CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

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BACKGROUND

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

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

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

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

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

PROGRAM DESCRIPTION

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

TBIW services include case management, personal attendant, non-medical transportation, personal emergency response systems (PERS), environmental accessibility adaptations (EAA) home and/or vehicle and pest eradication.

TBIW services are to be provided exclusively to the members eligible for services and only for necessary activities as listed in their Person-Centered Service Plan (PCSP). To avoid institutionalization, enrollment

on TBIW is contingent on a person requiring two or more of the services offered. One service, which must be utilized monthly, is Personal Attendant services, unless temporarily in a nursing home, hospital, or other inpatient medical facility. This may include hands-on assistance or supervision of activities of daily living (ADL)/instrumental activities of daily living (IADL). Personal attendant services must be used monthly either through a Traditional provider or Self-Direction. The other service required is case management. Individuals may not be enrolled in the TBIW for the sole purpose of obtaining Medicaid eligibility. Services may not solely involve ancillary tasks such as housekeeping, assistance with chores, essential errands, non-emergency transportation and/or community activities.

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

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

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

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

512.1 HOME AND COMMUNITY BASED SETTINGS REQUIREMENTS

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

Member-Controlled Settings

Member-controlled settings are defined as a home or apartment, owned or leased by an HCBS member or by one of their family members.

The member's case manager must assess the setting annually to determine that the member continues to reside in a setting with the characteristics of a member-controlled setting and that the setting continues to meet the standards described below:

- The setting is integrated in and supports full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

- The setting is selected by the member from among setting options including non-disability specific settings.
- The setting ensures a member's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
- The setting optimizes, but does not regiment, member initiative, autonomy, and independence in making life choices including but not limited to daily activities, physical environment, and with whom to interact.

The setting facilitates the members' choice regarding services and support and who provides them. If the setting does not meet the standards listed above, then remediation will occur. The case manager will assist the members to remediate the identified issue(s), including, as a last resort, transitioning to a setting that does meet requirements. A member that chooses not to comply with the home and community-based settings requirements may risk losing their services.

The member-controlled setting assessment may be found under the Resources section of the West Virginia Statewide Transition Plan webpage.

Provider-Controlled Settings

Provider-controlled settings are settings where a member resides with a paid unrelated caregiver or with an agency provider who provides HCBS services most of the day.

All provider-controlled settings and members who receive services in these settings will be evaluated at least annually by the BMS or its designee (the utilization management contractor) annually to determine that the setting continues to exhibit the characteristics of a provider-controlled setting and that the setting meets the standards as described below:

- The setting was selected by the member from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the member's needs, preferences, and, for residential settings, resources available for room and board.
- The member participates in unscheduled and scheduled community activities in the same manner as individuals not receiving Medicaid HCBS services.
- Members have opportunities to seek employment and work in competitively integrated settings and engage in community life.
- The members have their own bedroom or share a room with a roommate of choice.
- The member chooses and controls a schedule that meets their wishes in accordance with a person-centered plan.
- The members control their personal resources.
- The members choose when and what to eat and may have access to food at any time.
- The members choose with whom to eat or to eat alone.
- Member choices are incorporated into the services and supports received.
- The members choose from whom they receive services and support.
- The member has access to make private telephone calls/text/email at the member's preference and convenience.
- Members are free from coercion and restraint.
- The member, or a person chosen by the individual, has an active role in the development and updating of the member's person-centered plan.

- The setting does not isolate members from individuals not receiving Medicaid HCBS in the broader community.
- State laws, regulations, licensing requirements, facility protocols or practices do not limit members' choices.
- The setting is an environment that supports members' comfort, independence, and preferences.
- The member has unrestricted access in the setting.
- The physical environment meets the needs of those members who require support.
- Members have full access to the community.
- The members' right to dignity and privacy is respected.
- Members who need assistance to dress are dressed in their own clothes appropriate to the time of day and individual preferences.
- Staff communicate with members in a dignified manner.
- The member can have visitors of their choosing at any time.
- The members' unit has an entrance door that can be locked by the member, with only appropriate staff having keys to doors.

Any provider-controlled setting that does not meet these standards will be referred to the BMS or its designee for assistance with remediation to attempt to attain compliance. If the setting cannot be remediated to meet all these standards, then the setting will be removed from the approved provider listing, and the member(s) will be required to transition to an approved setting. If a transition is refused, the member will be discharged from the program.

The provider-controlled setting assessment may be found under the Resources section of the West Virginia Statewide Transition webpage.

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

Heightened Scrutiny: Overview

If a setting is unable or unwilling to become compliant with remediation, as determined by on-site review of the setting, then the state will initiate the process for resolution.

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

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

participate in community services, consistent with the member's person-centered service plan

These settings will be subject to a heightened scrutiny process. In such cases, the setting would be submitted to the CMS for a heightened scrutiny review. Evidence compiled by the State will accompany this submission. This evidence will include review documents, stakeholder interviews and comments and other evidence as necessary.

Transition of Members: Overview

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

The BMS will also notify the individual members five working days after the provider notification, to assure that all stakeholders are notified of the disenrollment. This information will include material on transition assistance and extensions and will be provided through:

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

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

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

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

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

6. The date of the change of provider/setting.

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

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

Should the member request assistance beyond that given by the provider, BMS will assist the member in the timely transition to another provider and/or setting. Requests should be made by phone, email or letter. In isolated instances, the BMS may extend the 90-day transition period for a member to assure that there is no interruption of services to the member.

This procedure would also apply to a provider which concurs with the setting review that the site is not HCBS-compliant.

