.

BMS restricts the entity that develops the POC from providing other CSEDW services without the direct approval of the state. The BMS will allow for language, cultural and geographical exceptions based on the availability of willing and qualified providers in the member's catchment area. If a member disagrees with the BMS regarding the availability of willing and qualified providers, this may be handled through the established grievance process beginning with the MCO.

For providers granted an exception to the conflict-free requirements, BMS has ensured conflict of interest protections, certifying that wraparound facilitators employed by that provider remain neutral during the development of the POC and including the requirement that the provider separate direct care services and wraparound facilitation into distinct functions, with separate oversight.

Wraparound facilitation agencies must have a policy that specifies, at a minimum:

- Members are given a choice of wraparound facilitators within the LBHC when there is a lack of alternative providers within 25 miles and/or those who speak/represent the CSEDW member's language or cultural background.
- Documentation of the member's choice from at least two wraparound facilitators, who have capacity on their caseload and are separately managed from the CSEDW service, is included in the file with the member's signature on the option letter, in ink or in an electronic documentation system.
- Describes how the LBHC ensures that the wraparound facilitator is free from influence of direct service providers regarding the member's POC.
- Includes a basic description of the duties of the wraparound facilitation services supervisor and the wraparound facilitation supervisor positions.

Any wraparound facilitator working for a LBHC that will also be providing other CSEDW services will sign a Wraparound Facilitator Conflict of Interest Assurance form and the completed form must be placed in the member file at the LBHC. Failure to have the form in the file when reviewed will result in sanctions. BMS will monitor the conflict free wraparound facilitation process via retro-reviews conducted by the ASO and may periodically request additional reports from the MCO. Evidence of administrative separation on organizational chart that includes position titles and names of staff must be available to BMS or their designee during all retro-reviews or upon request. Further, the ASO will review LBHC provider documentation during their annual quality reviews to verify that documentation aligns with separate and distinct services.

SERVICES

The services under this waiver are limited to additional services not otherwise covered under the Medicaid State plan, including Early Periodic Screening, Diagnosis and Treatment (EPSDT), but consistent with waiver objectives of avoiding institutionalization.

502.20 WRAPAROUND FACILITATION SERVICES

Wraparound facilitation services help to ensure and coordinate a comprehensive set of supports, resources, and strategies for each member and family.

502.20.1 Wraparound Facilitation

Procedure Code: T1016-HA
Service Unit: 15 minutes
Telehealth: Available with 02 place of service location only when due to inclement weather and excluding the monthly face-to-face contact for review of the POC. Telehealth justification must be provided within the service note.
Service Limit: Up to 874 units per service plan year; caseloads capped at 15 members per wraparound facilitator.

Site of Service: This service may be provided in the member's family residence, a licensed CSEDW provider agency office, public community locations, or via telehealth as indicated above.

Staff Credentials: Bachelor's degree in human services with two years post-college documented work experience serving this population and certified to complete the CANS assessment. Independent providers must be certified to practice independently per the certification process approved by the BMS. The wraparound facilitator will have documentation showing that training on the National Wraparound Initiative requirements has been completed.

Wraparound Facilitation will be subject to usage of the EVV utilization and all corresponding requirements.

Definition: The wraparound facilitator is responsible for engaging the member and family in a partnership of shared decision-making regarding the POC development and implementation throughout the member's enrollment in the CSEDW. The wraparound facilitator helps ensure and coordinate a comprehensive set

of supports, resources, and strategies for each member and family. They work closely with service providers to help assure that CSEDW services and clinical treatment modalities augment each other for optimal outcomes for members and parents/legal representatives. The wraparound facilitator will lead the CFT through engagement and team preparation, initial plan development, plan implementation, and transition, and provide intensive wraparound facilitation. This includes the development and implementation of a transition plan for participants who will reach the waiver's maximum age limit.

The wraparound facilitator, and the agency that employs them, cannot provide any other waiver or State plan services for the member, unless approved for a geographic exception by the MCO. The agency providing wraparound facilitation must provide FOC for all waiver and State plan services providers.

Services provided in this category will be in response to specific goals in the member's POC and will not duplicate any other services provided to the member.

If, between regular service planning sessions, the member requires access to a service not previously mentioned on the wraparound facilitation section of their service plan, both the member, the parent/legal representative, and the member's wraparound facilitator convene a significant life event CFT meeting to address adding the needed service to the plan.

Documentation: A Medicaid-enrolled provider of wraparound facilitation services must maintain the following information/documentation:

- An individual permanent clinical record for each member receiving wraparound facilitation services.
- Evidence in each clinical record that the member is shown to be in a targeted population as defined under the Applicant Eligibility and Enrollment section of this policy.
- Assesses and plans for coordination of health care needs within the POC.
- The wraparound facilitator will assist those waiver members who are planning to live independently in the community with securing a lease that provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law. The dwelling must include privacy in the unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit, ability of the waiver member to control his/her own schedule including access to food at any time, allow for visitors at any time, and be physically accessible. In addition, the wraparound facilitator will ensure the lease includes provisions to address bed bug infestations and other housing concerns that may impact the waiver member's health and stability, including a plan for relocation and seeking reimbursement from financially responsible party(s).
- A clinical record that must include documentation specific to services/activities reimbursed as CSEDW wraparound facilitation. This includes a specific note for each individual wraparound facilitation service/activity provided and billed.
- A signed case note for each home visit, unless there is documentation from the MCO granting an exception for any home visit not completed. These requests are generally based on the member and family's request, due to special circumstances, like a visit with relatives out of state.
- Documentation demonstrating that the wraparound agency has been certified as meeting NWI standards for high-fidelity wraparound.

Each case note must include all components as identified in the CSED Waiver wraparound facilitation Form including, but not limited to:

- Be dated and signed by the wraparound facilitator along with their credentials, e.g. BA, BSW
- Have relevance to a goal or objective in the member's POC
- Include the purpose and content of the activity as well as the outcome achieved
- Include a description of the type of contact provided (e.g., face-to-face, correspondence, telephone contacts)
- List the location the activity occurred
- List the actual time spent providing each activity by itemizing the start and stop time

502.20.2 Wraparound Facilitation Service Activities

Wraparound facilitation activities include, but are not limited to the following:

- Engages the member and parent/legal representative throughout CSEDW enrollment.
- Assembles the CFT, including the member and their parent/legal representative.
- Helps to identify strengths and needs of the member and parent/legal representative as a precursor to POC development.
- Leads CFT meetings.
- Develops and updates POC in partnership with the member and parent/legal representative that is reflective of the member's and parent/legal representative's priorities. The POC is individualized, strengths-based, addresses all life domains. The POC must be coordinated with any psychiatric treatment received through other providers, focused on developmental tasks, resiliency and wellness, inclusive of safety issues, targeted to address assessment indicators (e.g., CANS), and oriented towards discharge readiness.
- Administers the CANS to the member at any identified 'significant life event(s),' and in preparation for formal POC development at least every 90 days, but not more than one time in a calendar month.
- Works with the MCO care manager to identify service providers, natural supports, and other community resources to meet member and parent/legal representative needs and make necessary referrals to include behavioral health, health, and dental care providers.
- Facilitates connections with identified resources and providers; advocacy which includes the process of helping to empower members and parents/legal representatives to initiate and sustain interactions that support their overall wellness, interceding on their behalf when necessary to gain access to needed services and supports.
- Documents and maintains a record regarding the POC and all revisions to the POC.
- Monitors the implementation of POC, making sure the member and parent/legal representative are receiving the services identified in POC; on-going assessment and documentation of the member and parent/legal representative's strengths and needs, progress towards achieving goals, and efficacy of delivered services.
- Maintains communication among all team members.
- Consults with the family and other team members to help make sure the services the member and parents/legal representatives are receiving continue to meet their needs, and assembles the team to make necessary adjustments and revisions.

