

The State of West Virginia

Bureau for Medical Services

Renewal Application for Title XIX MR/DD Waiver Home and Community Based Services

July 1, 2005 – June 30, 2010

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**West Virginia MR/DD Waiver Application Renewal
July1, 2005 - June 30, 2010**

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Please note: The Home and Community Based MR/DD Waiver Application is a standardized template from the Centers of Medicare and Medicaid. Our additions to the template are indicated in blue. Please submit comments by June 13, 2005.

**STATE OF WEST VIRGINIA SECTION 1915(c) HOME AND COMMUNITY-BASED SERVICES
RENEWAL APPLICATION MR/DD WAIVER**

1. The State of West Virginia requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

This is a request for a model waiver.

- a. Yes b. No

If yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

This waiver is requested for a period of (check one):

- a. 3 years (initial waiver)
b. 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals **who, but for the provision of such services,** would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

- a. Nursing facility (NF)
b. Intermediate care facility for mentally retarded persons (ICF/MR)
c. Hospital
d. NF (served in hospital)
e. ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

- a. aged (age 65 and older)
b. disabled
c. aged and/or disabled
d. mentally retarded
e. developmentally disabled
f. mentally retarded and/or developmentally disabled
g. chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

- a. Waiver services are limited to the following age groups (specify):

- b. _____ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):
- c. _____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.
- d. _____ Other criteria. (specify):
- e. X Not applicable.
5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.
6. This waiver program includes individuals who are eligible under medically needy groups.
- a. _____ Yes b. X No
7. A waiver of 1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.
- a. _____ Yes b. _____ No c. X N/A
8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.
- a. _____ Yes b. X No
9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.
- a. _____ Yes b. X No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.
11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:
- a. Case management
 - b. Homemaker
 - c. Home health aide services
 - d. Personal care services
 - e. Respite care
 - f. Adult day health
 - g. Habilitation
 - Residential habilitation
 - Day habilitation
 - Prevocational services
 - Supported employment services
 - Educational services
 - h. Environmental accessibility adaptations
 - i. Skilled nursing
 - j. Transportation
 - k. Specialized medical equipment and supplies
 - l. Chore services
 - m. Personal Emergency Response Systems
 - n. Companion services
 - o. Private duty nursing
 - p. Family training
 - q. Attendant care
 - r. Adult Residential Care
 - Adult foster care
 - Assisted living
 - s. Extended State plan services (Check all that applies):
 - Physician services (annual medical evaluation only)
 - Home health care services
 - Physical therapy services
 - Occupational therapy services
 - Speech, hearing and language services
 - Prescribed drugs
 - Other (specify):
 - t. Other services (specify):

Crisis Services

u. ___ The following services will be provided to individuals with chronic mental illness:

- ___ Day treatment/Partial hospitalization
- ___ Psychosocial rehabilitation
- ___ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.
13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.

The recipient of waiver services will be involved in the development of the plan.
Refer to Attachment 11: Methodology for Determining Plan of Care

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

The state offers an exception for the location of respite services for individuals with extensive behavioral needs that arise due to the temporary change in environment while in a Medicaid certified hospital or a temporary crisis placement in an ICF-MR group home due to behavioral, medical, or socio-emotional issues. Reference section B-1 for location of respite services.

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):
- a. When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).
 - b. ___ Meals furnished as part of a program of adult day health services.
 - c. ___ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to HCFA:
- a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:
 1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);

[Refer to:](#)
[Attachment 1 - Quality Management System](#)
 2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements will be met on the date that the services are furnished; and
 3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
 - b. The agency will provide for an evaluation (and periodic re-evaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and re-evaluations are detailed in Appendix D.
 - c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:
 1. Informed of any feasible alternatives under the waiver; and
 2. Given the choice of either institutional or home and community-based services.
 - d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, sub-part E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.
 - e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

- f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.
- g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.
- h. The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by CMS.
- i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

- a. Yes b. No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

- a. Yes b. No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

Refer to:
[Attachment 1: Quality Management System](#)

19. An effective date of July 1, 2005 is requested.
20. The State contact person for this request is Pat Winston, who can be reached by telephone at (304) 558-1700. Email address: patwinston@wvdhhr.org.
21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Nancy V. Atkins, MSN, RN, NP
Commissioner

Signature:
Print Name:
Title:
Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449. The time required to complete this information collection is estimated to average 160 hours for each new and renewed waiver request and an average of 30 hours for each amendment, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

APPENDIX A – ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

The waiver will be operated by the [Bureau for Behavioral Health and Health Facilities, \(BHBF\)](#) a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the inter-agency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

The waiver will be operated by [Bureau for Behavioral Health and Health Facilities](#), a separate division within DHHR. ~~the single State agency.~~ The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

c. _____ Home Health Aide services:

_____ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

_____ Other Service Definition (specify):

d. _____ Personal care services:

_____ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. These services may include assistance with preparation of meals, but does not include the cost of the meals themselves. when specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

_____ Payment will not be made for personal care services furnished by a member of the individual's family.

_____ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached. (check one):

_____ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

_____ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that applies):

_____ A registered nurse, licensed to practice nursing in the State.

_____ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

_____ Case managers

_____ Other (specify):

3. Frequency or intensity of supervision (Check one):

As indicated in the plan of care

Other (specify):

4. Relationship to State plan services (check one):

Personal care services are not provided under the approved State plan.

Personal care services are included in the State plan, but limitations. The waived service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

Other service definition (Specify):

e. Respite care:

Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

Other service definition (specify):

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

(Check all that apply):

Individual's home or place of residence

Foster home

Medicaid certified Hospital

Medicaid certified NF

Medicaid certified ICF/MR

Group home

Licensed respite care facility

Other community care residential facility approved by the State that it's not a private residence
(Specify type):

Specialized Family Care Homes –

Licensed Day Care Providers { children only }

Developmental Disabilities Crisis Respite Site

Other service definition (specify):

Respite services are not available to individuals living in Individual Support Settings (1-3 individuals) or group home settings. (See adult companion services for supervision or monitoring supports for ISS or group home settings).

f. _____ Adult day health:

_____ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (check one):

1. ___ Yes 2. ___ No

_____ Other service definition (specify):

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g. X _____ Habilitation:

X Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

X Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. ~~Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family.~~ Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

There are federal requirements concerning services provided by relatives or friends of the MR/DD Waiver member stipulate that: "Services provided by relatives or friends may be covered only if the relatives or friends meet the qualifications for providers of care, there are strict controls to assure that payment is made to the relative or friend as providers only in return for specific services rendered, and there is adequate justification as to why the relative or friend is the provider of care, e.g., lack of other qualified providers in remote areas." (HHS/HCFA Medicaid Manual, Part 4, Transmittal #37, September, 1988, Regulation 4442.3 (B) (10))

The MR/DD Waiver Manual will state:

The MR/DD Waiver Program is not an entitlement program and Residential Habilitation is not a family stipend. In order to comply with Federal regulations concerning services provided by relatives or friends, MR/DD Waiver Program providers must adhere to the following provisions as a condition of participation in the MR/DD Waiver Program and as a condition of reimbursement for such services:

- Biological and adoptive parents and SFCPs may only deliver the service of Community Residential Habilitation to their own children, or family-based care recipient.
- If the Interdisciplinary Team (IDT) decides that a biological or adoptive parent or family member may be a good alternative choice for a Residential Habilitation provider, the IDT chooses him/her to provide Community Residential Habilitation under the following conditions:
 - The Service Coordination provider agency or behavioral health provider which is responsible for providing Residential Habilitation services has attempted to, and been unable, to recruit a trained and qualified provider who is not a family member.
 - The individual is at least 18 years of age. Proof of age must be kept on file
 - The individual has current certification in Cardio Pulmonary Resuscitation (CPR) and First Aide. Current certifications must be kept on file.
 - The individual has received training (It is necessary for providers of community residential habilitation services to receive training by a professional QMRP in instructional techniques necessary to achieve the objective specific to the member's IPP and issues related to health and welfare prior to the implementation of services. Following QMRP

Instruction, training, documentation of the specific training goals must be included on the Certification of Training for Habilitation Providers form (DD-13).

The Service Coordination provider agency monitors the Residential Habilitation services, as it does all services, through monthly home visits and other contacts. The agency, which is responsible for providing Residential Habilitation services arranges for or provides a QMRP who is responsible for training and monitoring to ensure the delivery of services in accordance with the IPP.

X Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

X Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety.

Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). ~~Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.~~

Check one:

 Individuals will not be compensated for prevocational services.

X When compensated, individuals are paid at less than fifty (50) percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. ~~The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.~~

The intent of the Home and Community Based Waiver program is not only to deinstitutionalize individuals; but to also prevent institutionalization. Waiver Recipients are permitted to receive prevocational services that have not been institutionalized.

_____ Educational services, which consist of special education and related services as defined in sections (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

X Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as

a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. ~~The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.~~

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

The intent of the Home and Community Based Waiver program is not only to deinstitutionalize individuals; but to also prevent institutionalization. Waiver Recipients are permitted to receive supported employment services that have not been institutionalized

~~Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.~~

1. Yes 2. No

Other service definition (specify):

Professional Staff will consist of a Skills Development Specialist (formerly known as QMRP 1, 2 services) and a Positive Behavioral Support Specialist (formerly known as a QMRP 2 Service).

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h. X Environmental accessibility adaptations:

X Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

X Other service definition (specify):
Environmental accessibility services, which include home and vehicle modifications, are limited to no more than \$1000.00 annually.

i. X Skilled nursing:

X Services listed in the plan of care which is within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

X Other service definition (specify):
Children: Below age 21 have coverage under state plan services
Adults: Age 21 and above will primarily be covered under MR/DD Waiver

j. X Transportation:

X Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. **Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.**

____Other service definition (specify):

k. ____Specialized Medical Equipment and Supplies:

____Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

____Other service definition (specify):

l. ____Chore services:

____Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, care-giver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

____Other service definition (specify):

m. ____Personal Emergency Response Systems (PERS)

____PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for

significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

_____ Other service definition (specify):

n. Adult companion services:

Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

_____ Other service definition (specify):

o. _____ Private duty nursing:

_____ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

_____ Other service definition (specify):

p. _____ Family training:

_____ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

_____ Other service definition (specify):

q. _____ Attendant care services:

_____ Hands-on care, of both a supportive and health-related nature,

specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (check all that apply):

_____ Supervision will be provided by a registered nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

_____ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

_____ Other supervisory arrangements (specify):

_____ Other service definition (specify):

r. _____ Adult Residential Care (check all that apply):

_____ Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. the total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed___. Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

_____ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or

unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that are provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (check all that apply):

- Home health care
- Physical therapy
- Occupational therapy
- Speech therapy
- Medication administration
- Intermittent skilled nursing services
- Transportation specified in the plan of care
- Periodic nursing evaluations
- Other (specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

Other service definition (specify):

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

- s. Other waiver services which are cost-effective and necessary to prevent Institutionalization (specify):

Crisis Services:

Under the provision of crisis services, one additional staff person is available for the primary purpose of supervision for the person as needed during an acute crisis situation so that the person can continue to participate in his/her daily routine and/or residential setting without interruption. It is appropriate to provide such support during periods of time in which the person is presenting episodes of unmanageable and/or inappropriate behaviors that require specialized staff intervention. An individual may display extreme, maladaptive behaviors that are not anticipated, are temporary in nature, and are beyond the daily behaviors that are addressed through other supports. Crises of this nature may be due to medication changes, reaction to situational stressors, or environmental trauma. By providing this service, an imminent institutional admission may be avoided while protecting the person from harming themselves or others.