PROVIDER PARTICIPATION REQUIREMENTS

512.2 BUREAU FOR MEDICAL SERVICES CONTRACTUAL RELATIONSHIPS

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

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

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

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

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

512.3 PROVIDER AGENCY CERTIFICATION

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

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

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

Conflicts of Interest

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

Conflict-Free Case Management

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

Safeguards

Case management agencies must have a policy to ensure there will not be a conflict of interest if an exception has been made. A conflict of interest is when the case manager, who represents the TBIW member, also provides personal attendant agency services through the same provider agency. Failure to abide by conflict-of-interest policy will result in the loss of provider certification for a period of one year and all current members being served will be transferred to another case management agency. Any case manager working for a case management agency that will also be providing personal attendant agency services will need to sign the case management Conflict of Interest Exception Application for home and community-based waiver services. The completed and approved application must be placed in the member's file at the case management agency. Failure to have the approved application in the file when reviewed could result in sanctions. If it is determined that a case manager has violated conflict of interest assurances, they may be subject to sanctions including being prohibited from billing for services.

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

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

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

- Case management agencies must have a policy to ensure there will not be a conflict of interest if an exception has been made:
    - Include a basic description of the duties of the home and community-based services supervisor(s) and the case management supervisor(s).
    - Explain how members are provided with a case manager.
    - Explain how members are given a choice of home and community-based services and other natural supports or services offered in the community.
    - Explain how the agency ensures that the case manager is free from the influence of direct service providers regarding member Service Plans.
    - Evidence of administrative separation on the organizational chart that includes position titles and names of staff.
    - The agency has administrative separation of supervision of case management and home and community-based services.
    - The attached organization chart shows two separate supervisors, one for case management and one for home and community-based services.
    - Case management members are offered a choice for home and community-based services between and among available service providers.
    - Case management members are not limited to home and community-based services provided only by this agency.
    - Case management members are provided with a case manager within the agency.
    - Disputes between case management and home and community-based services units are resolved.
    - Members are free to choose or deny home and community-based services without influence from the internal agency case manager and home and community-based service staff.
    - Members choose how, when, and where to receive their approved home and community-based services.
    - Members are free to communicate grievance(s) regarding case management and/or home and community-based services delivered by the agency.
    - The grievance/complaint procedure is clear and understood by members and legal representatives.
    - Grievances/complaints are resolved in a timely manner.

Becoming a Certified TBIW Provider

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

- A business license issued by the State of West Virginia.
- A federal tax identification number (FEIN).
- Insurance: The provider shall have the following:
    - A minimum of one million dollars in commercial liability insurance, which includes coverage for individuals' losses due to theft or property damage.
- Written instructions a member would use to obtain payment for loss due to theft or property damage caused by the provider's employee.
- Providers cannot require personal attendants or case managers to sign any type of agreement that limits employment opportunities that would affect member choice of provider agency.
- A competency-based curriculum for required training areas for personal attendant staff.

- An organizational chart.
- A list of the Board of Directors (if applicable).
- A list of all agency staff, which includes their qualifications.
- A Quality Management Plan for the agency.
- Written policies and procedures for processing complaints and grievances from staff or members receiving TBIW services that:
    - Addresses the process for submitting a complaint.
    - Provides steps for the remediation of the complaint including who will be involved in the process.
    - Steps include the process of notifying the member of the findings and recommendations.
    - Provides steps for advancing the complaint if the member/staff does not feel the complaint has been resolved.
    - Ensures that a member receiving TBIW services or agency staff are not discharged, discriminated, or retaliated against in any way if they have been a complainant, on whose behalf a compliant has been submitted or who has participated in an investigation process that involves a TBIW provider.
- Written policies and procedures for the use of personally and agency owned electronic devices which include, but are not limited to:
    - Prohibits using personally identifiable information in texts and subject lines of emails.
    - Prohibits the use of personally identifiable information in the body of emails unless the email is sent securely through a Health Insurance Portability and Accountability Act (HIPAA) compliant connection.
    - Prohibits personally identifiable information from being posted on social media sites.
    - Prohibits using public Wi-Fi connections without the use of a secure Virtual Private Network (VPN) connection.
    - Informs agency employees that during an investigation, information related to their personal cell phone is discoverable; and
    - Requires all electronic devices to be encrypted.
- Written policies and procedures for members to transfer.
- Written policies and procedures for the discontinuation of member's services.
- Written policies and procedures to avoid conflict of interest, if the agency provides both case management and personal attendant services.
- Education of case managers on general conflict of interest/professional ethics including verification.
- Annual signed Conflict of Interest Statements for all case managers and the agency director.
- Process for investigating reports on conflict-of-interest complaints.
- Process for complaints to professional licensing boards for ethics violations.
- Process for reporting to the BMS.
- Policy and procedure for reporting Medicaid Fraud to the BMS (Office of Program Integrity and program manager).
- Office space that allows for confidentiality of the members receiving TBIW services.
- An Agency Emergency Plan (for members receiving TBIW services and office operations). This plan must include:
    - Office Emergency Back-Up Plan ensuring office staffing and facilities are in place during emergencies such as floods, fires, etc. The alternate site can be used for 30 days. If the agency will be there longer than 30 days, the new temporary facilities must meet all requirements and the location be certified. The provider must notify the UMC within 48

hours of the location change. Providers must inform members receiving TBIW services of their Emergency Back-Up Plan.

- The agency must accept referrals within five business days or forfeit the referral.
- All providers are required to have and implement policies and procedures for members with limited English proficiency and/or accessible format needs that are culturally and linguistically appropriate to ensure meaningful access to services.
- Computer(s) for staff with HIPAA secure email accounts, UMC web portal software, internet access, and current (within last five years) software for spreadsheets.
- Hire and retain a qualified workforce.
- Ensure that a member receiving TBIW services is not discharged unless a viable Discharge/Transfer Plan is in place that effectively transfers all services that the members need to another provider(s) and is agreed upon by the member and the receiving provider(s).
- Ensures that services are delivered, and documentation meets regulatory and professional standards before the claim is submitted.
- Participate in all BMS mandatory training sessions.
- The written policy and procedures regarding personal attendant staff are not allowed to sub-contract their work responsibilities to another person.
- Provider must have written policy and procedures for reporting and documenting incidents if/when a program member presents an unsafe work environment for staff.
- Written policies and procedures to ensure that service provider staff that fail to report incidents and delays in incident reporting will result in appropriate employee discipline up to and including employee suspension or termination.
- Written policies and procedures to ensure that individuals including the member, staff and family members are free from retaliation or adverse consequences because they reported incidents or allegations of abuse, neglect, exploitation or other staff misconduct.
- Written policies and procedures to ensure that guardians are informed of reported incidents as soon as possible after learning about an incident and in all cases within 72 hours of learning of an incident.
- Written policy and procedures outlining agency personal attendant staff actions when the member is not home/doesn't respond to calls and the personal attendant has arrived to provide scheduled services.
- Written policy and procedures outlining case manager's actions when the member is not responding to a home visit and/or calls.
- The provider must comply with the CMS settings rule.
- Have written policy regarding member's right to request their records.
- All TBIW providers must provide any services, when they are needed, that are listed on the member's Service Plan. This includes services on weekdays and weekends.
- Have written Policy and Procedure for documentation training for case managers and personal attendants that at the minimum must include current program forms and proper documentation correction procedures.