- Initiates and coordinates discharge and after-care planning; linkage and referral to services and supports as specified in the POC including but not limited to: identifying local resources and services for use during both enrollment and discharge planning, sharing information with the member and parent/legal representative on relevant resources and service providers, including local family support programs, advisors and advocates, engaging the member and parent/legal representative in making informed choices.
- Meets in person with the member and their parent//legal representative in the member's home to verify services are delivered in a safe environment and appropriately documented in accordance with the POC, and that the member receiving services continues to meet eligibility. The purpose of these visits is to determine progress of the member receiving services and resources, assess achievement of training objectives, identify unmet needs, and provide for the appropriate support as necessary.
- Acts as the primary CSEDW contact for the member, parent/legal representative, or other CFT members.
- Manages and warehouses all information related to member, parent/legal representative, or other CFT member issues, questions, critical incidents, etc. and will work to help ensure all such items are addressed.
- Facilitates the development and implementation of an individualized transition plan for members who will reach the waiver's maximum age limit or will be discharged.

502.21 CRISIS SERVICES: MOBILE RESPONSE

Procedure Code: H2017-HA
Service Unit: 15 minutes
Telehealth: Available with 02 service location, only when distance does not permit staff to reach the member within one hour. Telehealth justification must be provided within the service note.
Service Limit: Up to 56 units per calendar week

Site of Service: This service may be provided in the member's family residence, a licensed CSEDW provider agency office, public community locations, or via telehealth as indicated above.

Staff Credentials: Bachelor's degree in human services (in social work, psychology, sociology or other human services field) with one year of documented experience working with this population.

Documentation: A service note must be included for each instance or day of service that reflects the name of the service provider, date of the service, start and stop time of the service, the service code and signature and credential of the provider, in ink or in an electronic documentation system.

Definition: Mobile Response services are 24-hour services designed to respond immediately to issues that threaten the stability of the member's placement and their ability to function in the community. This service is intended to be of very short duration and primarily to engage/link to other services and resources, e.g., intensive in-home supports and services. This service may only be delivered in an individual, one-to-one session. The service includes de-escalation, issue resolution support, and the development of a stabilization plan for any additional services that are needed to resolve the immediate situation. The wraparound facilitator will remain the primary contact for CSEDW; however, the agency providing the in-home family therapy will implement and oversee all mobile response activities; including

primary point of contact for the service, on-call coverage, staff training and credentialing, referral, and data reporting. Written policy and procedures, as defined by BMS, specific to Mobile Response must be developed and maintained by any agency providing the service. The wraparound facilitation agency will be notified of any mobile response activities. Services provided in this category will be in response to a specific goal(s) in the member's POC and will not duplicate any other services provided to the member.

Documentation: Providers must maintain a permanent clinical record for all members of this service in a manner consistent with applicable licensing regulations. Documentation must contain an activity note containing a summary of events leading up to the crisis, the therapeutic intervention used, and the outcome of the service. The activity note must include the signature and credentials of the staff providing the intervention, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times. The note documenting this review must include recommendations regarding appropriate follow-up and whether the treatment plan is to be modified or maintained, the practitioner's signature with credentials, and the date of service, in ink or in an electronic documentation system. The signature will serve as the order to perform the service.

Exclusions: The following activities are excluded from being performed through the Mobile Response Service Code:

- Response to a domestic violence situation
- Admission to a hospital, crisis stabilization unit (CSU), or PRTF
- Time waiting for transportation or the transportation itself
- Removal of a minor or an incapacitated adult from an abusive or neglectful household
- Completion of certification for involuntary commitment

502.22 DAY SERVICES

Documentation: Documentation for the following day services must contain an activity note describing the service/activity provided and the relationship of the service/activity to objectives in the member's POC. Documentation must include: the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times, in ink or in an electronic documentation system. Documentation must show progress or lack of progress toward the achievement of goals and objectives that are the focus of the sessions.

The services must be specified in the Initial and/or master POC of the member. The plan may be incorporated into the Initial or master POC, or after referencing the service on the POC, be a separate plan created by the professional clinician. The plan must be signed by the clinicians responsible for implementing the service.

The plan must identify the specific, sequential, steps necessary toward identified skill acquisition identified in the goal and be related to previously assessed deficits of the member (e.g., hand over hand, instruction, demonstration, practice, independent implementation, and mastery). The steps identified must establish a means for measuring achievement of objectives within the specified time frame. The plan must establish a realistic time frame for skill acquisition. If objectives have not been achieved within a realistic time frame established by the POC, it must be discontinued or revised.

502.22.1 Independent Living/Skills Building

Procedure Code: H2033-HA
Service Unit: 15 minutes
Telehealth: Not Available
Service Limit: Up to 160 units per calendar week in combination with job development and Supported Employment. Recipients must be aged 15-20 to access this service.
Site of Service: This service may be provided only in public community locations.

Staff Credentials: Bachelor's or associate degree in Human Services and a minimum of one year of documented experience working with this population *or* high school diploma or GED and a minimum of two years of documented experience working with this population.

Documentation: An approved authorization for services dated prior to the initiation of services must be included in the member's record and the service must be included in the POC. A service note must be included for each instance or day of service that describes the service activity provided (within guidelines of the CSED waiver manual, name of the service provider, date of the service, start and stop time of the service, the service code and signature and credential of the provider, in ink or in an electronic documentation system).

Independent Living/Skills Building will be subject to usage of the EVV utilization and all corresponding requirements.

Definition: Independent living/skills building (CMS defined: day habilitation) services focus on enabling the member to attain or maintain their maximum potential and shall be coordinated with any needed therapies in the individual's POC, such as physical, occupational, or speech therapy. Provision of regularly scheduled activities in a non-residential setting, separate from the member's private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Services are furnished consistent with the member's POC. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day). Independent living/skills building services will facilitate the member's achievement of their goals of community inclusion and remaining in/returning to their home. TM offers structured, one-to-one, strength-based support services between a therapeutic mentor and a youth for the purpose of addressing daily living, social, and communication needs. The mentor works with the in-home therapist to explore a youth's interests and abilities and creates activities that build various life skills and result in linkages to community activities. These services will include coaching, supporting, and training the youth in age-appropriate behaviors, interpersonal communication, conflict resolution and problem solving, and are provided in community settings (such as libraries, stores, parks, city pools, etc.). Independent living/skills building can be related to activities of daily living, such as personal hygiene, household chores, volunteering, household management, money management/budgeting, and socialization, if these skills are affected by the waiver member's SED. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy and informed choice necessary to successfully function in the community.

Services provided in this category will be in response to a specific goal(s) in the member's POC provided under the direction of the in-home therapist and will not duplicate any other services provided to the member.

502.22.2 Job Development

Procedure Code: T2021-HA
Service Unit: 15 minutes
Telehealth: Not Available
Service Limit: Up to 160 units per calendar week in combination with independent living/skills building and supported employment. Recipients must be aged 15-21 to access this service.

Site of Service: This service may only be provided in community locations.
Staff Credentials: High school diploma or GED, indirectly supervised by in-home support staff person. Indirect supervision is defined as supervision provided by a licensed individual who monitors but is not required to be present in the setting when services are rendered.