While receiving this service, the person is able to remain in his/her place of residence, in the day program, or in respite care, while a crisis plan is developed and implemented. Crisis Services staff will implement intervention plans that are directed at reducing the maladaptive behavior. This service is only offered in the setting(s) where the person receives services.

Crisis Services are provided for periods of up to fourteen (14) consecutive days per episode. There will be an authorization requirement for this service. The authorization will be for a seventy two (72) hour period of time. The prior authorization by the state within three days of service inception is required for this service. Following any use of Crisis Services, the individual's IPP will be reviewed and updated to reflect a plan for the prevention and interventions to ameliorate subsequent occurrences. The IPP must identify crisis early warning signals, triggers, and the necessary services and supports to insure the health and safety of the individual. Any plan that involves the use of restrictive intervention will be approved by a psychologist or psychiatrist and approved by the Client Rights Committee. A written order is required by a psychologist or a psychiatrist for this service.

- t. Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (check all that apply):

- Physician services (physical evaluation)
 Home health care services
 Physical therapy services

- Occupational therapy services
- Speech, hearing and language services
- Prescribed drugs
- Other State plan services (Specify):

u. _____ Services for individuals with chronic mental illness, consisting of (check one):

- Day treatment or other partial hospitalization services (check one):
- Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

- a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),
 - b. occupational therapy, requiring the skills of a qualified occupational therapist,
 - c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,
 - d. drugs and biologicals furnished for therapeutic purposes,
 - e. individual activity therapies that are not primarily recreational or diversionary,
 - f. family counseling (the primary purpose of which is treatment of the individual's condition),
 - g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and
 - h. diagnostic services.
- Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

_____ Other service definition (specify):

_____ Psychosocial rehabilitation services (check one):

- Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment),
- b. social skills training in appropriate use of community services,

- c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion), and
- d. telephone monitoring and counseling services,

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

- a. vocational services,
- b. prevocational services,
- c. supported employment services, and
- d. room and board.

_____ Other service definition (specify):

_____ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

_____ This service is furnished only on the premises of a clinic.

_____ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (specify):

APPENDIX B-2 PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation and State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Case Management (service Coordination)	Qualified MR/DD Professional	Per CFR	Per CFR	Defined in 42 CFR 483.430 (a) (b)
Respite Services	Paraprofessional	N/A	Individual Specific Training by provider Required to have CPR, First Aide, and disability specific training	Certification requirement in BMS regulations (manuals) filed with the Secretary of State
Adult Companion Services	Paraprofessional	N/A	Individual Specific Training by provider Required to have CPR, First Aide, and disability specific training	Certification requirement in BMS regulations (manuals) filed with the Secretary of State
Habilitation (professional) Skills Development Specialist, Positive Behavior Support	Qualified MR/DD Professional;	Per CFR	Per CFR	Defined in 42 CFR 483.430(a) (b)
Habilitation (paraprofessional)	Paraprofessional	N/A	N/A	Certification requirement in BMS regulations (manuals) filed with the Secretary of State
Habilitation: Pre-vocational and Supported Employment	N/A	N/A	As Certified by WV Division of Rehabilitation Services	N/A
Habilitation: -Residential – Program	N/A	Section 13 of the West Virginia Health Rules for Licensure of Behavioral Health Program/Facility	N/A	West Virginia Code 17- 9-1 West Virginia Code 27-17-3 West Virginia Code 27-2A-1
Skilled Nursing	Same as State Medicaid Plan	LPN or RN Licensed to practice in the State of WV	N/A	West Virginia Code 30-7-1 et seq West Virginia Code 30-7A-1 et.seq

Extended State Plan Services OT, PT, Speech Hearing Language	Same as State Medicaid Plan	Licensed to practice in the State of W.V.	N/A	West Virginia Code Chapter 30
SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Transportation	Paraprofessional	Section II.C.I of the West Virginia Licensing Regulations and Section II.C.I of the Program Standards Review Guide	N/A	N/A

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

The state operating agency, BHHF, maintains a memorandum of understanding between the operating agency and the Bureau for Public Health, the Office of Health Facility Licensure and Certification (OHFLAC). The state operating agency, BHHF, maintains a copy of the memorandum of understanding between Department of Health and Human Resources (DHHR) and Division of Rehabilitation Services, the state agency responsible for certification of vocational rehabilitation programs (pre-vocational and supported employment services).

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

Refer to:

Attachment 6: DD-7

Attachment 7: DD -7A:

APPENDIX B-3 KEY AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

- Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.
- A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

APPENDIX C Eligibility and Post-Eligibility

Appendix C-1 - Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. (check all that apply.)

1. Low income families with children as described in section 1931 of the Social Security Act.
2. SSI recipients (SSI Criteria States and 1634 States).
3. Aged, blind or disabled in 209(b) States who are eligible under ' 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
4. Optional State supplement recipients
5. Optional categorically needy aged and disabled who have income at (Check one):
 - a. 100% of the Federal poverty level (FPL)
 - b. % Percent of FPL which is lower than 100%.
6. The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

A. Yes B. No

Check one:

- a. The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or
- b. Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) A special income level equal to:

300% of the SSI Federal benefit (FBR)

% of FBR, which is lower than 300% (42 CFR 435.236)

\$_____ which is lower than 300%

- (2)____Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)
- (3)____Medically needy without spenddown in states which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)
- (4)____Medically needy without spenddown in 209(b) States. (42 CFR 435.330)
- (5)____Aged and disabled who have income at:
 - a.____ 100% of the FPL
 - b.____% which is lower than 100%.
- (6) Other (Include statutory reference only to reflect additional groups included under the State plan.)

7.____Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. ____Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

Appendix C-2 - Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic re-determination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under '435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community ('435.217). For individuals whose eligibility is not determined under the spousal rules ('1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR '435.726 and '435.735 just as it does for other individuals found eligible under '435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under '1924.

REGULAR POST-ELIGIBILITY RULES - '435.726 and '435.735

- o The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.
- o If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.
- o If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.
- o If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY - '1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of '1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The '1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in '1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual while in an institution." For institutionalized individuals this amount could be as low as \$30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable

amount for food and shelter as well as for clothing. The \$30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, states which elect to treat home and community-based services waiver participants with community spouses under the '1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipient's income.

A. 435.726 - States which do not use more restrictive eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (check one):

A. The following standard included under the State plan (check one):

(1) SSI

(2) Medically needy

(3) The special income level for the institutionalized

(4) The following percent of the Federal poverty level): %

(5) Other (specify):

300 % of the SSI Federal Benefit (FBR)

B. The following dollar amount:

\$ *

* If this amount changes, this item will be revised.

C. The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1 is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2 and 3** following.

2. spouse only (check one):

A. SSI standard

B. Optional State supplement standard

C. Medically needy income standard

D. ___ The following dollar amount:

\$ ___*

* If this amount changes, this item will be revised.

E. ___ The following percentage of the following standard that is not greater than the standards above: ___% of ___ standard.

F. ___ The amount is determined using the following formula:

G. Not applicable (N/A)

3. Family (check one):

A. ___ AFDC need standard

B. ___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C. ___ The following dollar amount:

\$ ___*

*If this amount changes, this item will be revised.

D. ___ The following percentage of the following standard that is not greater than the standards above: % ___ of ___ standard.

E. ___ The amount is determined using the following formula:

F. ___ Other

G. Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1. (b) ___ 209(b) State, a State that is using more restrictive eligibility requirements than SSI . The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipient's income.

B. 42 CFR 435.735--States using more restrictive requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A. ___ The following standard included under the State plan
(check one):

- (1) ___ SSI
- (2) ___ Medically needy
- (3) ___ The special income level for the institutionalized
- (4) ___ The following percentage of the Federal poverty
level: ___ %
- (5) ___ Other (specify):

B. ___ The following dollar amount:
\$ ___ *

* If this amount changes, this item will be revised.

C. ___ The following formula is used to determine the amount:

Note: If the amount protected for waiver recipients in item 1 is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under '435.217, **enter NA in items 2 and 3** following.

2. spouse only (check one):

A. ___ The following standard under 42 CFR 435.121:

B. ___ The medically needy income standard _____;

C. ___ The following dollar amount:

\$ ___ *

* If this amount changes, this item will be revised.

D. ___ The following percentage of the following standard that is
not greater than the standards above: ___ % of

E. ___ The following formula is used to determine the amount:

F. ___ Not applicable (N/A)

3. family (check one):

A. ___ AFDC need standard

B. ___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State=s approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C. ___ The following dollar amount:

\$ ___*

* If this amount changes, this item will be revised.

D. The following percentage of the following standard that is not greater than the standards above: ___% of ___ standard.

E. ___ The following formula is used to determine the amount:

F. ___ Other

G. ___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2. ___ The State uses the post-eligibility rules of '1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under '1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:
(check one)

(a) ___ SSI Standard

(b) ___ Medically Needy Standard

(c) ___ The special income level for the institutionalized

(d) ___ The following percent of the Federal poverty level:

___%

(e) ___ The following dollar amount

\$ ___**

**If this amount changes, this item will be revised.

(f) ___ The following formula is used to determine the needs allowance:

(g) ___ Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic re-evaluations) of the need for the level(s) of care indicated in the Executive Summary of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (check all that apply):

- Discharge planning team
 Physician (MD or DO) Physician Assistant or Nurse Practitioner
 Registered nurse, licensed in the state
 Licensed social worker
 Qualified mental retardation professional, as defined in 42 CFR 483.430(a)
 Other (specify):
Licensed Psychologist with QMRP certification

APPENDIX D-2

a. RE-EVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (specify):

- Every 3 months
 Every 6 months
 Every 12 months physician evaluation
 Other (specify): psychological evaluation:
Below age 18- evaluations every 12 months: Age 18 and
above- evaluations every 36 months (triennial)

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for all individuals performing reevaluations of level of care (specify):

- Physician (MD or DO)
- Registered nurse, licensed in the state
- Licensed social worker
- Qualified mental retardation professional, as defined in 42 CFR 483.430(a)
- Other (specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The state will employ the following procedures to ensure timely reevaluations of level of care (check below):

- “Tickler” file
- Edits in computer system
- Component part of case management
- Other (specify): Quality Management System

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (check all that apply):

- By the Medicaid Agency in its central office
- By the Medicaid Agency in district/local offices
- X (DD-2A) By the agency designated in Appendix A as having primary authority for the daily operation of the waiver program
- By the case managers (DD-2, 3, 4)
- By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

By service providers
 Other (specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation and screening procedures for individuals need for a level of care indicated in the Executive Summary of this request is attached to this Appendix.

Refer to :

Attachment 2: Physical Evaluation (DD2A),

Attachment 3: Psychological Evaluation (DD-3),

Attachment 4: Social History (DD-4), (if need indicated)

For persons diverted rather than deinstitutionalized, the state's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in the Executive Summary of this request.