Provider agencies will be reviewed by the UMC within six months of initial agency certification, and annually thereafter.
More information regarding provider participation requirements in Medicaid services can be found in *Chapter 300, Provider Participation Requirements*. Providers will be held accountable for information contained in all Medicaid common chapters. Providers are encouraged to contact the UMC for training needs and technical assistance.

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

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

512.4 ELECTRONIC VISIT VERIFICATION (EVV)

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

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

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

The personal attendant agency staff is responsible for installation of a Fixed Object (FOB) device in the members home to a stationary fixture if a personal attendant is unable or unwilling to download and use an app to meet check in/out requirements for EVV. The case manager is responsible for verifying that the FOB was installed when applicable on the Monthly Contact Form.

512.5 CRIMINAL BACKGROUND CHECKS

Refer to the West Virginia Clearance for Access: Registry & Employment Screening (WV CARES) website for criminal background check information, forms and program information.

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

512.6 OFFICE CRITERIA

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

- Physically located in West Virginia.
- An agency office site can serve the counties in West Virginia as designated in their application. TBIW providers wishing to make changes in the approved counties they serve **must** make the request in writing 30 days prior to providing services to the UMC.
- Changes can only be made annually unless it is a request for a provider to expand their service area by the BMS.
- Be readily identifiable to the public through signage that includes hours of operation.
- Meet Americans With Disabilities Act (ADA) requirements for physical accessibility (refer to 28 CFR 36, as amended). These include but are not limited to:
    - Maintains an unobstructed pedestrian passage in the hallways, offices, lobbies, bathrooms, entrance and exits.
    - The entrance and exit have accessible handicapped curbs, sidewalks and/or ramps.
    - The restrooms have bars for convenience. A telephone is accessible. Drinking fountains and/or water made available as needed.
- Maintain a primary telephone number that is listed with the name and local address of the business. (Note: Exclusive use of a pager, answering service, a telephone line shared with another business/individual, facsimile machine, cell phone, or answering machine does not constitute a primary business telephone.)
- Maintain an agency secure HIPAA compliant e-mail address for communication with the BMS and the UMC for all staff.
- At a minimum, have access to a computer, fax, email address, scanner, and internet.
- Utilize any database system, software, etc., compatible with/approved and/or mandated by the BMS.
- Be open to the public at least 40 hours per week. Observation of state and federal holidays is at the provider's discretion.
- Contain space for securely maintaining program and personnel records (refer to *Chapter 100, General Information*, and *Chapter 300, Provider Participation Requirements*, for more information on maintenance of records).
- Maintain a 24-hour contact method.
- Change in agency location due to emergencies such as flood or fire for over 30 days requires a site review of the agency by the UMC.
- Any authentication method for electronic and stamped signatures must meet the following basic requirements:
    - Unique to the person
    - Capable of verification
    - Under the sole control of the person, and

- Linked to the data in such a manner that if the data is changed, the signature is invalidated. Agencies that provide electronic devices for their staff must ensure all personally identifiable information is secure.

- Certified TBIW providers cannot subcontract any services they are approved to provide to another agency.
- TBIW provider agencies cannot obtain certification for the benefit of serving individuals receiving services from another program such as Veteran Administration (VA) clients. The BMS is not responsible for certifying other in-home service programs or its workers.

512.7 QUALITY IMPROVEMENT SYSTEM

The Quality Improvement System (QIS) is designed to:

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

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

- TBIW Administration and Oversight: The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.
- Level of Care Evaluation/Re-evaluation: The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/re-evaluating an applicant's/waiver member's level of care consistent with level of care provided in a hospital, nursing facility, or intermediate care facilities for individuals with intellectual disabilities (ICF/IID).
- Qualified Providers: The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.
- Person-Centered Service Plan: The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of person-centered service plans for waiver members.
- Health and Welfare: The state demonstrates it has designed and implemented an effective system for assuring waiver members health and welfare.
- Financial Accountability: The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

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

512.9 QUALITY IMPROVEMENT ADVISORY (QIA) COUNCIL

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

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

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

512.10 INITIAL/CONTINUING CERTIFICATION OF PROVIDER AGENCIES

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

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

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

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

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

- Employ adequate, qualified, and appropriately trained personnel who meet minimum standards for providers of the TBIW program.
- Provide services based on each member's individual assessed needs, including evenings and weekends.

- Maintain records that fully document and support the services provided.
- Furnish information to the BMS, or its designee, as requested. (Refer to *Chapter 100, General Information* and *Chapter 300, Provider Participation Requirements*, for more information on maintenance of records).
- Maintain a current list of members receiving TBIW services.
- Comply with WV IMS.

512.11 QUALITY REVIEWS

The primary means of monitoring the quality of the TBIW services is through provider reviews conducted by the UMC as determined by the BMS on a defined cycle. The UMC performs annual on-site or remote reviews and desk documentation reviews as requested by the BMS to monitor program compliance. The UMC also performs annual Continuing Certification reviews for agency and staff compliance. Targeted on-site TBIW reviews and/or desk reviews may be conducted at the discretion of the BMS or its agents.

Agency Continuing Certification Reviews

TBIW provider agencies are required to submit designated evidence to the UMC every 12 months to document continuing compliance with all certification requirements as specified in this chapter. This evidence must be attested to by an appropriate official of the provider agency (e.g., Director or Board Chair).