Documentation: An approved authorization for services dated prior to the initiation of services must be included in the member's record and the service must be included in the POC. A service note must be included for each instance or day of service that describes the service activity provided (within guidelines of the CSED waiver manual, name of the service provider, date of the service, start and stop time of the service, the service code and signature and credential of the provider, in ink or in an electronic documentation system).

Definition: Job development (CMS defined: prevocational services) provides learning and work experiences, including volunteer work and personal care activities, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time that does not exceed one year and have specific outcomes to be achieved, as determined by the member and their CFT through an ongoing POC process. Members receiving job development must have employment-related goals in their POC the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which a member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by members without disabilities is considered to be the successful outcome of job development. Job development should enable each member to attain the highest level of work in the most integrated setting and with the job matched to the member's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills that lead to competitive and integrated employment including, but not limited to ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training. Participation in job development is not a required pre-requisite for supported employment services provided under the waiver. Many members, particularly those transitioning from school to adult activities, are likely to choose to go directly into supported employment. Supported employment for members with behavioral health conditions emphasizes rapid job placement in lieu of job development. Documentation is maintained in the file of each member receiving this service that a referral

has been made to a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401 et seq.). Member may utilize the CSEDW non-medical transportation service for travel to and from the member's residence and their supported employment or job development sites. Services provided in this category will be in response to a specific goal(s) in the member's POC and will not duplicate any other services provided to the member.

502.22.3 Supported Employment, Individual

Procedure Code: T2019-HA
Service Unit: 15 minutes
Telehealth: Not Available
Service Limit: Up to 160 units per calendar week in combination with independent living/skills building and job development. Recipients must be aged 18-21 to access this service.

Site of Service: This service may only be provided in public community locations.

Staff Credentials: High school diploma or GED, indirectly supervised by in-home support staff person

Documentation: An approved authorization for services dated prior to the initiation of services must be included in the member's record and the service must be included in the POC. A service note must be included for each instance or day of service that describes the service activity provided (within guidelines of the CSED waiver manual, name of the service provider, date of the service, start and stop time of the service, the service code and signature and credential of the provider, in ink or in an electronic documentation system).

Definition: Supported employment - individual employment support services are the ongoing supports to adult members who, because of their disabilities need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above West Virginia's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by members without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals. Supported employment - individual employment supports may also include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits and work-incentives, planning and management, transportation, asset development and career advancement services. Other workplace support services including services not specifically related to job skill training that enable the member to be successful in integrating into the job setting such as personal care activities. Documentation is maintained in the file of each member receiving this service that a referral has been made to a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or 2. Payments that are passed through to users of supported employment

services. Member may utilize the CSEDW non-medical transportation service for travel to and from the member's residence and their supported employment or job development sites. Services provided in this category will be in response to a specific goal(s) in the member's POC and will not duplicate any other services provided to the member.

502.23 EXTENDED PROFESSIONAL SERVICES: SPECIALIZED THERAPY

Procedure Code: G0176-HA
Service Unit: $1.00
Telehealth: Not Available
Service Limit: Up to $1000.00 per service plan year in combination with Assistive Equipment

Site of Service: This service may be provided in the member's family residence, a licensed CSEDW provider agency office, and/or public community locations.

Staff Credentials: Professional license, certification and/or skills training in the specific specialized therapy

Definition: Specialized therapy refers to activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of a member's needs that arise as a result of their SED. The service is intended to assist the member in acquiring the knowledge and skills necessary to understand and address these treatment needs, e.g., developing and enhancing problem-solving skills, coping mechanisms, strategies for the member's symptom/behavior management. Specialized therapies are professional services that should promote full membership in the community and/or increase safety in the home environment and local public community and/or assist the individual in self-directing their services. Specialized therapy services must be directed and provided by professionals who are trained, qualified, and/or certified to provide activity therapies. Providers of specialized therapy cannot treat their own family members. Services provided in this category will be in response to a specific goal(s) in the member's POC and will not duplicate any other services provided to the member and based on medical necessity.

Documentation: An approved authorization for services dated prior to the initiation of services must be included in the member's record and the service must be included in the POC. A service note must be included for each instance or day of service that describes the service activity provided, name of the service provider, date of the service, start and stop time of the service, the service code and signature and credential of the provider, in ink or in an electronic documentation system.

Documentation must show progress or lack of progress toward the achievement of goals and objectives that are the focus of the sessions.

The services must be specified in the initial and/or master POC of the member. The plan may be incorporated into the initial or master POC, or after referencing the service on the POC, be a separate plan created by the professional clinician. The plan must be signed by the clinicians responsible for implementing the service.

The plan must identify the specific, sequential, steps necessary toward identified skill acquisition identified in the goal and be related to previously assessed deficits of the member (e.g., hand over hand, instruction, demonstration, practice, independent implementation, and mastery). The steps identified must establish a means for measuring achievement of objectives within the specified timeframe. The plan must establish a realistic time frame for skill acquisition. If objectives have not been achieved within a realistic time frame established by the POC, it must be discontinued or revised.

502.24 Other Services

Documentation: Documentation for equipment covered under the following services must be specified in the Initial and/or master POC of the member. The plan may be incorporated into the initial or master POC, or after referencing the service on the POC, be a separate document created by the professional clinician. The plan must be signed by the clinicians responsible for implementing the service. These services must be purchased from an established business or otherwise qualified entity or individual and must be documented by a dated and itemized receipt or other documentation.

502.24.1 Assistive Equipment

Procedure Code: T2035-HA
Service Unit: $1.00
Telehealth: Not Available
Service Limit: Up to $1000.00 per service plan year in combination with Specialized Therapy

Site of Service: N/A

Documentation: In order for this service to be reimbursed, it must be prior authorized by the MCO and included in the waiver member's POC as a service connected to the waiver members' needs and goals and within the guidelines identified in 502.18.2 (POC Development) of this policy.

Definition: Assistive equipment refers to an item or piece of equipment that is used to address the member's needs that arise as a result of their SED. The equipment should increase, maintain, or improve functional capabilities of the member, assist them to remain in the home and/or community and avoid an out-of-home placement.

Services provided in this category will be in response to a specific goal(s) in the member's POC and will not duplicate any other services provided to the member and based on medical necessity.

502.24.2 Community Transition

Procedure Code: T2038-HA
Service Unit: $1.00
Telehealth: Not Available
Service Limit: Up to $3,000 for a one-time transition period; a transition period can last up to six months. Recipient must be aged 18 through 21 years to access this service.

Site of Service: N/A

Definition: Community transitions services are non-recurring set-up expenses for adult individuals who are transitioning from an institutional living arrangement to a living arrangement in a private residence where the member is directly responsible for their own living expenses. Allowable expenses are those necessary to enable a member to establish a basic household that do not constitute room and board and may include:

- Security deposits that are required to obtain a lease on an apartment or home
- Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens
- Set-up fees or deposits for utility or service access, including telephone, electricity, heating, and water
- Services necessary for the individual's health and safety such as one-time cleaning prior to occupancy
- Moving expenses
- Necessary home accessibility adaptations
- Activities to assess need, arrange for, and procure needed resources

Community transition services are furnished only to the extent that they are reasonable and necessary as determining through the POC development process, clearly identified in the POC (See Section 502.18.2 POC Development) and the member is unable to meet such expense or when the services cannot be obtained from other sources.