Check one:

The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in the Executive Summary of this request, the individual or his or her legal representative will be:
 - a. Informed of any feasible alternatives under the waiver; and
 - b. Given the choice of either institutional or home and community-based services.
2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in the Executive

Summary of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

Refer to the following attachments:

Attachment 6: DD-7 form, Informed Consent to a choice between ICF/MR & Waiver

Attachment 7: DD -7a form, Informed Consent to a choice of providers and services

Attachment 10: MR/DD Level of Care Determination

*3. The following are attached to this Appendix:

Refer to the following attachments:

Attachment 1: Quality Management System

Attachment 8: Request for Hearing

Attachment 9: Notice of Decision /Denial

Attachment 10: MR/DD Level of Care Determination

a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing:

Refer to the following attachments:

Attachment 1: Quality Management System

Attachment 6: DD-7 form, Informed Consent to a choice between ICF/MR & Waiver

Attachment 7: DD-7a form, Informed Consent to a choice of providers and services

Attachment 8: Request for Hearing

b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;

Refer to the following attachments:

Attachment 1: Quality Management System

Attachment 10: MR/DD Level of Care Determination

c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and

Refer to the following attachments:

Attachment 1: Quality Management System

Attachment 6: DD-7 form, Informed Consent to a choice between ICF/MR & Waiver

Attachment 7: DD-7a form, Informed Consent to a choice of providers and services

Attachment 8: Request for Hearing

d. A description of how the individual (or legal representatives) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

Refer to the following attachments:

Attachment 1: Quality Management System

Attachment 10: MR/DD Level of Care Determination

FREEDOM OF CHOICE DOCUMENT

Specify where copies of this form are maintained:

The “Informed Consent” documents (DD-7 and DD-7a) are maintained with the local case management provider agency. A sample is attached.

The Quality Management System monitors by means of a data sample and the overall state-wide outcome is monitored by the Quality Improvement Council.

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

Registered nurse, licensed to practice in the State
 Licensed practical or vocational nurse, acting within the scope of practice under State law
 Physician (M.D. or D.O.) licensed to practice in the State
 Social Worker (qualifications attached to this Appendix)
 Case Manager (**Service Coordinator**)
 Other (specify):

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

At the Medicaid agency central office
 At the Medicaid agency county/regional offices
 By case managers (**Service Coordinators**)
 By the agency specified in Appendix A
 By consumers
 Other (specify):

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is

Every 3 months
 Every 6 months
 Every 12 months
 Other (specify):

In addition to the professional review of each Individual Program Plan, West Virginia employs program reviewers and registered nurses, all of whom are qualified Qualified Mental Retardation Professionals (QMRP's). These professional reviewers conduct on-site evaluations of provider credentialing, agency policy, evaluations, IPP and services, program quality, consumer outcomes, health and welfare, and consumer experience for provider agencies statewide. The overall results of the reviews are a component of the Quality Management System and monitored by the Quality Improvement Council where statewide issues are identified and addressed.

Additionally, monitoring and oversight is conducted by the OHFLAC. A Memorandum of Understanding exists between the Bureau for Public Health (OHFLAC) and the Bureau for Behavioral Health and Health Services (OBHS) that allows both agencies to conduct on site reviews as necessary and share data and information regarding monitoring results, status of behavioral health license, incident reports, or complaint investigations.

APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

Refer to Attachment 11: Methodology for Determining the Level of Support/Service Need

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.

A copy of the Individual Program Plan (IPP or DD-5)) is included in the appendix. The IPP form includes written prompts for each requirement. *(Note: This will be amended in the future to reflect a person centered philosophy)*

The Quality Management System monitors IPP requirements by means of a statewide sample where quality issues are identified and addressed within the Quality Improvement Council. Prior to the receipt of services, IPP's outlining specified services that exceed service limits or require exceptional services such as nursing require a prior authorization of the services.

2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

Refer to:

Attachment 5: DD-5 Individual Program Plan *(Note: This will be amended in the future to reflect a person centered philosophy)*

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a) (32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.
2. As required by section 1902(a) (27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.
[The state Medicaid agency, BMS, maintains a copy on file of provider agreements between BMS and Medicaid Waiver provider agencies.](#)
3. Method of payments (check one):
 Payments for all waiver and other State plan services will be made Through an approved Medicaid Management Information System (MMIS).
 Payments for some, but not all, waiver and State plan services will be Made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.
 Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an

audit trail for all State and Federal funds expended.
 Other (Describe in detail):

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the Mechanism in place to assure that all claims for payment of waiver services are made only:
[Refer to Attachment 13: Billing Process](#)
 - a. When the individual was eligible for Medicaid waiver payment on the date of service;
 - b. When the service was included in the approved plan of care;
 - c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the

Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

Yes

No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an Audit trail. Check one:

All claims are processed through an approved MMIS.

MMIS is not used to process all claims. Attached is a description of Records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

The Medicaid agency will make payments directly to providers of waiver Services.

The Medicaid agency will pay providers through the same fiscal agent used In the rest of the Medicaid program.

The Medicaid agency will pay providers through the use of a limited fiscal agent Who functions only to pay waiver claims?

Providers may *voluntarily* reassign their right to direct payments to the following Governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements
Are on file at the Medicaid agency.

The state Medicaid agency maintains a contractual agreement between BMS and an MMIS provider, Unisys.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G IS NOT FINALIZED FOR THIS REVIEW

APPENDIX G-1 COMPOSITE OVERVIEW COST NEUTRALITY FORMULA


INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete an Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE:

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____
4	_____	_____	_____	_____
5	_____	_____	_____	_____

APPENDIX G IS NOT FINALIZED FOR THIS REVIEW

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS 
1	<u>3844</u>
2	<u>3844</u>
3	<u>3844</u>
4	<u>3844</u>
5	<u>3844</u>

EXPLANATION OF FACTOR C:

Check one:

- The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.
- The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform CMS in writing of any limit which is less than factor C for that waiver year.

APPENDIX G-2 METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC:

The July 25, 1994 final regulation defines Factor D as:

"The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

APPENDIX G-2

FACTOR D

LOC:

Waiver Application MR/DD Waiver—draft

APPENDIX G IS NOT FINALIZED— THIS SECTION WILL BE COMPLETED AFTER ALL PUBLIC INPUT IS RECEIVED BY BMS

Demonstration of Factor D estimates:

Waiver Year 1 X 2___ 3___ 4___ 5___

	Waiver Service Column A	#Undup. Recip. (users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D (15 minute unit unless specified)
1	Respite Services (non-immediate family/friends)			1:1 ratio 1:2 ratio 1:3 ratio
2	Respite Services (agency based staff)			1:1 ratio 1:2 ratio 1:3 ratio
3	Environmental Accessibility			\$1000.00 Annual Maximum
4	Adult Companion (non-immediate family/friends)			1:1 ratio 1:2 ratio 1:3 ratio
5	Adult Companion –(agency based staff)			1:1 ratio 1:2 ratio 1:3 ratio
6	Skilled Nursing Services – LPN			1:1 ratio 1:2 ratio 1:3 ratio
8	Skilled Nursing Services – RN (formerly QMRP 1-2)			1:1 ratio
9	Habilitation, Day			1:1 ratio 1:2 ratio 1:3 ratio 1:4 ratio
10	Habilitation / Pre-Vocational			1:1 ratio Group
11	Habilitation / Supportive Employment			1:1 ratio group
12	Habilitation, Residential (family/community based)			1:1 ratio
13	Habilitation, Residential (agency based)			1:1 ratio 1:2 ratio 1:3 ratio 1:4 ratio
14	Habilitation, Skills Development Specialist (formerly QMRP 1, 2)			1:1 ratio
15	Habilitation Behavioral Management Specialist (formerly QMRP 2)			1:1 ratio
16	Therapeutic Consultation: Physician, P.T., O.T., Speech Therapy (formerly QMRP 3)			1:1 ratio
17	Crisis Services			Up to 2:1 ratio
18	Travel			0.41 mile or 5.95 trip
19	Case Management (Service Coordination)			1:1 ratio
21	Participation in the Individual Program Plan			
GRAND TOTAL (sum of Column E):				
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				\$
FACTOR D (Divide total by number of recipients):				
AVERAGE LENGTH OF STAY:				

APPENDIX G IS NOT FINALIZED— THIS SECTION WILL BE COMPLETED AFTER ALL PUBLIC INPUT IS RECEIVED BY BMS

Waiver Year 1__ 2__ 3 X 4__ 5__

	Waiver Service Column A	#Undup. Recip. (users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D (15 minute unit unless specified)
1	Respite Services (non-immediate family/friends)			1:1 ratio 1:2 ratio 1:3 ratio
2	Respite Services (agency based staff)			1:1 ratio 1:2 ratio 1:3 ratio
3	Environmental Accessibility			\$1000.00 Annual Maximum
4	Adult Companion (non-immediate family/friends)			1:1 ratio 1:2 ratio 1:3 ratio
5	Adult Companion –(agency based staff)			1:1 ratio 1:2 ratio 1:3 ratio
6	Skilled Nursing Services – LPN			1:1 ratio 1:2 ratio 1:3 ratio
8	Skilled Nursing Services – RN (formerly QMRP 1-2)			1:1 ratio
9	Habilitation, Day			1:1 ratio 1:2 ratio 1:3 ratio 1:4 ratio
10	Habilitation / Pre-Vocational			1:1 ratio Group
11	Habilitation / Supportive Employment			1:1 ratio group
12	Habilitation, Residential (family/community based)			1:1 ratio
13	Habilitation, Residential (agency based)			1:1 ratio 1:2 ratio 1:3 ratio 1:4 ratio
14	Habilitation, Skills Development Specialist (formerly QMRP 1, 2)			1:1 ratio
15	Habilitation Behavioral Management Specialist (formerly QMRP 2)			1:1 ratio
16	Therapeutic Consultation: Physician, P.T., O.T., Speech Therapy (formerly QMRP 3)			1:1 ratio
17	Crisis Services			Up to 2:1 ratio
18	Travel			0.41 mile or 5.95 trip
19	Case Management (Service Coordination)			1:1 ratio
21	Participation in the Individual Program Plan			
GRAND TOTAL (sum of Column E):				
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				\$
FACTOR D (Divide total by number of recipients):				
AVERAGE LENGTH OF STAY:				