If appropriate documentation is not provided within 30 calendar days of expiration of current certification, a Provisional Certification may apply. Provider agencies who receive a Provisional Certification will be required to have a review by the UMC prior to full recertification.

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

Quality Reviews

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

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

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

Upon completion of each provider Quality Review, the UMC conducts an exit summation with the agency director or their designated staff. Within 10 business days of the conclusion of the exit interview, the UMC will email a Provider Review Report and draft Plan of Correction, if needed, to the provider and to the BMS. If a draft Plan of Correction is required by a provider, they must complete it and submit it to the

UMC within 30 days of notice of the deficiency. If the UMC returns the draft Plan of Correction to the provider requesting additional information the provider must complete and re-submit the draft Plan of Correction within 10 business days. If the draft Plan of Correction and required documentation is not submitted within the time frame, the BMS may hold provider reimbursement and remove the provider from the Freedom of Choice Selection forms until an approved Plan of Correction is in place.

After the 30-day comment period has ended, the BMS will review the draft Review Report, and any comments submitted by the TBIW provider and issue a Final Review Report to the TBIW provider's director.

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

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

Failure to provide written comments to the draft report will result in forfeiture of being able to request a Document/Desk Review.

If the TBIW provider disagrees with the final disallowance report, the TBIW provider may request a Document/Desk Review within 30 days of receipt of the final report pursuant to the procedures in *Chapter 800, Program Integrity, Section 800.11.2 Provider Request for Document/Desk Review* of the BMS Provider Manual. If a provider requests a DDR, a written repayment arrangement must still be completed within 30 days of receipt of the final report. A request for a DDR does NOT postpone the repayment process. *Chapter 800, Section 800.11.2* states:

"If the overpayment determination is reversed by the DDR decision, BMS will refund any previous payments made by the provider, not to exceed the disallowance amount determined in the DDR decision. Additional information regarding the appeal process can be found in *Chapter 800, Program Integrity Section 800.11, Appeal Process*.

Plan of Correction

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

A Plan of Correction must include:

- How the deficient practice cited in the deficiency will be corrected. What system will be put into place to prevent recurrences of the deficient practice.

- How the provider will monitor to assure future compliance and who will be responsible for the monitoring.
- The date each item on the Plan of Correction will be completed; and
- Any provider-specific training requests related to the deficiencies.

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

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

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

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

512.12 TRAINING AND TECHNICAL ASSISTANCE

The UMC develops and conducts training for TBIW providers and other interested parties as necessary to improve systemic and provider-specific quality of care and regulatory compliance. Training is available through both face-to-face and web-based venues.

All TBIW providers must have at least one representative participant in the BMS mandatory quarterly provider meetings, trainings and calls. That representative is responsible for dissemination of the information learned at the quarterly provider meetings to all other pertinent agency personnel. If it is determined that a representative is not present, it becomes the agency's responsibility to obtain the information shared and follow any directives provided. Continued and ongoing non-participation may result in sanctions.

512.13 SELF-AUDIT

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

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

TBIW providers must use the approved format for submitting self-audits to the OPI. Failure to submit an assigned self-audit may result in the BMS withholding Medicaid payments until the self-audit is submitted. TBIW providers are required to send all completed forms in an electronic format to the OPI along with the original Excel spreadsheet and repayment forms.

For more information on sanctions available to the BMS, see *Chapter 800, Program Integrity*. Forms necessary to complete a self-audit can be found on the OPI webpage.

512.14 RECORD REQUIREMENTS

Providers must fully complete all required TBIW forms and follow published forms instructions. Forms with corrective fluid/tape or removeable labels used on them will not be accepted. Documentation must be member-specific, legible and errors in documentation cannot be completely covered over but should be indicated with a line through the error and noted/initialed by the person making the correction. Any alteration or change in documentation after a medical professional, member or Medicaid provider has signed it could result in a targeted review and disallowances. Forms and instructions can be found on the TBIW website.

TBIW providers must meet the following program record requirements:

- The provider must keep a file on each member utilizing the TBIW.
- The files must contain all original documentation for services provided to the member by the provider responsible for development of the document (for example the case management agency should have the original Person-Centered Service Plan, the complete service assessment, contact notes, enrollment confirmation, etc.).
- Original documentation on each member and employee must be kept by the Medicaid provider for five years, and an additional three years after audits, with all exceptions having been declared resolved by the BMS, in the designated office that represents the county where services were provided. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years, whichever is greater.
- The provider must upload the following documentation into the UMC web portal within 12 calendar days from the date of the Service Plan meeting:
    - Person Centered Service Plan (initial/annual/six-month)
    - Person Centered Assessment (initial/annual/six-month)
    - Discovery Tools
    - Any legal documents pertaining to power of attorney, legal guardianship, conservatorship, etc.
    - Member-Controlled Settings Assessment
    - Environmental Accessibility Adaptions (EAA) required documentation (if applicable)
    - Budget
    - Conflict of Interest Exception application approved by the BMS (if applicable)
    - Service Plan Addendum (if applicable)
    - Responsibility Agreements (if applicable)

Provider Personnel Records

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

- Minimum credentials for professional staff (case manager) must be verified upon hire and thereafter based upon their individual professional license requirements.
- All documentation on each staff member must be kept by the provider in a designated office that represents the county where services were provided.

TBIW providers must agree to abide by all applicable federal and state laws, policy manuals, and other documents that govern the waiver program. Providers must also agree to make themselves, Board members (if applicable), their staff, and all records pertaining to TBIW services available to any audit,

Desk Review, or other service evaluation that ensures compliance with billing regulations and program goals.

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

512.15 LEGAL REPRESENTATIVES

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

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

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

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

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

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

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

512.16 STAFF QUALIFICATIONS AND TRAINING REQUIREMENTS

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

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

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

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

Case managers must complete mandatory training on the Settings Rule prior to completing the Member-Controlled Setting Assessments. The case manager training is available on the WV Learning Management System (LMS). Personal staff must also receive mandatory training on the Settings Rule. This training can be the same training available to case managers or can be in the form of the educational brochure available to members. The provider agency must document how the paid caregiver was trained and if using the brochure, the agency must ensure the paid caregiver passes a test with 80% competency. Members will receive educational information on the Settings Rule from their case manager in the form of the brochure and documented that it was provided on the member's Person-Centered Service Plan.