Community transition services cannot be used to cover the following items. Please note that this is not intended to be an all-inclusive list of exclusions:

- Rent/mortgage expenses;
- Home improvements or repairs that are considered regular maintenance or upkeep;
- Recreational or illegal drugs;
- Alcohol;
- Medications or prescriptions;
- Credit card or medical bills (even if they are past due);
- Payments to someone to serve as a representative;
- Gifts for staff, family, or friends;
- Electronic entertainment equipment;
- Regular utility payments;
- Swimming pools, hot tubs or spas or any accessories, repairs or supplies for these items;
- Travel;
- Vehicle expenses including routine maintenance and repairs, insurance and gas money;
- Internet service;
- Pet/service/support care, including food and veterinary care;
- Experimental or prohibited treatments;
- Education;
- Personal hygiene services (manicures, pedicures, haircuts, etc.);
- Assistive technology, or;
- Discretionary cash
- Groceries

- Household appliances
- Items that are intended for purely diversional/recreational purposes

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

Services provided in this category will be in response to a specific goal(s) in the member's POC and will not duplicate any other services provided to the member and based on medical necessity.

All community transition services must be approved by the MCO prior to being purchased/provided. The funding request process is as follows:

- The fund request is completed by the wraparound facilitator to request an item that has been determined necessary by the CFT, is not an excluded item/is an approvable item (listed above), and is incorporated on the POC.
- The wraparound facilitator will ensure the items listed do not exceed $3000.00.
- Email the estimate and request form/invoice, to the MCO. If a retailer for the item has been identified, a link to the cart with the items or a link for each item to be purchased can be included in the email.
- If the request is approved, the wraparound facilitation agency will invoice the MCO, who will pay the wraparound facilitation agency, who will purchase items required from the vendor directly for the items to be sent to the member.
- At no time will the member or legal guardian be reimbursed directly for community transition items.
- All fund requests and supporting documentation are saved in the waiver member's file.

If there is a question about whether an item is able to be approved, the wraparound facilitator can reach out to the MCO in advance of the request.

502.25 CHILD AND FAMILY SUPPORTS

Documentation: Documentation for in-home family therapy and in-home family support must indicate and support how often this service is to be provided. Within the master POC, the intervention must be reflective of a goal and/or objective on the plan. There must be an activity note describing each service/activity provided that includes the following:

- Date, location, and start/stop times of service
- Signature with credentials, in ink or in an electronic documentation system
- Reason/purpose for the service and relationship of the service to the member's identified behavioral health treatment needs
- Symptoms and functioning of the member
- Therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change that is directly related to the diagnosed condition that is the focus of the treatment
- Member's response to the intervention and/or treatment

- Plan for continued therapy

502.25.1 In-Home Family Therapy

Procedure Code: H0004-HO-HA
Service Unit: 15 minutes
Telehealth: Available with 02 service location and telehealth justification must be provided within the service note
Service Limit: Up to 8 units per day

Site of Service: This service may be provided in the member's family residence or via telehealth as indicated above

Staff Credentials: Staff qualified for this service are as follows: licensed psychologist (LP); supervised psychologist (SP); licensed professional counselor (LPC); licensed graduate social worker (LGSW); licensed independent social worker (LICSW); licensed clinical social worker (LCSW); board certified behavior analyst (BCBA); advanced alcohol and drug counselor (AADC) and an alcohol and drug counselor (ADC). Staff providing this service must have documented experience in trauma-informed care and using generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work.

Definition: In-home family therapy consists of counseling and training services for the member and family provided by a mental health professional listed within Section 502.3.3 Enrollment Requirements: CSEDW Providers – Staff Qualifications of this Chapter. This service includes trauma-informed individual and family therapy in the family home. It should assist the family to acquire the knowledge and skills necessary to understand and address the specific needs of the member in relation to their SED and treatment, such as developing and enhancing the family's problem-solving skills, coping mechanisms, and strategies for the member's symptom/behavior management.

In-home family therapy providers will implement and oversee all mobile response activities; including primary point of contact for the service, on-call coverage, staff training and credentialing, referral, and data reporting. Written policy and procedures, as defined by the BMS, specific to mobile response must be developed and maintained by any agency providing the service. Additionally, the in-home family therapist indirectly supervises the in-home family support and respite care positions.

Services provided in this category will be in response to a specific goal(s) in the member's POC and will not duplicate any other services provided to the member.

502.25.2 In-Home Family Support

Procedure Code: H0004-HA
Service Unit: 15 minutes
Telehealth: Available with 02 service location and telehealth justification must be provided within the service note
Service Limit: Up to 8 units per day

Site of Service: This service may be provided in the member's family residence or via telehealth as indicated above.

Staff Credentials: Bachelor's degree in human services with one year of documented experience working with this population

Definition: In-home family support services allow the member and family to practice and implement the coping strategies introduced by the in-home therapist. The family support worker works with the member and family on the practical application of the skills and interventions that will allow the member and family to function more effectively. The family support worker assists the family therapist by helping the parent/child communicate their concerns; providing feedback to the therapist about observable family dynamics; helping the family and youth implement changes discussed in family therapy and/or parenting classes; providing education to the parent/legal representative regarding their child's mental illness; coaching, supporting, and encouraging new parenting techniques; helping parents/legal representatives learn new parenting skills specific to meet the needs of their child; participating in family activities and supports parents/legal representatives in applying specific and on-the-spot parenting methods in order to change family dynamics. Additionally, the in-home family support staff person supervises the job development and supported employment position(s).

Services provided in this category will be in response to a specific goal(s) in the member's POC and will not duplicate any other services provided to the member. The worker supervises the peer parent support worker and will be supervised by the in-home family therapist.

502.25.3 Peer Parent Support

Procedure Code: H0038-HA
Service Unit: 15 minutes
Telehealth: Available with 02 service location and telehealth justification must be provided within the service note
Service Limit: Up to 8 units per week

Site of Service: This service may be provided in the member's family residence, a licensed CSEDW provider agency office, and/or public community locations.

Staff Credentials: High school diploma or general education development test (GED) *and* lived experience as an individual or family member of a child with SED.

Definition: Peer parent support services are designed to offer support to the parent/legal representative with SED. The services are geared toward promoting parent/legal representative empowerment, enhancing community living skills, and developing natural supports. This service connects the parent/legal representative with a parent(s) who is raising or has raised a child with SED and are personally familiar with the associated challenges. Peer parent support providers are mentors who have shared experiences as the member, family, or both member and family and who provide support and guidance to the member and their family members. Peer parent support providers explain community services, programs and strategies they have used to achieve the waiver member's goals. It fosters connections and relationships which builds the resilience of the member and their family. This service,

limited in nature, is aimed at providing support and advice based on lived experience of a family member or self-advocate. Peer parent support providers cannot mentor their own family members. Peer parent support services encourage members and their family members to share their successful strategies and experiences in navigating a broad range of community resources beyond those offered through CSEDW with other waiver members and their families. Service includes facilitation of parent or family member "matches" and follow-up support to assure the matched relationship meets peer expectations. Peer parent support providers will not supplant, replace, or duplicate activities that are required to be provided by the wraparound facilitator, in-home family therapy, or in-home family support.

Services provided in this category will be in response to a specific goal(s) in the member's POC and will not duplicate any other services provided to the member. The worker will be supervised by the in-home family support worker.