APPENDIX G IS NOT FINALIZED— THIS SECTION WILL BE COMPLETED AFTER ALL PUBLIC INPUT IS RECEIVED BY BMS

	Waiver Service Column A	#Undup. Recip. (users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D (15 minute unit unless specified)
1	Respite Services (non-immediate family/friends)			1:1 ratio 1:2 ratio 1:3 ratio
2	Respite Services (agency based staff)			1:1 ratio 1:2 ratio 1:3 ratio
3	Environmental Accessibility			\$1000.00 Annual Maximum
4	Adult Companion (non-immediate family/friends)			1:1 ratio 1:2 ratio 1:3 ratio
5	Adult Companion –(agency based staff)			1:1 ratio 1:2 ratio 1:3 ratio
6	Skilled Nursing Services – LPN			1:1 ratio 1:2 ratio 1:3 ratio
8	Skilled Nursing Services – RN (formerly QMRP 1-2)			1:1 ratio
9	Habilitation, Day			1:1 ratio 1:2 ratio 1:3 ratio 1:4 ratio
10	Habilitation / Pre-Vocational			1:1 ratio Group
11	Habilitation / Supportive Employment			1:1 ratio group
12	Habilitation, Residential (family/community based)			1:1 ratio
13	Habilitation, Residential (agency based)			1:1 ratio 1:2 ratio 1:3 ratio 1:4 ratio
14	Habilitation, Skills Development Specialist (formerly QMRP 1, 2)			1:1 ratio
15	Habilitation Behavioral Management Specialist (formerly QMRP 2)			1:1 ratio
16	Therapeutic Consultation: Physician, P.T., O.T., Speech Therapy (formerly QMRP 3)			1:1 ratio
17	Crisis Services			Up to 2:1 ratio
18	Travel			0.41 mile or 5.95 trip
19	Case Management (Service Coordination)			1:1 ratio
21	Participation in the Individual Program Plan			
GRAND TOTAL (sum of Column E): TOTAL ESTIMATED UNDUPLICATED RECIPIENTS: FACTOR D (Divide total by number of recipients):				\$
AVERAGE LENGTH OF STAY:				

	Waiver Service Column A	#Undup. Recip. (users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D (15 minute unit unless specified)
1	Respite Services (non-immediate family/friends)			1:1 ratio 1:2 ratio 1:3 ratio
2	Respite Services (agency based staff)			1:1 ratio 1:2 ratio 1:3 ratio
3	Environmental Accessibility			\$1000.00 Annual Maximum
4	Adult Companion (non-immediate family/friends)			1:1 ratio 1:2 ratio 1:3 ratio
5	Adult Companion –(agency based staff)			1:1 ratio 1:2 ratio 1:3 ratio
6	Skilled Nursing Services – LPN			1:1 ratio 1:2 ratio 1:3 ratio
8	Skilled Nursing Services – RN (formerly QMRP 1-2)			1:1 ratio
9	Habilitation, Day			1:1 ratio 1:2 ratio 1:3 ratio 1:4 ratio
10	Habilitation / Pre-Vocational			1:1 ratio Group
11	Habilitation / Supportive Employment			1:1 ratio group
12	Habilitation, Residential (family/community based)			1:1 ratio
13	Habilitation, Residential (agency based)			1:1 ratio 1:2 ratio 1:3 ratio 1:4 ratio
14	Habilitation, Skills Development Specialist (formerly QMRP 1, 2)			1:1 ratio
15	Habilitation Behavioral Management Specialist (formerly QMRP 2)			1:1 ratio
16	Therapeutic Consultation: Physician, P.T., O.T., Speech Therapy(formerly QMRP 3)			1:1 ratio
17	Crisis Services			Up to 2:1 ratio
18	Travel			0.41 mile or 5.95 trip
19	Case Management (Service Coordination)			1:1 ratio
21	Participation in the Individual Program Plan			
GRAND TOTAL (sum of Column E):				
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				\$
FACTOR D (Divide total by number of recipients):				
AVERAGE LENGTH OF STAY:				

APPENDIX G IS NOT FINALIZED— THIS SECTION WILL BE COMPLETED AFTER ALL PUBLIC INPUT IS RECEIVED BY BMS

Waiver Year 1__ 2__ 3__ 4__ 5_ X

	Waiver Service Column A	#Undup. Recip. (users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D (15 minute unit unless specified)
1	Respite Services (non-immediate family/friends)			1:1 ratio 1:2 ratio 1:3 ratio
2	Respite Services (agency based staff)			1:1 ratio 1:2 ratio 1:3 ratio
3	Environmental Accessibility			\$1000.00 Annual Maximum
4	Adult Companion (non-immediate family/friends)			1:1 ratio 1:2 ratio 1:3 ratio
5	Adult Companion –(agency based staff)			1:1 ratio 1:2 ratio 1:3 ratio
6	Skilled Nursing Services – LPN			1:1 ratio 1:2 ratio 1:3 ratio
8	Skilled Nursing Services – RN (formerly QMRP 1-2)			1:1 ratio
9	Habilitation, Day			1:1 ratio 1:2 ratio 1:3 ratio 1:4 ratio
10	Habilitation / Pre-Vocational			1:1 ratio Group
11	Habilitation / Supportive Employment			1:1 ratio group
12	Habilitation, Residential (family/community based)			1:1 ratio
13	Habilitation, Residential (agency based)			1:1 ratio 1:2 ratio 1:3 ratio 1:4 ratio
14	Habilitation, Skills Development Specialist (formerly QMRP 1, 2)			1:1 ratio
15	Habilitation Behavioral Management Specialist (formerly QMRP 2)			1:1 ratio
16	Extended State Plan Services Physician, P.T., O.T., Speech Therapy(formerly QMRP 3)			1:1 ratio
17	Crisis Services			Up to 2:1 ratio
18	Travel			0.41 mile or 5.95 trip
19	Case Management (Service Coordination)			1:1 ratio
21	Participation in the Individual Program Plan			
GRAND TOTAL (sum of Column E):				
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				\$
FACTOR D (Divide total by number of recipients):				
AVERAGE LENGTH OF STAY:				

APPENDIX G IS NOT FINALIZED— THIS SECTION WILL BE COMPLETED AFTER ALL PUBLIC INPUT IS RECEIVED BY BMS

APPENDIX G-3 METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual(e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

APPENDIX G-4 METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

_____The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

_____The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

APPENDIX G-5

FACTOR 'D'

LOC:

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

APPENDIX G IS NOT FINALIZED— THIS SECTION WILL BE COMPLETED AFTER ALL PUBLIC INPUT IS RECEIVED BY BMS

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services **WHILE THE INDIVIDUAL WAS ON THE WAIVER.**

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began **AFTER** the person's first day of waiver services and ended **BEFORE** the end of the waiver year **IF** the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred **BEFORE** the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5

FACTOR 'D' (cont.)

LOC:

Factor 'D' is computed as follows (check one):

_____ Based on HCFA Form 2082 (relevant pages attached).

_____ Based on HCFA Form 372 for years ____ of waiver

____, which serves a similar target population.

Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

_____ Other (specify):

APPENDIX G-6

FACTOR G

APPENDIX G IS NOT FINALIZED— THIS SECTION WILL BE COMPLETED AFTER ALL PUBLIC INPUT IS RECEIVED BY BMS

LOC:

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

_____Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

_____Based on trends shown by HCFA Form 372 for years ____ of waiver #____, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.

_____Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

_____Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

_____Other (specify):

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

APPENDIX G-7

FACTOR G'

LOC:

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor 'G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

APPENDIX G IS NOT FINALIZED— THIS SECTION WILL BE COMPLETED AFTER ALL PUBLIC INPUT IS RECEIVED BY BMS

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor 'G'.

APPENDIX G-7

FACTOR 'G'

LOC:

Factor 'G' is computed as follows (check one):

_____ Based on HCFA Form 2082 (relevant pages attached).

_____ Based on HCFA Form 372 for years _____ of waiver

_____, which serves a similar target population.

_____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

_____ Other (specify):

APPENDIX G-8 DEMONSTRATION OF COST NEUTRALITY

LOC:

YEAR 1

FACTOR D: _____ FACTOR G: _____

FACTOR D': _____ FACTOR G': _____

TOTAL: _____ < _____ TOTAL: _____

YEAR 2

FACTOR D: _____ FACTOR G: _____

FACTOR D': _____ FACTOR G': _____

TOTAL: _____ < _____ TOTAL: _____

YEAR 3

APPENDIX G IS NOT FINALIZED— THIS SECTION WILL BE COMPLETED AFTER ALL PUBLIC INPUT IS RECEIVED
BY BMS

FACTOR D: _____ FACTOR G: _____

FACTOR D': _____ FACTOR G': _____

TOTAL: _____ < _____ TOTAL: _____

APPENDIX G-8 DEMONSTRATION OF COST NEUTRALITY (cont.)

LOC:

YEAR 4

FACTOR D: _____ FACTOR G: _____

FACTOR D': _____ FACTOR G': _____

TOTAL: _____ < _____ TOTAL: _____

YEAR 5

FACTOR D: _____ FACTOR G: _____

FACTOR D': _____ FACTOR G': _____

TOTAL: _____ < _____ TOTAL: _____

APPENDIX G IS NOT FINALIZED– THIS SECTION WILL BE COMPLETED AFTER ALL PUBLIC INPUT IS RECEIVED BY BMS

FACTOR D: _____ FACTOR G: _____

FACTOR D': _____ FACTOR G': _____

TOTAL: _____ < _____ TOTAL: _____

APPENDIX G-8 DEMONSTRATION OF COST NEUTRALITY (cont.)

LOC:

YEAR 4

FACTOR D: _____ FACTOR G: _____

FACTOR D': _____ FACTOR G': _____

TOTAL: _____ < _____ TOTAL: _____

YEAR 5

FACTOR D: _____ FACTOR G: _____

FACTOR D': _____ FACTOR G': _____

TOTAL: _____ < _____ TOTAL: _____

West Virginia Title XIX Waiver Quality Management Program

The West Virginia MR/DD Waiver Program has established a quality management system with stakeholder involvement that is based on quality principles and focuses on quality improvement. This quality management system has been developed, in part, to meet quality assurance standards (*The Protocol*) issued by the Centers for Medicare and Medicaid Services.

With increased demands by consumers to receive more supports and services in the community, West Virginia recognized the need to address the specific quality assurance and improvement concerns in its home and community-based waiver programs. In the past, the MR/DD waiver has primarily collected quality assurance information through compliance reviews and an incident reporting process. This has been primarily a paper reporting methodology, with little capability for critical analysis. Recently the waiver has begun to address the need for improved QA/QI systems development, including more efficient utilization of information technology for incident reporting, performance monitoring, and direct-care service management.

Initial steps in the development of West Virginia's new quality system began with a survey of attendees at the annual MR/DD Waiver Conference. The survey was utilized as baseline data for the development of West Virginia's quality principles for Waiver by means of a stakeholder committee. By means of the driving principles, the committee developed a new quality review tool and the quality management system that included oversight by a MR/DD Waiver Quality Council.

As the state operating agency for West Virginia's MR/DD Waiver, the Bureau of Health and Health Facilities (BHFF) has the responsibility of oversight of the Quality Management System. The State Quality Management Work Plan embraces the basic concepts of assurance and improvement. It is based on the four principles of design, discovery, remediation and system improvement. The Work Plan was developed in collaboration with the MR/DD Waiver Quality Council, which are now the Quality Assurance and Improvement Advisory Council (QA/I Advisory Council). This council is comprised of representatives of families and participants, providers, advocacy groups and other state stakeholders. Workgroups from this council are assigned specific tasks related to quality assurance and improvement efforts. Information gained from the assimilation, integration, and analysis of data is presented to this council at their quarterly meetings.

West Virginia was awarded a grant through CMS for a Quality Assurance and Improvement Project for the MR/DD and A/D Home and Community Based Waivers. Through the efforts of the grant committee, a Quality Assurance and Improvement Team (QA/I Team) have been formed to serve both waivers whose goals are:

1. Develop, implement and support a quality assurance process and improvement infrastructure in the design of home and community-based services.