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

512.17 Staff Training Documentation

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

CPR/First Aid Documentation

TBIW Provider Agencies: Personal attendants must have a CPR/First Aid card. While an agency is waiting for the card, if the agency staff is a certified trainer from a UMC-approved certifying agency, then

the BMS will accept the Training Log in each personal attendant's personnel file as evidence. The sign-in sheet documentation is valid for 30 days from the date of the class, the card must be secured and copied into the staff record after 30 days.

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

Certification cards belong to the individual that took the course, not the agency. These cards should be made available to the employee.

512.18 INCIDENT CLASSIFICATION AND MANAGEMENT

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

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

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

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

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

Critical Incidents

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

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

Simple Incidents

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

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

512.19 Reporting Requirements, Incident Management Documentation and Investigation Procedures

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

An Incident Report documenting the outcomes of the investigation must be completed and entered into the WV IMS within 14 calendar days of learning of the incident.

If a death occurs it must be entered into the WV IMS, and the Notification of Death form is generated from system. The provider agency who learned of the death first is responsible for entering the incident into the IMS.

All deaths must be reported in the WV IMS within one business day of learning about the incident. For incident type, choose “critical” incident category, then choose “death” as incident sub-type.
For *Personal Options*, if the resource consultant learns of any incidents first, they must report the incidents into the WV IMS as well as notify the case manager within the next business day of learning of the incident. All incidents involving A/N/E must be reported to APS or CPS (as applicable) but also must be reported into the WV IMS. If the case manager becomes aware of an incident before the resource consultant, the case manager must report the incident into the IMS and inform the resource consultant. The WV IMS does not supersede the reporting of incidents to APS or CPS (as applicable). At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the provider, shall immediately notify APS per WV Code §9-6-9 or CPS per WV Code §49-2-803.

An agency is responsible for investigating all incidents, including those reported to APS or CPS. If requested by APS or CPS (as applicable), a provider shall delay its own investigation and document such request in the online WV IMS. The provider will also contact the UMC with such delay requests. When reporting to APS/CPS, the agency needs to obtain the referral number so they can follow up with investigation results.

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

- The report includes the date of the incident, date the agency learned of the incident, facts of the incident, type of incident, initial determination of the incident and verification that an approved professional conducted the investigation.
- All parties were interviewed, and incident facts were evaluated.
- Member was interviewed.

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

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

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

512.20 Incident Management Tracking and Reporting

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

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

512.21 MEDICAID FRAUD AND REPORTING REQUIREMENTS

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

512.22 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

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

General Requirements:

- TBIW program provider agencies must comply with the documentation and maintenance of records requirements described in *Chapter 100, General Information*; and *Chapter 300, Provider Participation Requirements* of the BMS Provider Manual.
- TBIW program provider agencies must comply with all the other documentation requirements of this chapter.
- All required documentation must be maintained by the TBIW provider for at least five years and an additional three years after audits, with all exceptions having been declared resolved by the BMS, in the file of the member receiving TBIW services subject to review by authorized BMS personnel or contracted agents. Employee files must be kept for at least

five years. In the event of a dispute concerning a service provided, documentation must be maintained until three years after the dispute resolution or five years, whichever is greater.
- All required documentation and records must be available upon request from the BMS or federal monitors, or contracted agents for auditing and/or medical review purposes.
- Failure to maintain all required documentation and in the manner required by the BMS, may result in the disallowance and recovery by the BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to the BMS upon request.

Specific Requirements

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

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

PROGRAM ELIGIBILITY AND ENROLLMENT

512.23 TBIW PROGRAM ELIGIBILITY

Applicants for the TBIW program must meet all the following criteria to be eligible for the program.

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

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

The applicant must first meet the financial eligibility requirements before a determination of the applicant's medical eligibility will be made. A slot must be available for an applicant to participate in the program. If no slots are available, applicants determined financially and medically eligible for the program will be placed on the Managed Enrollment List (MEL). As slots become available, applicants on the MEL will be notified and provided detailed instructions on continuing the enrollment process. Eligible applicants are assigned an available slot on a first-on-first-off basis, i.e. the first person on the MEL is the first person off the MEL. The BMS does not issue, or rank applicants' health care needs for emergency slots or to be placed higher on the MEL.

512.24 FINANCIAL ELIGIBILITY

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

Application Process

Once the applicant (including Take Me Home Transition program applicants) submits the MNER to the UMC, within two business days a letter will be sent to the applicant: The UMC will send the Long-Term Care (LTC) application to the applicant and email the yellow DHS-2 to the West Virginia DoHS Long-Term Care Unit. Applicants have 60 calendar days from receipt of letter to complete the LTC application and submit it to the West Virginia DoHS Long-Term Care unit. The West Virginia DoHS has 30 calendar days to determine financial eligibility once receipt of the LTC application. Once financial eligibility is determined, the West Virginia DoHS will email the yellow DHS-2 to the UMC. When the UMC receives the yellow DHS-2, they will then contact the applicant to schedule their medical eligibility assessments.

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

Ineligible Applicants

An applicant may be determined ineligible for various reasons:

- The applicant is over the income/asset guidelines.
- The applicant did not complete and submit the required paperwork to determine eligibility.

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

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

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

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

The UMC will fax the DHS-2 (White) form to the West Virginia DoHS LTC Unit. The UMC will inform the applicant and case management provider that the LTC Unit has received the DHS-2 form and financial eligibility is pending. Once financial eligibility has been determined, the MEL Applicant must be enrolled in the TBIW program within 30 calendar days from the dated DHS-2 form (white).