Documentation: Documentation report must be maintained in the member's medical record and contain the following:

- Member name
- Date, location, and start/stop time of service/meeting;
- Activity note (describing each activity):
    - Self Help: Cultivating the member's ability to make informed, independent choices. Helping the member develop a network of contacts for information and support based on experience of the peer parent support. Assist in developing social skills, repairing, rebuilding, or establishing prevention networks.
    - System Advocacy: Assisting the member and their family to talk about what it means to struggle with behavioral health issues (including substance use) and including other co-occurring health or habilitation needs to an audience or group. Assisting the member with communicating about an issue related to maintaining their mental health.
    - Individual Advocacy: Discussing concerns about medication at the individual's request. Assisting with developing independence in self-referral techniques, accessing appropriate care, and understanding clear communication and coordination with any health care provider.
    - Treatment Planning: Helping the member and family make appointments for all medical treatment when requested. Guiding the member toward a proactive role in health care, jointly assessing services, and building support network.
    - Crisis Support: Assisting the individual with the development of a personal crisis plan. Helping with stress management and developing positive strategies for dealing with potential stressors and crisis situations.
    - Crisis Prevention: Giving feedback to the member on early signs of crisis and how to request help to prevent a crisis. Assisting the member in learning how to use the crisis plan. Educating on crisis prevention and identifying triggers, developing a crisis plan and prevention skills. Learn new ways to cope with behavioral health issues, skills building for such things as time management and connecting with prosocial activities.
    - Housing: For members who are working towards living independently, assisting the member with learning how to maintain stable housing through bill paying and organizing their belongings. Assisting the member in locating improved housing situations. Teaching

the member to identify and prepare healthy foods according to cultural and personal preferences of the member and their medical needs.
    - Education/Employment: Assisting the member in gaining information about going back to school or job training. Facilitating the process of asking an employer for reasonable accommodation for psychiatric disability (mental health day, flex time, etc.)
- Type of Service:
    - Emotional: Should demonstrate empathy, caring, or concern to bolster a member's self-esteem and confidence.
    - Informational: Share knowledge and information and/or provide life or vocational skills training.
    - Instrumental: Provide concrete assistance to help others accomplish tasks.
- Signature of the peer support staff providing the service and agency where the provider is employed, in ink or in an electronic documentation system.

NOTE: More than one activity can be utilized at any one service/meeting.
If there is a master POC, the intervention should be reflective of a goal and/or objective on the plan. The activity note must include the reason for the service, symptoms and functioning of the member, and the member's response to the intervention and/or treatment.

Peer parent support services may not be provided during the same time/at the same place as any other direct support Medicaid service. A fundamental feature of peer parent support is that the services are provided in the natural environment as much as possible.

502.26 RESPITE CARE

Documentation for in-home and out-of-home respite must be completed on the Direct-Support Service Log (WV-BMS-CSED-07) to include the items listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues, the staff person should complete the accompanying Direct Support Progress Note (WV-BMS-CSED-07) to detail the issue. The Direct-Support Service Log (WV-BMS-CSED-07) must include all of the following items:

- Name of member who receives service
- Provider name and signature of the person providing respite services, in ink or in an electronic documentation system
- Date of service; start and stop times; total time spent
- Service code including modifier to indicate ratio of staff to members who receive services
- Indication (Y/N) of whether training was provided
- Transportation Log (WV-BMS-CSED-07) including beginning location (from) and end location (to) and total number of miles for the trip

502.26.1 Respite Care, In-Home

Procedure Code: T1005-HA
Service Unit: 15 minutes
Telehealth: Not Available

Service Limit: Up to 24 calendar days per year in combination with out-of-home respite care. Members residing in a foster care, facility, or independent living setting do not qualify for the service. Foster parents/homes are excluded from this service under the waiver, as the Title IV-E payment to foster care families should include respite. Waiver funds are not available to pay for room and board and supervision of children who are under the state's custody, regardless of whether the child is eligible for funding under Title IV-E of the Social Security Act. The costs are associated with maintenance and supervision of these children are considered a state obligation and not reimbursable via the waiver.

Site of Service: Must be provided in the member's home that may include biological homes, kinship homes, and adoptive homes. Respite may be provided in the local public community if delivery begins and ends in the member's home.
Staff Credentials: High school diploma or GED and must be indirectly supervised by the in-home family therapist

Documentation: An approved authorization for services dated prior to the initiation of services must be included in the member's record and the service must be included in the POC. A service note must be included for each instance or day of service that describes the service activity provided (within guidelines of the CSED waiver manual, name of the service provider, date of the service, start and stop time of the service, the service code and signature and credential of the provider, in ink or in an electronic documentation system).

In-Home Respite will be subject to usage of the EVV utilization and all corresponding requirements.

Definition: Respite care services provide temporary relief to the member's regular caregiver and include all the necessary care that the usual caregiver would provide during that period. Service can be used to support the member in engaging in age-appropriate community activities, such as shopping, volunteering, attending concerts, etc.

Services provided in this category will be in response to a specific goal(s) in the member's POC and will not duplicate any other services provided to the member. The worker will be supervised by the therapist. The services under the waiver are limited to additional services not otherwise covered under the Medicaid State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Service cannot be provided while the member is asleep.

502.26.2 Respite Care, Out-Of-Home

Procedure Code: T1005-HA-HE
Service Unit: 15 minutes
Telehealth: Not Available
Service Limit: Up to 24 calendar days per year in combination with in-home respite care. Members residing in a foster care, facility, or independent living setting do not qualify for the service. Foster parents/homes are excluded from this service under the waiver, as the Title IV-E payment to foster care families should include respite. Waiver funds are not available to pay for room and board and supervision of children who are under the state's custody, regardless of whether the child is eligible for funding under Title IV-E of the Social Security Act. The costs are associated with maintenance and supervision of these children are considered a state obligation and not reimbursable via the waiver.

Site of Service: Provided in the local public community if delivery begins and ends in a certified therapeutic foster care home.

Staff Credentials: High school diploma or GED and must be supervised by the In-Home Family Therapist

Documentation: An approved authorization for services dated prior to the initiation of services must be included in the member's record and the service must be included in the POC. A service note must be included for each instance or day of service that describes the service activity provided (within guidelines of the CSED waiver manual, name of the service provider, date of the service, start and stop time of the service, the service code and signature and credential of the provider, in ink or in an electronic documentation system.

Definition: Respite care services provide temporary relief to the member's regular caregiver and include all the necessary care that the usual caregiver would provide during that period. Please note waiver services may be furnished to children in foster care living arrangements but only to the extent that waiver services supplement maintenance and supervision services furnished in such living arrangements and waiver services are necessary to meet the identified needs of the children. Service can be used to support the member in engaging in age-appropriate community activities, such as shopping, volunteering, attending concerts, etc.

Services provided in this category will be in response to a specific goal(s) in the member's POC and will not duplicate any other services provided to the member.

502.27 NON-MEDICAL TRANSPORTATION

Members who receive CSEDW services should access non-emergency medical transportation (NEMT) services for State Plan (non-CSEDW) Medicaid services, such as doctors' appointments. For more information see BMS website under *Chapter 524, Transportation*.
Non-medical transportation services are only to be utilized for services covered under the CSEDW in this chapter.

Procedure Code: A0160-HA
Service Unit: 1 mile
Telehealth: Not Available
Service Limit: Up to 800 miles per month. CSEDW members placed in foster care are eligible for CSEDW NEMT services, but foster families cannot be reimbursed for providing transportation as this would be considered a duplication of Title IV-E reimbursed services.

Staff Credentials: Any person who provides transportation services via personal or agency vehicle(s) must abide by local, state, and federal laws regarding operation and maintenance of current licensing, insurance, registration, and inspections according to the West Virginia Department of Motor Vehicles.