2. Define a core measurement set for assessing quality of home and community-based services for the A/D waiver program and expand the core measurement set for the MR/DD waiver program.
3. Develop and implement a data collection strategy of “real time” and retrospective information for assessing the performance of HCBS waiver services.
4. Select, design and implement quality assurance and improvement strategies for WV HCBS waiver services.
5. Develop and implement a quality assurance and improvement system that involves HCBS waiver participants, their families, advocates and allies in active roles.
6. Evaluate and upgrade West Virginia’s technology- based direct care service management and data collection system

The QA/I Team meets bi-monthly. Maureen Booth has acted as consultant, and the QA/I Team is utilizing strategies outlined in the workbook “Improving the Quality of Home and Community -Based Services and Supports” developed for the Centers for Medicare and Medicaid Services (CMS) by the University of Southern Main. Initial data mapping has been done in order to construct a gap analysis of data.

BHHF has developed a Quality Review Tool with the assistance of consumers, providers, families and advocates. The tool is a method of review and data collection utilized to assess the status of health and welfare, level of care, plan of care, financial, on-site review of homes/programs, agency systemic infrastructure (policy, personnel, etc.), consumer experience, and financial review of service utilization.

A team of Qualified Mental Retardation Professionals consisting of nurse reviewers and program reviewers visit the consumer or family, the program, or conduct a desk review at the agency. BMS oversees the development and dissemination of Quality reports and information to all stakeholders.

The state operates three methods currently targeting consumer/family input. The methods include the QA/I Advisory Council, Core Indicators Project, and the Quality Tool utilized when reviewing provider agencies. The Core Indicators Project is a national consumer experience survey that is conducted both by written survey and face-to-face interviews of consumers or families. West Virginia currently participates in this project and is compared to participating states nationally by means of the project outcomes data. Additionally, the Waiver Quality Review Tool implements a consumer or family survey that presents a series of consumer experience questions that is conducted at the time of each provider review. Results are reported to the Quality Improvement Council.

West Virginia’s state code mandates that providers report incidents of abuse and neglect or critical incidents. There are two primary agencies that shoulder this responsibility in West Virginia: Bureau for Children and Family (Adult and Child Protective Services) and Bureau for Public Health (OHFLAC). The state operating agency, BHHF, currently has a Memorandum of Understanding with both Bureaus that outlines the relationship, roles,

and responsibilities of the respective agencies. All reported incidents or events that are reported to OHFLAC are shared with the Quality Assurance Coordinator at BHHF.

During provider agency reviews, BHHF staff assess provider incident reporting policies, types of incidents, action taken, and systems for tracking of agency incidents for health/safety or quality improvement purposes. Reports are reviewed to analyze the operational implementation of incident reporting at the direct care level and agency level. Findings are reported to the executive director of the agency and plans of action are requested when systems are found to be lacking. Statewide results of health and welfare data from the reviews or reports are presented to the QA/I Advisory Council for analysis of trends and identification of issues for improvement.

BHHF is the operating agency and as such conducts and/or facilitates waiver operational or administrative functions. The standing committees and work groups for the Waiver are:

- *QA/I Advisory Council* -comprised of participants, family members, providers, advocacy groups, Office of Health Facility Licensure and Certification (OHFLAC), BMS staff and BHHF/Waiver staff.
- *QA/I Team* -comprised of BMS staff, BHHF/Waiver staff, Bureau of Senior Services (BOSS) staff, Program Director of the MR/DD and A/D Waivers, QA/I Advisory Councils for MR/DD and A/D waivers, and West Virginia Center for Excellence in Disabilities (WVCED) staff
- *Special Request Committee* -comprised of MR/DD Waiver Program reviewers, BMS Nurse Reviewers, MR/DD Waiver Nurse Reviewers, MR/DD Program Staff.

The sources of data include:

- *Desk Reviews:* conducted by Licensed Psychologists contracted by BMS to review medical eligibility (application packet) of applicants to the MR/DD waiver.
- *Desk Audits:* conducted by Waiver reviewers to review a particular service delivered by a provider for a specific time period.
- *Waiver Quality Review Tool:* congregates Agency Quality Review information and outcome data
- *Medicaid Claims:* payment claims for services provided to Waiver participants.
- *Appeals/Fair Hearings:* attended by representatives of BHHF and BMS for eligibility, service provision, IPP disagreements
- *Site Visits:* conducted by Waiver Program reviewers as part of a Quality Review or a complaint/investigation
- *APS/CPS Abuse/Neglect Reports:* provided to BHHF on complaints/investigations
- *National Core Indicators:* data and trends provided to BHHF
- *OHFLAC Licensure reports:* provided to BHHF for all Licensure reviews for Waiver Providers
- *Focus Groups/Public Forums:* conducted in accordance with QA/I Project and/or waiver application

- *Office of Quality and Program Integrity Reports:* conducts audits of Waiver Providers as provided for in the Quality
- *Special Requests (DDIA):* requests for prior approval to exceed service limits established in the policy manual.
- *Waiver Application (DDIA):* formal request to apply for Waiver services.

West Virginia's quality management system is organized into six (6) system principles. The MR/DD Waiver Quality Council was responsible for assisting in the development of specific goals and objectives.

A. Participant Health, Safety and Welfare

1. Program review process
2. Provisions for ensuring participants are free from physical and chemical restraints
3. Provisions for ensuring participants are free from abuse, neglect and exploitation
4. Serious incidents are promptly and effectively reported, tracked and appropriate follow-up is implemented
5. All deaths are thoroughly investigated
6. Provisions for ensuring health, safety and welfare during a natural disaster
7. Provisions for a formal tracking and monitoring system for complaints
8. Written agreement with the Office of Social Services to receive all abuse and neglect investigations and complaints
9. Monitoring the use of psychotropic medications
10. Human Rights functions are established within provider agencies
11. Informed Consent
12. Informing and educating participants of their rights

B. Service Planning

1. Person-centered planning and supports
2. Freedom of Choice with providers and services
3. Service planning approval process
4. Methods for determining if service planning includes the participants needed and wanted services
5. Program review process
6. Informal and formal appeal process, fair hearing process
7. Surveys form participants and family members which focus on unmet needs and whether participants received all the services identified on the service plan
8. Participant satisfactions and outcomes
9. Core Indicators Project
11. Informed Consent
12. Independent Service Coordination options

C. Determining Level of Care

1. Level of care eligibility determination

2. Using processes and instruments described in the approved waiver for determining level of care
 3. Second opinions for determining level of care
 4. Automated system for reminding responsible persons when a waiver participant is due for re-determination
 5. Automated system to track reevaluation dates
 6. Automated system for tracking and monitoring level of care evaluations and reevaluations
 7. Provides for re-evaluation annually
 8. Maintains documentation pertaining to all evaluations and reevaluations
- D. Qualified Providers
1. Program review process
 2. Verification of provider qualifications
 4. Assurance that all training requirements are met
 5. Standardized training curriculums
 6. Providing technical assistance
 7. Overseeing implementation of correction plans
 8. Publishing review outcomes for participants and applicants
 9. Provider qualifications
 10. Process for enrolling qualified providers
 11. Written agreement with OHFLAC to receive all survey reports, complaints and complaint investigations.
 12. Dissemination of information pertaining to the MR/DD Waiver Program
 13. Statewide and regional training opportunities
- E. Financial Accountability
1. Maintenance of financial records by the State and providers
 2. Nature and frequency of reviews and audits
 3. Actions the State will take if problems are identified
 4. Explore Individual budgets, voucher system, etc.
- F. State Administrative Authority
1. Interagency agreement between BHHF and BMS
 2. State Medicaid agency assumes the responsibility for all policy decisions regarding the waiver and monitors the implementation by the operating agency
 3. Due Process, Fair Hearing Process, Notice of Decision Process

The Q A/I Advisory Council will identify the specific criteria to be used for prioritizing the list of quality issues and concerns. The Councils will consider criteria such as prevalence of concern, potential impact on desired outcome, probability of success, availability of technical assistance, cost and time lines. WVCED staff will assist the Council in developing these criteria and applying them to the list of quality issues/concerns. It is projected that the initial priority issue/concern will be identified by the Council by the fall of 2005. The principles and tools outlined in the workbook “Improving the Quality of Community-Based Services and Supports” are applied for

measurement of achievement of desired outcome. The QA/I Advisory Council is the driving force behind quality in West Virginia and will lead the state in the development of specific initiatives that produce improvement of service and experience for MR/DD Waiver consumers.

QM reports are disseminated to the QA/I Advisory Council, BMS, stakeholders, and all interested parties via Quality Assurance and Improvement Review reports, State “report card”, and data analysis reports. The QM program is updated based upon the data, when deemed needed by stakeholder input.

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
ANNUAL MEDICAL EVALUATION

County of Residence _____

Participant Name: _____

Birthdate: _____

Name of Behavioral Health Center: _____

Date: _____

Address of BHC: _____

SS#: _____

Location of Physical Exam: _____

Medicaid #: _____

* **Illness/Accidents since Last Examination (Give dates and summarize):**

* **Allergies:**

* **CURRENT MEDICATIONS:**

Name of Medication	Date Started	Dosage	Frequency

* **LIST ANY PREVIOUS MEDICATIONS THAT COULD MOCK SYMPTOMS OR MIMIC MENTAL ILLNESS:**

Name of Medication	Date Started	Date Stopped	Dosage	Frequency

* **LIST ANY OTHER MEDICATIONS THE PARTICIPANT IS USING OR USES FREQUENTLY (OVER THE COUNTER AND PRESCRIPTION):**

Name of Medication	Reason for Taking

* **NUTRITIONAL STATUS SUMMARY:**

Participants Name _____ Name of Behavioral Health Center _____ Date _____

LABORATORY PROCEDURES

TYPE OF TEST	DATE DONE	RESULTS - DATE REC.	TYPE OF TEST	DATE DONE	RESULTS - DATE REC.
URINALYSIS					
CBC					
SYPHILIS SEROLOGY					
HEPATITIS B (UNLESS IMMUNE)					
BLOOD SUGAR (AS INDICATED)					
MEDICATION BLOOD LEVELS (AS INDICATED)					

DENTAL EXAMINATION

DATE:

CONDITION OF MOUTH/GUMS:

CARIES:

DESCRIBE PROPHYLAXIS AND/OR REPAIR WORK COMPLETED:

 SIGNATURE DATE

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NAME: _____

TEMPERATURE:

HEIGHT:

WEIGHT:

B/P:

PULSE:

RESPIRATION:

CODE: ✓ =NORMAL N = NOT DONE NA = NOT APPLICABLE X = ABNORMAL & DESCRIBE

SKIN		
SCALP		
EYES		
NOSE		
THROAT		
LYMPH NODES		
THYROID		
HEART		
LUNGS		
BREAST		
ABDOMEN		
EXTREMITIES		
SPINE		
GENITALIA		
RECTAL (MALES INCLUDE PROSTATE)		
BI-MAN. VAGINAL		
LYMPH		

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CODE: ✓ =NORMAL N = NOT DONE NA = NOT APPLICABLE X = ABNORMAL & DESCRIBE

NEUROLOGICAL		
ENDOCRINE		

ALERTNESS		
COHERENCE		
ATTENTION SPAN		
VISION		
HEARING		
SPEECH		
SENSATION		
COORDINATION		
GAIT		
MUSCLE TONE		
REFLEXES		
OTHER		