The applicant has a total of 30 calendar days from the release of the MEL to be enrolled. If the enrollment is not completed within 30 calendar days, the UMC will close the referral and notify the applicant. The letter will include the reason for the closure, the applicable TBIW policy chapter section(s), notice of free legal services, and a Request for Hearing form to be completed if the applicant wishes to contest the decision. The letter will outline specific timeframes for filing an appeal.

If the applicant wants TBIW services after closure, a new MNER form is required to be sent to the UMC, and the application process starts again.

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

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

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

512.26 MEDICAL ELIGIBILITY

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

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

512.26.1 Medical Criteria

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

Section	Description of Deficits	
#24	Decubitus; Stage 3 or 4	
#25	In the event of an emergency, the person is c) mentally unable or d) physically unable to vacate a building. a) Independently and b) With supervision are not considered deficits.	
#26	Functional abilities of the person in the home	
a.	Eating	Level 2 or higher (physical assistance to get nourishment, not preparation)
b.	Bathing	Level 2 or higher (physical assistance or more)
c.	Dressing	Level 2 or higher (physical assistance or more)
d.	Grooming	Level 2 or higher (physical assistance or more)
e. f.	Continence, Bowel Continence, Bladder	Level 3 or higher; must be incontinent
g.	Orientation	Level 3 or higher (totally disoriented, comatose)
h.	Transfer	Level 3 or higher (one-person or two-person assistance in the home)
i.	Walking	Level 3 or higher (one-person assistance in the home)
j.	Wheeling	Level 3 or higher (must be Level 3 or 4 on walking in the home to use Level 3 or 4 for wheeling in the home. Do not count outside the home.)
k.	Vision	Level 3 or higher (Impaired/Not Correctable)
l.	Hearing	Level 3 or higher (Impaired/Not Correctable)
m.	Communication	Level 3 or higher (Understandable with aids)
#27	The person has skilled needs in one or more of these areas: (a) Physical therapy, (b) Speech therapy, (c) Occupational Therapy, (e) Continuous oxygen (g) Suctioning, (h) Tracheostomy, (i) ventilator, (k) Parenteral fluids, (l) Sterile dressings, or (m) Irrigations.	
#28	The person is not capable of administering their own medications **or** needs prompting/ supervision.	
#34	(f) Disoriented), (k) Seriously impaired judgment, (m) Cannot communicate basic needs, (p) Physically dangerous to self and others, If unsupervised	

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

512.26.2 Initial Medical Evaluation

The following is an outline of the initial medical evaluation process:

- An applicant shall initially apply for the TBIW program by having their treating physician (Doctor of Medicine (MD) or Doctor of Osteopathy (DO), physician assistant (PA), neuropsychologist, or nurse practitioner (NP)) (here after calling the referent) complete and sign a MNER form including ICD diagnosis code(s). The referent, applicant, family member, advocate, or other interested party, may submit this form by fax, mail or electronically to the UMC. The UMC will not process any MNER form if the referent's and/or applicants' signature is more than 60 calendar days old. If the MNER form is incomplete, it will be returned for completion and resubmission within two weeks, and the applicant will be notified.
- Once a completed and signed MNER Is received, the UMC will email the yellow DHS-2 form to the West Virginia DoHS so financial eligibility can be established.
- Once the completed DHS-2 form is emailed back to the UMC from the West Virginia DoHS economic service worker, if financially eligible, the UMC will attempt to contact the applicant (or legal representative) to schedule the medical assessment. If contact is made, a notice shall be sent to the applicant and/or contact person detailing the scheduled home visit date and time.
- The UMC will make up to three attempts to contact the applicant. The UMC will issue a potential referral closure letter to the applicant and the referent. If no contact is made with the UMC within 10 business days, the referral will be closed. If the applicant chooses to have the evaluation after the referral is closed, a new referral is required if the referent's and/or applicants' signature on the MNER is greater than 60 calendar days.
- If the MNER form indicates that the applicant has a court appointed legal guardian, the assessment will not be scheduled without the court appointed legal guardian present to assist the applicant.
- The UMC will provide Case Management Agency/Personal Attendant Agency Selection forms, Service Delivery Model forms during the assessment and collect them at the end of the Medical Assessment.

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

512.26.3 Results of Initial Medical Evaluation

Approval

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

If the applicant is determined medically eligible and a slot is not available, a notice of approved medical eligibility will be sent to the applicant/legal representative informing them a slot is not currently available, and the person will be placed on the MEL, and they will be contacted when one becomes available. When a slot becomes available, the applicant will be sent a letter, and financial eligibility must be redetermined. The case management agency, personal attendant agency, and the F/EA, if applicable, are also notified.

Denial

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

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

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

512.26.4 Medical Re-evaluation

Annual re-evaluations for medical eligibility for members utilizing the TBIW are conducted as follows:

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

512.26.5 Results of Medical Re-evaluation

Approval

If the member meets the medical eligibility criteria, a Notice of Approved Continued Medical Eligibility is sent to the member along with the completed PAS and Rancho by the UMC. The UMC will fax the Notice of Approved-Continued Medical Eligibility letter only to the West Virginia DoHS LTC Unit.

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

Denial

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

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

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

512.27 ENROLLMENT

Once an applicant has been determined both financially and medically eligible, the UMC will complete the enrollment and provide a confirmation notice to the case management agency and the personal attendant service provider agency or the F/EA, if the person chooses *Personal Options*.

No Medicaid reimbursed TBIW services may be provided until the case management agency is in receipt of the person's Enrollment Confirmation Notice. The case management and personal attendant agencies are responsible for maintaining a copy of the Enrollment Confirmation Notice in the members' file.

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

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

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

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

512.28 DESCRIPTION OF SERVICE DELIVERY MODELS

Two service models are offered in the TBIW:

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

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

512.28.1 Traditional Service Delivery Model

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

If the member chooses this service delivery model, all services accessed will be done through a TBIW provider after being determined necessary, appropriate, and within the assessed needs. The TBIW provider has employer authority as well as fiscal responsibility for the services listed on the service plan of the member. These services are provided where the member resides and participate in community activities. The providers are responsible for all facets of the program, taking into consideration the member's individual wishes and needs. Providers must try to match personal attendants with reasonable criteria set forth by the member, i.e., member requests non-smoker. Services are provided when the member needs them, within the assessed need and not at the convenience of the provider.