Definition: Service offered in order to enable waiver members to be transported to and from local, public community locations for services specified in the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the Medicaid

State Plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Services provided in this category will be in response to a specific goal(s) in the member's POC and will not duplicate any other services provided to the member.

Documentation: Documentation must be completed on the Direct-Support Service Log (WV-BMS-CSED-07) to include the items listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues, the staff person should complete the accompanying Direct Support Progress Note (WV-BMS-CSED-07) to detail the issue. The Direct Support Service Log (WV-BMS-CSED-07) must include all of the following items:

- Name of member who receives service
- Provider name and Signature of the staff person providing transportation services, in ink or in an electronic documentation system
- Date of service; start and stop times; and total time spent
- Service code including modifier to indicate ratio of staff to members who receive services
- Indication (Y/N) of whether training was provided
- Transportation Log (WV-BMS-CSED-07) including beginning location (from) and end location (to) and total number of miles for the trip
- Copy of current, valid driver's license, registration and proof of vehicle insurance for staff providing transportation
- Current, valid proof of vehicle inspection in the state where the vehicle is registered

This service may be billed concurrently with day services, respite care services, or peer parent support. The number of miles per service must be included on the member's POC.

502.28 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 Provider Manual and Section 502.18.2 POC Development of this chapter. Reimbursement for services is made pursuant to *Chapter 600, Reimbursement Methodologies*. The following limitations also apply to the requirements for payment of services that are appropriate and necessary for CSEDW services described in this chapter. CSEDW services are made available with the following limitations:

- All CSEDW regulations and policies must be followed in the provision of the services. This includes the requirement that all CSEDW providers be licensed in the State of West Virginia, enrolled in the West Virginia Medicaid program, and contracted with the MCO
- The services provided must conform with the stated goals and objectives on the member's POC
- Individual service and limitations described in this manual must be followed
- The CSEDW services may be provided within 30 miles of the West Virginia border to members residing in a West Virginia county bordering another state.
- In addition to the non-covered services listed in *Chapter 100, General Administration and Information* of the West Virginia Medicaid Provider Manual, the BMS will not pay for the following services:

- The CSEDW program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973
- Public school services, including children who are home-schooled, receive home-bound instruction, and children who are eligible for public school services but are not enrolled
- Service payments may not be made for room and board or the cost of facility maintenance and upkeep
- Birth-to-Three services paid for by Title C of Individuals with Disabilities Education Act (IDEA) for children enrolled in the CSEDW program
- CSEDW services may not be provided concurrently
- Telephone consultations between providers, except for wraparound facilitators gathering updates for the purposes of case planning
- Meeting with the member or member's family for the sole purpose of reviewing evaluation and/or results
- Missed appointments, including but not limited to, canceled appointments and appointments not kept
- Services not meeting the waiver definition of medical necessity
- Services that duplicate other services, e.g., CSEDW in-home therapy services cannot be provided at the same time as intensive individual therapy and group therapy provided under the Medicaid State Plan
- Time spent in preparation of reports or documentation following provision of services
- A copy of medical report when the agency paid for the original service
- Experimental services or drugs
- Any activity provided for leisure or recreation
- Services rendered outside the scope of a provider's license

- Reimbursement for CSEDW services cannot be made for services provided outside a valid POC. To be considered valid, the POC must be current (dated within the past year and reviewed quarterly by CFT), signed by all required CFT members, and include all provided services. The following are considered reasons for invalid POC:
  - Services provided when eligibility has not been established
  - Services provided when there is no POC
  - Services provided without supporting documentation
  - Services provided by unqualified staff
  - Services provided outside the scope of a defined service

502.29 PRIOR AUTHORIZATIONS

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

General information on prior authorization requirements for additional services and contact information for submitting a request may be obtained by contacting the MCO.

502.30 BILLING PROCEDURES

Claims from providers must be submitted on the designated form or electronically transmitted to the fiscal agent and must comply with the following:

- Must include all information required to process the claim for payment
- The amount billed must represent the provider's usual and customary charge for the services delivered
- Claims must be accurately completed with required information
- By signing the Provider Enrollment Agreement, providers certify that all information listed on claims for reimbursement from Medicaid is true, accurate, and complete. Therefore, claims may be endorsed with computer-generated, manual, or stamped signatures
- Claim must be filed on a timely basis, i.e., filed within 360 calendar days from the date of service, and a separate claim must be completed for each individual member

502.31 HOW TO OBTAIN INFORMATION

Please refer to the CSEDW website for program contact information.

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.

Abuse and Neglect: As defined in and West Virginia Code §9-6-1 and West Virginia code §49-1-201.

Administrative Service Organization (ASO): Acts as an agent of BMS and screens potential waiver applicants during the initial eligibility determination process and facilitates both initial evaluations and annual re-determinations of medical eligibility. The ASO also conducts education for providers, persons, advocacy groups, and state staff.

Agency Staff: Staff or contracted extended professional staff employed by a CSEDW provider to provide services to members in the CSEDW Program through the Traditional Option.

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 assigned by the ASO by which the member's medical eligibility must be recertified and is determined by the anniversary date that is the first day of the month following the date when initial medical eligibility was established by the MECA.

Approved Medication Assistive Personnel (AMAP): An unlicensed staff person who meets the eligibility requirements to become an AMAP, has successfully completed the required training and

competency testing and has been deemed competent by the RN to administer medications to residents in the covered facilities in accordance with OHFLAC AMAP policy.

Behavior Assessment System for Children (BASC): is a standardized assessment used to evaluate the behavior and self-perceptions of children and young adults, ages two (2) through 25 years.

Certificate of Need (CON): A process often associated with cost containment measures. Additionally, the Legislative findings in the CON law declare the need for health services to be provided in an orderly, economical manner that discourages unnecessary duplication. The CON is to be submitted to the Health Care Authority. West Virginia issues a CON to indicate a health service's compliance with West Virginia Code §16-2D-1 et seq.

Child and Adolescent Functional Assessment Scale (CAFAS): A standardized instrument which assesses the degree of impairment in youth with emotional, behavioral, psychiatric, or substance use problems. It provides an objective, comprehensive assessment of a youth's needs as they change over time.

Child and Adolescent Needs and Strengths (CANS): A functional assessment tool developed to support decision-making, including treatment planning, facilitating quality improvement initiatives, and monitoring the outcomes of services..

Child and Family (Service Planning) Team (CFT): The member and/or parent/legal representative, the member's wraparound facilitator, representatives of each professional discipline, provider and/or program providing services to that member (inter- and intra-agency), and MCO care coordinator (if requested) and others who possess the knowledge, skill, and expertise necessary to accurately identify the comprehensive array of services required to meet the individual's needs and design appropriate services and specialized programs responsive to those needs. It is a goal in developing the CFT, to have greater than 50% participation from natural supports and community resources identified by the waiver member and family. The POC meetings are guided by the member's needs, wishes, desires, and goals.

Community Behavioral Health Clinic: A healthcare provider offering behavioral health services licensed under West Virginia Code §64-11.

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

Corrective Action Plan: the report that providers must submit to the ASO with a plan to address any concerns stemming from a provider quality review, where standards were not sufficiently met, based upon on-site and desk documentation, staff interviews, telephone satisfaction surveys with members who receive services and/or their parent/legal representative, and day service visits to validate certification documentation and address CMS quality assurance standards.