PROBLEMS REQUIRING SPECIAL CARE (Check appropriate blanks)

- | | | |
|---|--|---|
| <p>MOBILITY:</p> <p><input type="checkbox"/> Ambulatory</p> <p><input type="checkbox"/> Ambulatory w/Human</p> <p><input type="checkbox"/> Ambul. w/Mechanical Help</p> <p><input type="checkbox"/> Wheelchair</p> <p><input type="checkbox"/> Wheelchair/Self Propelled</p> <p><input type="checkbox"/> Wheelchair w/Assistan</p> <p><input type="checkbox"/> Lifted Bed To Chair</p> <p><input type="checkbox"/> Bedfast</p> | <p>CONTINENCE STATUS:</p> <p><input type="checkbox"/> Continent</p> <p><input type="checkbox"/> Incontinent</p> <p><input type="checkbox"/> Not Toilet Trained</p> <p><input type="checkbox"/> Catheter</p> <p><input type="checkbox"/> Ileostomy</p> <p><input type="checkbox"/> Colostomy</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> | <p>FEEDING:</p> <p><input type="checkbox"/> Feeds Self</p> <p><input type="checkbox"/> Needs To Be Fed</p> <p><input type="checkbox"/> Gastric Tube</p> <p><input type="checkbox"/> Special Diet</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> |
|---|--|---|

- | | | |
|---|--|--|
| <p>PERSONAL HYGIENE:</p> <p><input type="checkbox"/> Self-Care</p> <p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Needs Assistance</p> <p><input type="checkbox"/> Needs Total Care</p> | <p>MENTAL AND BEHAVIORAL DIFFICULTIES:</p> <p><input type="checkbox"/> Alert</p> <p><input type="checkbox"/> Confused/Disoriented</p> <p><input type="checkbox"/> Irrational Behavior</p> <p><input type="checkbox"/> Needs Close Supervision</p> <p><input type="checkbox"/> Unable to Communicate</p> | <p>OTHER:</p> <p><input type="checkbox"/> Unable to Communicate</p> |
|---|--|--|

ADDITIONAL RECOMMENDATIONS:

- | | | |
|--|---|---|
| <input type="checkbox"/> SPEECH THERAPY | <input type="checkbox"/> PHYSICAL THERAPY | <input type="checkbox"/> OCCUPATIONAL THERAPY |
| <input type="checkbox"/> TRACHEOSTOMY | <input type="checkbox"/> OXYGEN THERAPY | <input type="checkbox"/> IV FLUIDS |
| <input type="checkbox"/> DIAGNOSTIC SERVICES | <input type="checkbox"/> SOAKS, DRESSING | |

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Please Complete All Sections Below To Ensure Certification For The Program

DIAGNOSTIC SECTION:

MENTAL: (List All Cognitive, Developmental, Behavioral, Emotional and/or
Psychiatric Conditions)

PHYSICAL: (List Chronic and Handicapping Conditions As Well As Current, Acute
and/or Communicable Conditions)

PROGNOSIS:

I certify that this Patient's Developmental Disability, Medical Condition and Related
Health Needs Are As Documented Above and Patient Requires the Level of Care and
Services Provided in an *Intermediate Care Facility for Individuals with Mental
Retardation and/or Related Conditions **Yes** _____ **No** _____

**(Note: ICF/MR level of care means the individual needs a high level of habilitation training and supervision. This level of care
does not have to occur in an institution and can be provided in a community setting.)*

Date	Physician's Signature	License #
------	-----------------------	-----------

FOR DEPARTMENT OF HEALTH AND HUMAN RESOURCES USE ONLY

Approved for ICF/MR Level of Care	_____	Yes	_____	No
Approved for Community Support Services	_____	Yes	_____	No

Name of Reviewer: _____ Date _____

West Virginia Title XIX Waiver Quality Management Program

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1. Develop, implement and support a quality assurance process and improvement infrastructure in the design of home and community-based services.

2. Define a core measurement set for assessing quality of home and community-based services for the A/D waiver program and expand the core measurement set for the MR/DD waiver program.
3. Develop and implement a data collection strategy of “real time” and retrospective information for assessing the performance of HCBS waiver services.
4. Select, design and implement quality assurance and improvement strategies for WV HCBS waiver services.
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WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
ANNUAL MEDICAL EVALUATION

County of Residence _____

Participant Name: _____
 Birthdate: _____

Name of Behavioral Health Center: _____ Date: _____

Address of BHC: _____ SS#: _____

Location of Physical Exam: _____ Medicaid #: _____

* **Illness/Accidents since Last Examination (Give dates and summarize):**

* **Allergies:**

* **CURRENT MEDICATIONS:**

Name of Medication	Date Started	Dosage	Frequency

* **LIST ANY PREVIOUS MEDICATIONS THAT COULD MOCK SYMPTOMS OR MIMIC MENTAL ILLNESS:**

Name of Medication	Date Started	Date Stopped	Dosage	Frequency

* **LIST ANY OTHER MEDICATIONS THE PARTICIPANT IS USING OR USES FREQUENTLY (OVER THE COUNTER AND PRESCRIPTION):**

Name of Medication	Reason for Taking

* **NUTRITIONAL STATUS SUMMARY:**

Participants Name _____ Name of Behavioral Health Center _____ Date _____

LABORATORY PROCEDURES

TYPE OF TEST	DATE DONE	RESULTS - DATE REC.	TYPE OF TEST	DATE DONE	RESULTS - DATE REC.
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CBC					
SYPHILIS SEROLOGY					
HEPATITIS B (UNLESS IMMUNE)					
BLOOD SUGAR (AS INDICATED)					
MEDICATION BLOOD LEVELS (AS INDICATED)					

DENTAL EXAMINATION

DATE:

CONDITION OF MOUTH/GUMS:

CARIES:

DESCRIBE PROPHYLAXIS AND/OR REPAIR WORK COMPLETED:

 SIGNATURE DATE

***This page may be mailed separately room the other pages of this medical report.**

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NAME: _____

TEMPERATURE:

HEIGHT:

WEIGHT:

B/P:

PULSE:

RESPIRATION:

CODE: ✓ =NORMAL N = NOT DONE NA = NOT APPLICABLE X = ABNORMAL & DESCRIBE

SKIN		
SCALP		
EYES		
NOSE		
THROAT		
LYMPH NODES		
THYROID		
HEART		
LUNGS		
BREAST		
ABDOMEN		
EXTREMITIES		
SPINE		
GENITALIA		
RECTAL (MALES INCLUDE PROSTATE)		
BI-MAN. VAGINAL		
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CODE: ✓ =NORMAL N = NOT DONE NA = NOT APPLICABLE X = ABNORMAL & DESCRIBE

NEUROLOGICAL		
ENDOCRINE		

ALERTNESS		
COHERENCE		
ATTENTION SPAN		
VISION		
HEARING		
SPEECH		
SENSATION		
COORDINATION		
GAIT		
MUSCLE TONE		
REFLEXES		
OTHER		

PROBLEMS REQUIRING SPECIAL CARE (Check appropriate blanks)

- | | | |
|---|--|---|
| <p>MOBILITY:</p> <p><input type="checkbox"/> Ambulatory</p> <p><input type="checkbox"/> Ambulatory w/Human</p> <p><input type="checkbox"/> Ambul. w/Mechanical Help</p> <p><input type="checkbox"/> Wheelchair</p> <p><input type="checkbox"/> Wheelchair/Self Propelled</p> <p><input type="checkbox"/> Wheelchair w/Assistan</p> <p><input type="checkbox"/> Lifted Bed To Chair</p> <p><input type="checkbox"/> Bedfast</p> | <p>CONTINENCE STATUS:</p> <p><input type="checkbox"/> Continent</p> <p><input type="checkbox"/> Incontinent</p> <p><input type="checkbox"/> Not Toilet Trained</p> <p><input type="checkbox"/> Catheter</p> <p><input type="checkbox"/> Ileostomy</p> <p><input type="checkbox"/> Colostomy</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> | <p>FEEDING:</p> <p><input type="checkbox"/> Feeds Self</p> <p><input type="checkbox"/> Needs To Be Fed</p> <p><input type="checkbox"/> Gastric Tube</p> <p><input type="checkbox"/> Special Diet</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> |
|---|--|---|

- | | | |
|---|--|--|
| <p>PERSONAL HYGIENE:</p> <p><input type="checkbox"/> Self-Care</p> <p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Needs Assistance</p> <p><input type="checkbox"/> Needs Total Care</p> | <p>MENTAL AND BEHAVIORAL DIFFICULTIES:</p> <p><input type="checkbox"/> Alert</p> <p><input type="checkbox"/> Confused/Disoriented</p> <p><input type="checkbox"/> Irrational Behavior</p> <p><input type="checkbox"/> Needs Close Supervision</p> <p><input type="checkbox"/> Unable to Communicate</p> | <p>OTHER:</p> <p><input type="checkbox"/> Unable to Communicate</p> |
|---|--|--|

ADDITIONAL RECOMMENDATIONS:

- | | | |
|--|---|---|
| <input type="checkbox"/> SPEECH THERAPY | <input type="checkbox"/> PHYSICAL THERAPY | <input type="checkbox"/> OCCUPATIONAL THERAPY |
| <input type="checkbox"/> TRACHEOSTOMY | <input type="checkbox"/> OXYGEN THERAPY | <input type="checkbox"/> IV FLUIDS |
| <input type="checkbox"/> DIAGNOSTIC SERVICES | <input type="checkbox"/> SOAKS, DRESSING | |

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Please Complete All Sections Below To Ensure Certification For The Program

DIAGNOSTIC SECTION:

MENTAL: (List All Cognitive, Developmental, Behavioral, Emotional and/or
Psychiatric Conditions)

PHYSICAL: (List Chronic and Handicapping Conditions As Well As Current, Acute
and/or Communicable Conditions)

PROGNOSIS:

I certify that this Patient's Developmental Disability, Medical Condition and Related
Health Needs Are As Documented Above and Patient Requires the Level of Care and
Services Provided in an *Intermediate Care Facility for Individuals with Mental
Retardation and/or Related Conditions **Yes** _____ **No** _____

**(Note: ICF/MR level of care means the individual needs a high level of habilitation training and supervision. This level of care
does not have to occur in an institution and can be provided in a community setting.)*

Date	Physician's Signature	License #
------	-----------------------	-----------

FOR DEPARTMENT OF HEALTH AND HUMAN RESOURCES USE ONLY

Approved for ICF/MR Level of Care	_____	Yes	_____	No
Approved for Community Support Services	_____	Yes	_____	No

Name of Reviewer: _____ Date _____

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

COMPREHENSIVE PSYCHOLOGICAL EVALUATION (TRIENNIAL)

NAME: _____ EVALUATION DATE: ___/___/___

BIRTHDATE: ___/___/___ AGENCY/FACILITY: _____

REASON FOR EVALUATION: _____

I. RELEVANT HISTORY:

A. Prior Hospitalization/Institutionalization

B. Prior Psychological Testing

C. Behavioral History

2. Results:

3. Discussion:

B. Adaptive Behavior:

1. Instruments used: ABS I & II Others (list)

2. Results:

3. Discussion:

C. Other:

1. Instruments used:

2. Results:

3. Discussion:

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D. Indicate the individual's level of acquisition of these skills commonly associated with need for active treatment.