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

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

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

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

The hourly wage of agency staff employed by a TBIW provider is determined by the agency that employs the staff person, and must comply with all local, state, and federal employment requirements. All agency staff hired by a TBIW provider must meet the requirements listed in this manual. As the common law employer, the TBIW provider is responsible for:

- Recruiting and hiring qualified agency staff.
- Providing required training for agency staff, including training on needs specific to the member.
- Determining agency staff work schedule and how and when agency staff should perform the required tasks.
- Determining agency staff's daily activities.
- Evaluating agency staff performance.
- Maintaining and processing agency staff payroll.
- Maintaining documentation in a secure location and ensuring employee confidentiality; and
- Discharging agency staff when necessary.

Regarding the provision of the Traditional Service Delivery Model, the UMC is responsible for:

- Conducting agency satisfaction surveys with a sample of members who receive services and receiving and analyzing the survey results and reporting them to the BMS annually.
- Conducting provider reviews on a defined cycle using an approved review protocol based on TBIW requirements.
- Authorizing services within the members' assessed budget.

512.28.2 Self-Directed Service Delivery Model

The Self-Directed Service Delivery Model, also known as *Personal Options*, is available to every member who receives TBIW services. Members who choose to self-direct their services are still required to have a case manager from a traditional agency provider to perform case management functions such as Assessment and Service Plan development.
The member who chooses this service model can exercise choice and control over the self-directed services they choose and the individuals and the organizations who provide them (employer authority); and/or how the portion of their budget associated with self-directed services is spent (budget authority). The self-directed services over which members can exercise choice and control are personal attendant, PERS, EAA home and/or vehicle, Pest eradication, and non-medical transportation. When a member is making the choice for a service delivery model the UMC will provide information about the roles and responsibilities with self-direction to be able to make an informed choice of service delivery models.

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

The hourly wage of personal attendant staff employed by a member may not exceed the Medicaid rate minus all mandatory deductions and must be at least the current minimum wage amount. All personal attendant staff hired by the member must meet the requirements listed under applicable sections. The member who chooses to Self-direct their TBIW services will do so with the support of an FMS vendor. If

utilizing *Personal Options,* the member is the common law employer, or employer of record, of the personal attendant staff hired.

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

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

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

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

- Evidence of initial and annual personal attendant training as required by policy.
- Provide program representative training and agreement (if applicable).

The *Personal Options* FMS is not the common law employer of the personal attendant staff of the member. Rather, the *Personal Options* FMS assists the member/common law employer in performing all that is required of an employer for wages paid on their behalf and all that is required of the payer for the requirements of back-up withholding, as applicable. The *Personal Options* FMS operates under §3504 of the IRS code, Revenue Procedure 80-4 and Proposed Notice 2003-70, applicable state and local labor, employment tax and Medicaid program rules, as required.

Personal Options make available Information and Assistance (I&A) services through the resource consultants to common law employers to support their use of self-directed services and to perform effectively as the common law employer of their personal attendant staff. I&A provided by the *Personal Options* FMS include:

- Common law employer orientation sessions once the member chooses to use self-directed services and enrolls with the *Personal Options* FMS.
- Skills training to assist common law employers to effectively use self-directed services and the FMS and perform the required tasks of an employer of record of personal attendant staff.
- Common law employer orientation provides information on:
    - The roles, responsibilities of, and potential liabilities for each of the interested parties related to the delivery and receipt of self-directed services (i.e., common law employer, FMS, *Personal Options*, UMC, case manager, BMS),
    - How to use FMS *Personal Options*,
    - How to effectively perform as a common law employer of their personal attendant staff,
    - How to ensure that the common law employer is meeting Medicaid and *Personal Options* FMS requirements, and,
    - How a member would stop using self-directed services and begin to receive traditional services, if they so desire.

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

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

- Providing or linking common law employers with program materials in a format that they can use and understand.
- Providing and assisting with the completion of enrollment packets for common law employers.
- Providing and assisting the common law employer with employment packets.
- Presenting the common law employer with the *Personal Options* FMS role regarding payment for services.

- Assisting common law employers by determining budget expenditures (hiring).
- Assisting with the development of an individualized spending plan based upon the annual budget.
- Making available to the member/program representative a process for voicing complaints/grievances pertaining to the *Personal Options* FMS' performance.
- Providing additional oversight to the common law employer as requested or needed.
- Monitoring and reporting information about the utilization of the self-directed budget to the member, program representative, case manager, and the BMS; and
- Explaining all costs/fees associated with self-directing to the member.

Regarding the provision of self-directed services, the F/EA is responsible for:

- Distributing the *Personal Options* FMS satisfaction survey to members and receiving and analyzing the survey results and reporting them to the BMS annually.

Regarding the provision of self-directed services, the UMC is responsible for:

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

Program Representative

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

Involuntary Transfers

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

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

Reasons for Involuntary Transfer of Service Delivery Model may include:

- Non-compliance with the Self-Direction program requirements.
- Non-compliance with TBIW program requirements.

- Demonstrated inability to supervise their employee(s).
- Demonstrated inability to complete and keep track of employee paperwork.
- Inability to hire an employee (within 90 days of enrollment and/or maintaining an employee)
- The program representative left, and member does not have another choice for replacement.

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

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

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

- Non-compliance with the Self-direction program requirements.
- Non-compliance with TBIW program requirements; and
- Demonstrated inability to supervise their employee(s).

Involuntary Transfers due to the members' inability to maintain staff would require a 12-month wait before being able to transfer back to self-direction.

Involuntary Transfers due to the allegation of the member committing Medicaid fraud would require a 12-month wait before being able to transfer back to self-direction unless determined unsubstantiated by the Medicaid Fraud Unit.