Critical Incidents: Critical incidents are serious in nature and pose immediate risk to health, safety and welfare to the individual receiving services or others.

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

Direct-Care Staff: The individuals who provide the day-to-day care to Personal Care members. Sometimes referred to as homemakers or personal assistants.

Days: Calendar days unless otherwise specified.

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.

DSM: Abbreviation for the "Diagnostic and Statistical Manual of Mental Disorders," a comprehensive classification of officially recognized psychiatric disorders, published by the American Psychiatric Association, for use by mental health professionals to help ensure uniformity of diagnosis.

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.

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

Freedom of Choice (FOC): The guaranteed right of a beneficiary to select a participating provider of their choice.

Frequency: As it relates to service planning, the frequency refers to how often a service is provided. Example: Monday – Friday, daily, etc.

Formal Plan of Care meeting: A Child and Family Team meeting where all services and supports are present for the meeting to provide support to the member and caregiver and an update on the progress with the goals in the Plan of Care.

Foster Child: The West Virginia DHHR defines a foster child as a child receiving 24-hour substitute care while placed away from his or her parents or guardians and for whom the State agency has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and pre-adoptive homes.

GED: General Educational Development Test or General Equivalency Diploma that is used for educational testing services designed to provide a high school equivalency credential.

Goals: Statement of outcome with specific tasks and objectives to achieve those outcomes. Goals are set to help ensure that effective services are being provided to the member.

Home or Residence: The member's place of residence which includes a boarding home or home for the aged. Home does not include a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the intellectually disabled.

Home and Community-Based Services (HCBS): Services which enable individuals to remain in the community setting rather than being admitted to an institution.

Human Services Degree: A master's or bachelor's degree granted by an accredited college or university in one of the following human services fields: Psychology; Nursing; Sociology; Social Work; Counseling/Therapy; Teacher Education; Behavioral Health; or other degrees approved by the WV Board of Social Work. Also, a Regents Bachelor of Arts (RBA) with a social sciences area of emphasis is permissible. **Note:** Some services require specific degrees as listed in the manual; see specific services for detailed information on staff qualification.

Incident: Any unusual event occurring to a member that needs to be recorded and investigated for risk management or Quality Improvement purposes.

Incident Management System (IMS): A program used by the MCO to track and report on critical and non-critical incidents.

Independent Evaluator (IE): A West Virginia licensed provider who is a West Virginia Medicaid Provider who performs comprehensive evaluations independent of CSEDW providers and who is a person of the IEN trained by the MECA. Independent evaluators qualified to assess medical eligibility for the CSEDW include psychologists, supervised psychologists, licensed independent clinical social workers, and licensed professional counselors. They must be licensed to practice independently and must follow the internal regulations of their accrediting body, licensing board, and/or certification board.

Independent Evaluation (IE): An evaluation completed by a licensed provider of the IEN which includes background information, behavioral observations, documentation that addresses the six major life areas, developmental history, mental status examination, diagnosis, and prognosis.

Independent Evaluator Network (IEN): West Virginia licensed providers who are enrolled West Virginia Medicaid providers and have completed the required IEN Training provided by the MECA training and agreed to complete the IE as defined.

Indirect Supervision: Supervision provided by a licensed individual who monitors, but is not required to be present in the setting when services are rendered.

Informal Plan of Care meeting: A monthly review of the goals and progress with the Plan of Care held every 30 to 45 days with the member and their caregiver. If the meeting reveals that there is a need for a change in services, the wraparound facilitator will convene a formal Plan of Care meeting with the Child and Family Team.

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

Internal Credentialing: An individual approved to provide Licensed Behavioral Health Center (LBHC) Services by the agency's working committee composed of experienced licensed and/or certified staff representative of the appropriate disciplines or practitioners. A provider agency with few clinical staff may designate a credentialing officer.

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: The parent of a minor child or a court appointed legal guardian for an adult or child, or anyone with the legal standing to make decisions for the member.

Level of Care (LOC): These standard references the CMS requirements that individuals receiving home and community-based services must require an institutional level of care to be medically eligible for waiver services. For the CSEDW, applicants must require a PRTF level of care and specifically have either resided in a PRTF within the past six months, or through medical evaluation, it is determined that there is a reasonable indication that the applicant is in danger of being placed in a PRTF.

Licensed Behavioral Health Clinic (LBHC): A healthcare provider offering behavioral health services licensed under West Virginia Code §64-11.
Licensed Professional Counselor: An individual who has obtained full licensure as defined by the West Virginia Board of Examiners in Counseling and by West Virginia Code §30-31-8.

Licensed Psychologist: A psychologist who has completed the requirements for licensure that have been established by the West Virginia Board of Examiners of Psychologist and is in current good standing with the board.

Licensed Independent Clinical Social Worker: An individual who has obtained Level D status as defined by the West Virginia Board of Social Work and by West Virginia Code §30-30-9.

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

Managed Care Organization (MCO) – An entity that has, or is seeking to qualify for, a comprehensive risk contract under the following:

- A Federally qualified Health Maintenance Organization (HMO) that meets the advance directive requirements of subpart I of part 489 of the Federal Register definition of a Federally Qualified HMO;
- Any public or private entity that meets the advance directive requirements and is determined to also meet the following conditions:
    - Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid members within the area serviced by the entity
    - Meets the solvency standards of Section 438.116

Managed Enrollment List: A waiting list for waiver applicants who are determined eligible when there is no waiver slot available. Waitlisted waiver enrollees are offered a waiver slot once a slot becomes available, in the chronological order in which they were determined eligible.

Medical Eligibility: The decision by the BMS or its agent that the health care status and treatment requirements as prescribed by a medical practitioner substantiate the level of care and criteria for the Waiver Program.

Medical Eligibility Contracted Agent (MECA): The contracted entity that acts as an agent of BMS and evaluates potential waiver applicants during the initial eligibility determination process and annual re-determinations of medical eligibility.

Member (aka person, user, client, beneficiary, recipient, or enrollee): An individual who is eligible to receive or is receiving benefits from Medicaid – or an individual who is enrolled in a managed care plan.

Member's Family Residence: A residence where the member has a 911 address and lives with at least one biological, adoptive, natural, or other family member and/or a certified Specialized Family Care Provider.

National Wraparound Initiative (NWI Wraparound): Wraparound provides a comprehensive, holistic, youth and family-driven way of responding when children or youth experience serious mental health or behavioral challenges. Wraparound puts the child or youth and family at the center. The wraparound team can include the family's friends and people from the wider community, as well as providers of services and supports. With the help of the team, the family and young person take the lead in deciding team vision and goals, developing a plan, monitoring how well it's working, and changing it as needed.

Non-critical Incidents: Incidents that do not require an urgent response but may require clinical follow-up or further investigation.

Office of Health Facility Licensure and Certification (OHFLAC): The state agency that inspects and licenses CSEDW providers to help assure the health and safety of CSEDW member. Licensed entities include but are not limited to behavioral health providers, CSEDW providers, facility-based day programs, group homes, supported employment facilities, and wraparound facilitation agencies.

Physician: As defined in West Virginia Code §30-3-10, an individual who has been issued a license to practice medicine in the state of West Virginia by the West Virginia Board of Medicine and is in good standing with the board; or an individual licensed by the West Virginia Board of Osteopathy in accordance with West Virginia Code 30-14-6.

Plan of Care: A document developed with a CSEDW waiver member that is rooted in what is most important to the member and involves them directly with their community, network of connections, and close personal relationships in order to look at the innovative ways to attain specific life goals.