1. Able to take care of most personal care needs. yes no
2. Able to understand simple commands. yes no
3. Able to communicate basic needs and wants. yes no
4. Able to be employed at a productive wage level without systematic long term supervision or support. yes no
5. Able to learn new skills without aggressive and

- consistent training. yes no
6. Able to apply skills learned in a training situation to other environments or settings without aggressive and consistent training. yes no
7. Able to demonstrate behavior appropriate to the time, situation or place without direct supervision. yes no
8. Demonstrates severe maladaptive behavior(s) which place the person or others in jeopardy to health and safety. yes no
9. Able to make decisions requiring informed consent without extreme difficulty. yes no
10. Identify other skill deficits or specialized training needs which necessitates the availability of trained MR personnel, 24 hours per day, to teach the person to learn functional skills. _____

E. Developmental Findings/Conclusions

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IV. RECOMMENDATIONS:

- A. Training
- B. Activities
- C. Therapy/Counseling/Behavioral Intervention

V. DIAGNOSIS:

VI. PROGNOSIS:

VII. PLACEMENT RECOMMENDATIONS:

Signature of Supervised Psychologist

Signature of Licensed Psychologist

Title

License #/Title

Date

Date

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WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
SOCIAL HISTORY

PARTICIPANT NAME: _____

DATE: _____

I. DEVELOPMENTAL HISTORY: Provide information summarizing personal growth from infancy through adolescence with attention to the development of his/her physical, social, and emotional competencies. As outlined below, if development is delayed, describe the circumstances or conditions associated with the delay and date of onset. If more space is needed, use back of this sheet and identify information by Roman Numeral and Letter.

a) Physical

b) Social

c) Emotional

II. FAMILY: List parents, spouse, children, siblings, significant others, and type of relationships, i.e., are they an available source of support and/or resources. Include description of family's socio-economic circumstances, and family composition. Past and current living arrangements, special problems, such as alcohol, substance abuse, and mental illness should be included.

III. EDUCATION/TRAINING: Describe education and training experiences, identify schools and programs attended, relationships with peers and teachers, any adjustment problems, levels of accomplishment and any other pertinent information.

IV. FUNCTIONAL STATUS: Describe levels of functioning relating to employment capabilities, work-related experiences, and assessment of skills relevant to the activities of daily living and self-care skills. Is applicant/participant now, or ever been gainfully employed? Indicate level of care recommendation.

V. RECREATION/LEISURE ACTIVITIES: Identify and describe recreational and leisure time activities, frequencies, accessibility, and degree of involvement.

VI. HOSPITALIZATIONS: List medical and psychiatric hospital dates and reason for admissions.

VII. FAMILY MEDICAL HISTORY (Identify relationship to the participant):

_____ MR/DD	_____ Heart Disease	_____ Cerebral Palsy
_____ Autism	_____ Diabetes	_____ Tuberculosis
_____ Hepatitis	_____ Mental Illness	_____ Kidney Disease
_____ Cancer	_____ Hypertension	_____ Metabolic Disease
_____ Allergies	_____ Thyroid Disease	_____ Muscular Dystrophy
_____ Epilepsy	_____ Other	_____ Other

Deceased Siblings (Cause of Death) _____

VIII. LEGAL STATUS: (Guardianship, committee, custody).

IX. OTHER RELEVANT INFORMATION: (Family medical history; applicant/participant military service; religious preference; or significant events or circumstances not covered in other sections).

DATE

DATE

SIGNATURE OF TEMPORARY LSW

SIGNATURE/CO-SIGN OF DEGREED/LSW

LICENSE #/DEGREE

LICENSE #/DEGREE

II Evaluation and Assessment Summary: (List Strengths/Needs in all Areas)

<p>A. Medical/Health:</p> <p style="text-align: center;"><u>Strengths</u></p>	<p style="text-align: center;"><u>Needs</u></p>
---	---

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CONFIDENTIAL

NAME _____

DATE ____ / ____ / ____

II. (cont'd)

<p>B. Psychological</p> <p style="text-align: center;"><u>Strengths</u></p>	<p style="text-align: center;"><u>Needs</u></p>
---	---

<p>B. Psychological</p> <p><u>Strengths</u></p>	<p><u>Needs</u></p>
<p>C. Social</p> <p><u>Strengths</u></p>	<p><u>Needs</u></p>

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CONFIDENTIAL

NAME _____

DATE ____/____/____

II. (cont'd)

<p>D. Habilitation</p> <p style="text-align: center;"><u>Strengths</u></p>	<p style="text-align: center;"><u>Needs</u></p>
<p>C. Other</p> <p style="text-align: center;"><u>Strengths</u></p>	<p style="text-align: center;"><u>Needs</u></p>

F. Projected Date of Community Placement: ____/____/____

CONFIDENTIAL

DATE ____/____/____

NAME _____

____ of ____ Page

III. Individual Service Plan (Staff Actions Based on Assessment Results)

Area	Service Needs	Availability Accessibility	Provider

Frequency Days/Hours	Duration	Plan of Action	Responsible Person

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CONFIDENTIAL

DATE ____/____/____

NAME _____

____ of

III. Individual Service Plan (Staff Actions Based on Assessment Results)

Area	Service Needs	Availability Accessibility	Provider

Frequency Days/Hours	Duration	Plan of Action	Responsible Person

REEVALUATION DATE _____ 3 MOS. 6 MOS. 9 MOS. 12 MOS.

_____/_____/_____ _____/_____/_____
 PARTICIPANT DATE
 SERVICE COORDINATOR DATE

_____/_____/_____ _____/_____/_____
 PARENT/LEGAL REPRESENTATIVE DATE SERVICE COORDINATOR DATE

CONFIDENTIAL

DATE ___/___/___

NAME _____

_____ of

IV. Individual Habilitation Plan

#	Goal/Need	#	Behavioral Objective	Barriers

Activities and Methods	Date Initiated	Date Completed	Responsible Person

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#	Goal/Need	#	Behavioral Objective	Barriers

Activities and Methods	Date Initiated	Date Completed	Responsible Person

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**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
INFORMED CONSENT
TO A CHOICE OF
ALTERNATIVES BETWEEN INSTITUTIONAL
AND WAIVER HOME AND COMMUNITY-BASED SERVICES**

NAME: _____

AGENCY/FACILITY

- _____ 1. The findings and results of the evaluations and needs have been discussed with the participant and/or family or legal representative.
- _____ 2. Alternative plans for providing services to meet the participant's needs have been discussed and a choice of services between ICF/MR and community-based MR/DD Waiver services has been presented to the participant and/or family or legal representative.
- _____ 3. The participant and/or family or legal representative have chosen _____ as described by the Interdisciplinary Team.
- _____ 4. The participant and/ or family or legal representative have requested that an Individual Program Plan be developed for their approval.
- _____ 5. The right to a fair hearing and the agency and state appeal process have been discussed with the participant and/or family or legal representative.
- _____ 6. A copy of the MR/DD Manual has been offered to the participant and/or family or legal representative and he/she has _____ accepted _____ refused the copy of the handbook.

A. _____
Participant Date

B. _____
Service Coordinator Date

OR

C. _____
Parent or Legal Representative Date

D. _____
Service Coordinator Supervisor Date

E. _____
Relationship to Participant

F. _____
Witness Date

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
INFORMED CONSENT
TO A CHOICE OF
MR/DD WAIVER PROVIDERS AND MR/DD WAIVER SERVICES**

NAME: _____
AGENCY/FACILITY

- _____ 1. The right to choose **services** among all qualified providers has been discussed with the participant and/or family or legal representative.
- _____ 2. **All enrolled service coordination agencies in the participant's catchment area have been discussed with the participant, family and/or legal representative.**
- _____ 3. The participant and/or family or legal representative have chosen _____ as their service coordination agency.
- _____ 4. The right to choose among all available MR/DD Waiver services to meet the participant's needs have been discussed with the participant and/or family or legal representative.
- _____ 5. The participant, family and/or legal representative has been informed of their right to a fair hearing if denied service(s) and the provider(s) of their choice.
- _____ 6. **A copy of the MR/DD Waiver Manual has been offered to the participant, family and/or legal representative have _____ accepted _____ refused a copy of the Reference Guide.**

A. _____ Date _____ B. _____ Date _____
Participant Service Coordinator

OR

C. _____ Date _____ D. _____ Date _____
Parent or Legal Representative Service Coordinator Supervisor

E. _____ F. _____
Relationship to Participant Witness Date

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**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES (MEDICAID)**

REQUEST FOR HEARING

NAME:

ADDRESS:

RECIPIENT NAME and ID #:

TELEPHONE NUMBER WHERE YOU CAN BE REACHED:

I am requesting a fair hearing for the following reason(s):

Please list service that was denied or terminated. Be as specific as possible. Use other side of this form, if necessary for more space.

You may be contacted by a representative of the Department of Health and Human Resources regarding this request.

You may be requested to participate in a pre-hearing conference (most likely by telephone).

Which type of hearing would you prefer (please check one):

- _____ All persons participate by telephone conference.
_____ In person at local office (Medical Consultant by telephone).
_____ Hearing at Bureau for Medical Services office in Charleston. (with reimbursement for travel mileage, if requested.)

Signature: _____ Date:

If hearing is by telephone and you have any documents to present, please mail your documents before the hearing to the hearing examiner whose name is on the hearing notice that you will receive.

If you know you will be represented by an attorney or other individual, please list his/her name, address, and telephone number:

Check here if you know you will have a second medical exam in preparation for the hearing.

Return this request to: Bureau for Medical Services
Board of Review
350 Capitol Street, Room 251
Charleston, WV 25301-3707

A Staff member will try to contact you by telephone within approximately five days of receipt of this form.

After the telephone contact, you will be notified in writing of the date and time of the hearing.

If we are unsuccessful in contacting you by telephone, you will receive written notice of the hearing date and time within 30 days

Title XIX MR/DD Waiver
Home and Community Based Program

WV Home & Community Base
Services Waiver Application – MR/DD Waiver

VERSION 06-95

Bureau of Medical Services NOTICE OF DENIAL
Policy Units STATE OF WEST VIRGINIA
Room 251 DEPT. OF HEALTH & HUMAN RESOURCES
350 Capitol Street
Charleston, West Virginia 25301-3707
Telephone: 1-800-642-8589
Telephone: 1-304-558-2400
Case Number:

Date:

Name: _____

Address: _____

Medicaid MR/DD Waiver Program:

- Your Waiver Application is hereby denied.
- Your Waiver services have been terminated.

Your application was denied because:

The Reviewer(s) relied on the following facts:

You have right to a **second medical exam** at the department's expense if the decision was based on medical reasons. You have the right of access to your file and copies free of charge.