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

Preschool And Early Childhood Functional Assessment Scale (PECFAS): standardized assessment tool which assesses a preschool-aged child's day-to-day functioning across critical life domains AND determines whether a child's functioning improves over time.

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

Professional Experience: A position that requires a minimum of a bachelor's degree or a professional license.

Public Community Location: Any community setting open to the general public such as libraries, banks, stores, post offices, etc. Facility-Based Day and Pre-Vocational sites are not considered public community locations.

Regents Bachelor of Arts: The Regents Bachelor of Arts (RBA) degree program is a nontraditional program offered by the state-supported baccalaureate degree granting institutions in West Virginia. The program is designed for adults who are interested in obtaining a bachelor's degree.

Respite Care: Short term or intermittent care and supervision in order to provide an interval of rest or relief to family or caregivers.

Safe Environment: A place where people feel secure; where they are not at risk of being subject to harm, abuse, neglect or exploitation; and where they have the freedom to make choices without fear of recourse.

Significant Life Event: Any time that there is an event or change in the member's life that requires a meeting of the CFT. The occurrence may require that a service needs to be decreased, increased or changed. A significant life event constitutes a change in the member's needs such as behavioral, mental health or physical health, service/service units, support, setting, or a crisis.

Statewide Transition Plan (STP): A document required by CMS describing how West Virginia will comply with the HCBS regulation requirements demonstrating that living arrangements are truly community-based for HCBS waiver members.

Supervised Psychologist: An individual who is an unlicensed psychologist with a documented completed degree in psychology at the level of M.A., M.S., Ph.D., Psy.D. or Ed.D. and has met the requirements of, and is formally enrolled in, the West Virginia Board of Examiners of Psychologists Supervision program.

Universe: The totality of provider records that could be sampled for review during the specified time period. When a provider is due for a quality review, a representative, random sample of records are selected from the total population.

Telehealth: For purposes of Medicaid, telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the

distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.

Wraparound Facilitation Agency (WFA): A privately operated for profit or nonprofit organization/agency licensed to do business in West Virginia, having a provider agreement with BMS and enrolled as a provider of wraparound facilitation services.

Wraparound Facilitator (WF): A person who assists in the planning, coordination, monitoring, and evaluation of medical services for a member with emphasis on quality of care, continuity of services, and cost-effectiveness; also referred to as a caseworker.

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
New Chapter	Chapter 502, Children with Serious Emotional Disorder Waiver (CSEDW)	February 1, 2020
Entire Chapter	Updated language throughout to include wraparound facilitation replacing case management, changing Person-Centered Plan to Plan of Care, changing Person-Centered Planning Team to Child and Family Team Updated rates and limits to align with proposed waiver amendment effective 7/1/2021 502.3.3 Added language to include the Cures Act requirement that BMS will implement an Electronic Visit Verification (EVV) system to verify in-home visits by in-home respite workers, independent living service providers, and wraparound facilitators by April 1, 2021 Updated Program Description to include ten principles of the wraparound process. 502.1 BMS Contractual Relationships—Clarified responsibilities of contractors under the waiver 502.3.2 Enrollment Requirements: CSEDW Medical Eligibility Evaluators—Language updated, added to Staff Qualifications section to clarify training and experience requirements for medical eligibility evaluation network 502.3.3 Enrollment Requirements—Language added to clarify CSEDW waiver provider requirements. Language added to clarify that training documentation may be on another form or in a tracking system as long as the	July 1, 2021

	documentation includes all elements on the CSED-06 form. 502.7 Provider Reviews—Added process for ASO to obtain a sample and data for quality reviews 502.9 Added to Other Administrative Requirements section to require providers to monitor utilization in alignment with expected service usage based on POCs and electronic records. Also, added clarification that CSEDW cannot bill for administrative tasks. 502.10 Telehealth Services—Added clarification on billing 502.12 Added to Incident Reporting Requirements section to include documentation requirements and clarify definitions and requirements 502.13.2 Quality Improvement Advisory Council—Added responsibilities of the MCO and ASO 502.14.1 Streamlined eligibility process and made the process more chronological 502.14.2 Added new section for Right to Appeal, separating it from 502.14.1, made clarifications consistent with the approved waiver 502.14.2.1 Level of Care Instruments—separated this section from Functionality and Diagnosis section 502.14.2.2 Diagnosis—separated this section from Functionality 502.14.2.3 Functionality- changed BASC score threshold for medical eligibility from 70 to 60 502.14.2.4 PRTF Level of Care—separated this section from functionality and provided more detail 502.14.3 Slot Allocation Referral and Selection Process- clarified the waitlist process	

	502.15 Clarified billing for wraparound facilitation services and other CSEDW services. Clarified eligibility process at redetermination. 502.16.2 Added language regarding continued eligibility for services 502.18 Updated Plan of Care (POC) Requirements section to include initial case plan completion within 7 days of waiver enrollment, remove physicians as participants in the POC meeting, and clarify plan requirements 502.18.1 Child and Family Service Team—Added language regarding composition of the team to align with NWI requirements 502.18.2 Updated POC Development section to clarify plan components, attendee and documentation requirements 502.18.2.1 Added to Seven Day CFT Meeting to include initial case plan completion within 7 days of waiver enrollment and clarify plan, prior authorization, attendee and documentation requirements 502.18.2.2 Thirty Day CFT Meeting and Ninety Day Review CFT Meetings- added Ninety Day Review to section title, removed language allowing for less frequency than every ninety days for POC and updated plan, prior authorization, attendee and documentation requirements. Added language regarding continuing eligibility based upon progress with the POC and suspension of waiver services. 502.18.2.3 Updated Transfer/Discharge CFT Meeting section to clarify plan components, attendee and documentation requirements 502.18.2.4 Updated Significant Life Event CFT Meeting section to provide guidance on when meetings should be held, added attendee and documentation requirements 502.19 Added responsibilities and documentation requirements to Wraparound facilitation section.	

	502.19.1 Member Choice of Single Wraparound Facilitation Provider- Added special provisions to clarify situations and requirements when a provider offers both wraparound facilitation and other CSEDW services to the same member. 502.20.1 Wraparound Facilitation—clarified requirements and added EVV requirements 502.21 Updated Crisis Services: Mobile response to add documentation and remove review within 72 hours of crisis requirements 502.22.1 Added Independent Living/Skills Building added documentation and authorization requirements and added EVV requirements 502.22.2 Job Development added documentation and authorization requirements 502.22.3 Supported Employment, Individual added documentation and authorization requirements 502.23 Extended Professional Services: Specialized Therapy added documentation and authorization requirements 502.24 Other Services—Added summary of requirements for services that have a limit counted in dollars per service plan year 502.24.1 Assistive Equipment added documentation and authorization requirements, updated limit amount 502.24.2 Community Transition added allowable items, documentation and authorization requirements, removed pest eradication as an allowable service 502.25.3 Peer Parent Support removed requirement that Peer Parent be certified 502.26.1 Respite Care, In-Home added documentation and authorization requirements 502.26.2 Respite Care, Out-Of-Home added documentation and authorization requirements	

	502.27 Added provider requirements to Non-Medical Transportation section, clarified that foster parents cannot be reimbursed as providers of non-emergency medical transportation 502.28 Clarified billing requirements for telephone consultation and preparation of reports. Added additional definitions to the Glossary based on changes in names of services and to add further clarity Technical corrections and edits were also made to the document for clarity. Added Appendix A- Initial Plan of Care template Added Appendix B- Master Plan of Care template	