FAIR HEARING: If you do not agree with the decision, you may ask for a **Fair Hearing** and/or a Pre-Hearing Conference within 90 days of the action taken. A form to ask for a Fair Hearing and/or Pre-Hearing Conference is enclosed. If this action is termination of your benefit, your services may continue until your hearing is held. Within 90 days, you must complete this form and submit it to the address on the bottom of the form. You must ask for a Hearing/Pre-Hearing Conference within 13 days of this notice in order to receive continued benefits. The following organizations provide **free legal services** to eligible persons: WV Advocates, 1207 Quarrier Street, Charleston, WV 25301; 1-800-950-5250; Legal Aid of WV, 922 Quarrier Street, 4th Floor, Charleston, WV 25301; 1-800-642-8279; WV EMS TSN, Behavioral Health Services Program, P.O. Box 100, Elkview, WV 25701-0100; (304) 965-0578. The department will assist in arranging transportation if needed.

The policy upon which the decision is based: MR/DD Waiver Manual Chapter 1 Eligibility Criteria, Pages 1.1-1.3.

cc: Behavioral Health Center

MR/DD Waiver Level of Care Determination Process

Initial Application

(only necessary for initial applicants)

1. DD-14 completed by the member or family.
2. Member chooses provider agency
3. DD-14 submitted to State Office.
4. State Office notifies provider agency to begin Level of Care evaluations (45 days).

Level of Care Evaluation/Re-evaluation

(process for all members)

1. Annual physical evaluation (DD2-A)
2. Annual psychological evaluation (DD-3)
3. Other assessments as indicated.

Eligibility Determination

(process for all members)

1. Evaluations submitted to the State determination of medical eligibility..
2. Medical review team conducts a determination of medical eligibility based on DD2-A,DD-3, or additional information as indicated (45 days)
3. Member's financial eligibility determination is conducted at one of the 55 DHHR offices located in the member's home county.

Eligibility Notification
(process for all members)

1. Based upon medical review team's decision, BHHF notifies member of decision.
2. If eligible, member is notified of need to determine financial eligibility at local DHHR office.
3. Member is notified by DHHR of the determination of financial eligibility

Appeal Rights
(process for all members)

1. If determined ineligible, the member is notified of the decision, rationale for the decision, and information utilized to make the decision (denial letter).
2. Member is notified of the right to a fair hearing at the time of the notification of the decision (Fair Hearing Request Form).

Introduction to Methodology for Determining the Level of Support/Service Needed

During the fall of 2004, the *Lewin Group* conducted an independent assessment of the MR/DD Waiver Program. Base upon evidence reported by recipients, families, provider agencies, and advocacy groups, a person-centered approach to services had been identified as a high priority for the state. Additionally, the Bureau for Medical Services has received comments from consumers and families indicating a desire for “transparent” service planning and budgeting services. “Up-front” education around budgeting and service planning has been expressed as a concern. Families want an individualized level of service based upon the person’s assessed needs and identified needs and wants.. Stakeholders expressed a desire to reduce the complication of services and processes and increased controls over service planning. A perception of a “one-size-fits-all” approach was prevalent.

Constituent feedback has led the state along a new path for planning purposes. Evidence clearly exists to support a new model for a system of supports for individuals with developmental disabilities in West Virginia. The state is presenting a new concept *called Personal Needs Budgeting*.

In preparation for the new model, the State has established a supports method for service delivery. This is in contrast to the current “medical model” that focuses primarily upon the person’s adaptive behavior deficits. This service delivery method will focus on the services and supports the person needs to maintain an active, involved life in the community rather than deficits. This method incorporates “person-centered” planning that is facilitated by the service coordinator and directed by the consumer. It is believed that this model will balance the needs as assessed with other factors that impact a person’s services and supports.

The Personal Needs Budget places the person in charge of their budget and allows for a choice of services that is tailored to meet the individual needs of the person. An independent assessment is conducted initially by an Administrative Services Organization (ASO), APS Healthcare, Inc. The Personal Needs Assessors at APS Healthcare will conduct an assessment jointly with the recipient or family (or others with a vested interest in the individual, if desired). The needs assessment guides the person’s individualized budgeting by assigning a score indicating a level of need for the person divided into seven distinct levels. There will be a process in place to override a budget level for extenuating circumstances.

Each level is based upon the unique needs of the person. Factors such as living situation, behavioral supports and medical care will be included in the formulary for determining the level of need. Each level of need establishes an upper range for a personal needs budget and a lower range based upon factors such as setting, intensity of supports needed, and access to natural supports. Following the determination of a budget range, **the personal needs budget is then distributed to the consumer and family** to begin planning for services with the service coordinator (case manager) and the rest of the interdisciplinary team.

Below is an outline of the methodology for determining the level of support/service that will be needed for each recipient of the waiver program. Please note the methodology only pertains to the level of service/need (plan of care) not the level of care (eligibility for the program). The level of care is an entirely different process and is utilized only to determine if a recipient meets the criteria for the program.

Methodology for Determining the Level of Support/Service Needed

CONSUMER EDUCATION

Personal Needs Assessor will provide the Consumer and family/guardian education in the following areas:

- Self Direction
- Services Available
- Budgeting
- Program Parameters
- Provider Choices (Service Coordination, Direct Services, etc)
- Consumer Rights
- Assessment of Risk

PERSONAL NEEDS ASSESSOR: PROCESS FOR ASSESSING NEED AND DETERMINING BUDGET

Personal Needs Assessor, Recipient and Family/Guardian, etc of Recipient will complete:

- Client & Agency Planning Assessment (ICAP) and Supports Intensity Scale (SIS).

The Budget:

- The ICAP will determine the budget – The SIS will determine the supports needed.
- The Scores on the ICAP will fall into one of 7 levels. A budget range will be attached to each of the levels. An individual's score on the ICAP will determine the budget range for the individual.
- Each level of need establishes an upper range for a personal needs budget and a lower range based upon factors such as setting, intensity of supports needed, and access to natural supports.

SERVICE COORDINATOR:

Consumer and service coordinator identify his/her support network.

- Consumer authorizes the Personal Assessor to inform the Service Coordinator, selected by the Consumer, of their personal needs and their budget range
- Service Coordinator facilitates the plan of care and IPP team meeting (Individual Program Plan based on Person Center philosophy).

INTERDISCIPLINARY TEAM

- Consumer identifies preferences, skills, and goals necessary to pursue his/her vision for life experiences and conditions that support the life experiences.
- Consumer will choose from an array of services that meets their needs with assistance and recommendations from the Interdisciplinary Team. The team will utilize both the ICAP and SIS to guide their service needs.
- Provider agency collaborates with the consumer regarding the settings and activities that the consumer chooses to participate in throughout the day.

CHOICE OF SERVICES

- The Service Coordinator informs the ASO of the services that have been selected by the consumer.

LOGISTICS OF CONNECTION TO CLAIMS PROCESSOR

- The ASO will link request with Claims Processor

OVER RIDE TO EXTEND BUDGET LEVEL - UNPLANNED EVENTS

- Consumer Crisis
- Family Crisis
- Consumer Medical Need
- Family Medical Need

In conclusion, West Virginia has established a plan to move MR/DD Waiver services from a predominately medical model to a supports model via a “person-centered planning” approach. Following the determination of Level of Care, “consumer-driven” needs assessment is conducted by an independent assessor that yields a personal needs budget. The process encourages an independent identification of needs or supports that are known to the consumer, service coordinator, provider, and other members of the interdisciplinary team. This process establishes a “fire-wall” between the consumer and service provider agency, thereby, allowing the service coordinator to independently advocate on behalf of the consumer. Additionally, consumer choice and consumer education are key functions in the independent assessor model. The process provides a mechanism to review that basic needs are addressed and services are delivered. When “outliers” exist, the service coordinator will assist the consumer in the acquisition of supports that are not addressed in his/her Personal Needs Budget or educate the consumer regarding his/her right to appeal.

MR/DD Waiver Member Rights: Choice and Appeal

Choice Between ICF-MR Facility and Home and Community Based Services

1. Member has a choice of an ICF-MR facility or home and community based services.
2. Member's choice is indicated on consent forms (sample forms DD-7 and DD-7a.)
3. Service coordinator educates member or family of options.
4. Witness verifies that options were presented, discussed, and informed choice occurred.

Choice of Provider

1. Member has a choice of provider within available Waiver provider agencies.
2. Member's choice is indicated on consent forms (sample forms DD-7 and DD-7a.)
3. Service coordinator educates member or family of provider agency options available.
5. Witness verifies that options were presented, discussed, and informed choice occurred.
6. Member may choose to transfer to another provider agency at any point in service, providing that the transition process occurs.
7. Member may choose to receive Waiver services from more than one agency (example: Provider A is the service coordination provider; Provider B is the residential habilitation provider; Provider C is the supported employment provider, etc).

Appeal of Eligibility Decision or Service

1. Points of member notice of appeal rights: initial application, determination of ineligibility for Level of Care (medical eligibility), financial eligibility, or reduction in service.
2. Member may complete a "Request for Fair Hearing" form.
3. Representative of the WV Board of Hearing Examiners will objectively hear the case and submit a final decision to BMS.
4. If the member is not satisfied with the outcome of the hearing, the member may choose to appeal to circuit court for a final ruling.
5. Members have the right to a second medical evaluation prior to the hearing. The member may submit either a second physical evaluation (DD2-A) or a second psychological evaluation (DD-3) or both. The evaluation(s) must be submitted to BHHF at a minimum of ten (10) days prior to hearing date.

Appeal of Individual Program Plan

1. *Option 1- BHHF Appeal Process:* BHHF, State Operating Agency, has implemented a statewide clinical policy outlining the requirement for provider agencies to develop/implement an agency-level grievance process. The member may choose to file a grievance or appeal at the agency level.
2. *Option 1- BHHF Appeal Process: BHHF Appeal Process:* The BHHF clinical policy also outlines a second level of grievance or appeal in regards to the IPP- State Level Appeal directly to BHHF by the member.
3. *Option 2-BMS Appeal Process:* A member may file an appeal through the Medicaid appeal process, thereby requesting a fair hearing for reduction in benefits.
4. *Option 2-BMS Appeal Process:* Member may complete a "Request for Fair Hearing" form
5. *Option 2-BMS Appeal Process:* Representative of WV Board of Hearing Examiners will objectively hear the case and submit a final decision to BMS.
6. *Option 2-BMS Appeal Process:* If the member is not satisfied with the outcome of the hearing, the member may choose to appeal to circuit court for a final ruling.
7. Members have the right to a second medical evaluation prior to the hearing. The member may submit either the physical evaluation (DD2-A) or the psychological evaluation (DD-3) or both.
8. The second evaluation(s) must be submitted to BHHF at a minimum of ten (10) days prior to the hearing date for review.

BILLING PROCESS

- Administrative Service Organization (ASO) will conduct assessments in conjunction with the recipient which will determine a budget range for the individual.
- Recipient and his team will develop an Individualized Program Plan (IPP)
- The service coordinator of the individual will forward the services they identified as being needed to the ASO.

- The ASO will “link” the services identified by the recipient and his/her team to the claims processing agent .

- Restrictions will be placed in the Claims processing system that will only allow those services that have been identified as being needed by the recipient to be reimbursed to the provider.

- The provider of the service bills either by paper or electronically to a state contracted claims processing entity
- The claims submitted will be processed by the claims processing agent.

- Once the claim is granted approved status by the claims processing system it is transferred to Budget Relief Processing which enables the claim to be selected for payment
- Payment if made to the provider either electronically or manually.