512.29 PERSON-CENTERED ASSESSMENT

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

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

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

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

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

512.30 PERSON-CENTERED SERVICE PLAN DEVELOPMENT

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

- A Person-Centered Plan with individually identified goals and preferences.
- Will assist the member in achieving personally defined outcomes in the most integrated community setting.
- Ensure delivery of services in a manner that reflects personal preferences and choices.
- Contribute to the assurance of health and welfare.
- Risk Assessment and Mitigation Planning.
- 24-hour emergency backup planning.
- Required person-centered discovery tools to find out what is important to the member.
- Additional person-centered discovery tools are available and may be used in addition to the required tools to assist in Person-Centered Service Plan development.

Risk Assessment and Mitigation Planning

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

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

24-Hour Emergency Backup Planning

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

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

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

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

The case manager must send the members' Service Plan, assessment, and Request for Service Authorization form (which identifies the member's budget) to the UMC within seven business days of the Service Plan meeting. The UMC will review the request for service authorization and when approved, will provide the Prior Authorization Notice and approved final Budget to the case management agency, personal attendant agency or the F/EA (if applicable). It is the case management agency's responsibility to send a copy of the Service Plan, Person-Centered Assessment and the approved final budget to the member within seven business days of receipt of approval from the UMC. The case management agency must have the original documents in the member's file.
The Person-Centered Service Plan must contain reference to any other service(s) received by the member, regardless of the source of payment. A TBIW provider agency that provides private-pay services to a member must ensure that documentation is maintained separately.

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

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

Service Plan Disagreement

Resolution of Person-Centered Service Plan disagreements occur within the Person-Centered Service Planning meeting. The case manager must document the disagreement on the Person-Centered Service Plan and the resolution when the member disagrees with the Person-Centered Service Plan. When there is a disagreement with the Person-Centered Service Plan, the member is to continue to receive services throughout the resolution process. A resolution to a disagreement must not override any TBIW policy or other Medicaid policy. The member can follow the agency's grievance process. The member will receive

services listed on the Person-Centered Service Plan that is being disagreed with throughout the grievance process.

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

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

Participation in the six-month Person-Centered Service Plan and Annual Person-Centered Service Plan development is mandatory for the member, the case manager, and the personal attendant provider agency. The member may choose to have whomever else they wish to participate in the process such as personal attendant, family members, other service providers, informal supports, resource consultant (if applicable) etc. The personal attendant staff providing services can bill one hour for attendance at the members' Service Plan meetings using the personal attendant service code.

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

Copies of the six-month review are sent to the member and their legal representative by the case manager. The case manager is responsible for uploading the six-month review documents to the UMC Web portal within seven business days of the meeting.

Service Plan Addendum

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

Responsibility Agreement

A Responsibility Agreement is between the TBIW program member and the provider agency. The agreement must address the specific actions/outcomes that are expected by the member for their services to continue. Some examples of when a Responsibility Agreement should be developed can include the following: the noted pattern of members' non-compliance with program policies such as non-attendance for required Service Planning meetings, refusal to allow the case manager to conduct

required home visits in member's residence, not permitting personal attendant staff to perform services or asking personal attendant staff to perform services not outlined in the member's Service Plan. Safety concerns in the members' home should be addressed promptly when first displayed or noticed and addressed in a Responsibility Agreement. The Agreement must be written on the BMS-approved TBIW Responsibility Agreement template. An Addendum should also be used if a Responsibility Agreement needs to be implemented and/or EAA, PERS, Pest eradication or other covered service changes. The addendum should discuss the reasons that lead to the need for the Responsibility Agreement and/or need for additional services.

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

512.30.2 Interim Person-Centered Service Plan Development

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

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

512.31 Budget Development

A member's budget is developed once their Person-Centered Service Plan is completed. A member utilizing the TBIW program would have access to an annual maximum budget of $47,250.00 for members using the Traditional Service Delivery Model and $39,550.00 for those using the Self-Directed Service Delivery Model. Not everyone will receive the maximum budget amount. An individual budget is based on the frequency of program covered services as outlined in the Person-Centered Service Plan. If the covered services of EAA, PERS and Pest eradication are not utilized by the member, the dollar amount for those covered services cannot be rolled over to use toward personal attendant services or non-medical transportation.

Case managers must submit the budget template with the service planning documents. Case management services are outside of the maximum annual budget available to the member. The UMC will pro-rate a member's budget when necessary to align with the member's Anchor Date.

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

The maximum amount of a member's self-directed budget is the equivalent monetary value of approved covered services as outlined in the member's Person-Centered Service Plan. Once all the equivalent monies are transferred into the member's self-directed budget, the member, along with their *Personal*

Options resource consultant, create a spending plan. The member chooses the types of services, the number of services, and the wages of the members' employees within the parameters of the entire participant-directed budget.

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

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

512.32 ACTIVATION OF PERSONAL ATTENDANT SERVICES

Once the Person-Centered Service Plan is developed, the agency providing personal attendant services will begin providing those services within 30 calendar days from the Service Plan development, using the Personal Attendant Worksheet to document all services provided. If the current agency providing personal attendant services is unable to meet this timeline, they must notify the UMC of any delays in staffing and an emergency transfer request must be made unless the member has informal supports in place to safely wait for provider's staffing.

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

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

512.33 COVERED SERVICES

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

- Case management services
- Personal attendant services
- Non-medical transportation services
- PERS
- EAA home and/or vehicle
- Pest eradication

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

512.34 CASE MANAGEMENT SERVICES

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

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

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

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

512.34.1 Case Management Responsibilities

The case manager is responsible for follow-up with the members to ensure that services are being provided as described in the Person-Centered Service Plan, ensure quality of services and to identify any potential issues. Initial contact, via telephone or face-to-face, must be made within seven calendar days after personal attendant services have begun by the personal attendant provider agency. At a minimum, a monthly phone contact and a quarterly face-to-face home visit are required with the member. If the member cannot be reached by phone, then the case manager must attempt to reach the individual(s) listed on the members 24-hour emergency backup plan within one business day. In addition, the case manager will contact the personal attendant provider agency (if the Traditional Model is used) to see if there has been any disruption of services. If contact is not made within 48 hours with the member or contact person, a face-to-face home visit is required. If there is no answer at the member's home, then a well person/welfare/wellness check must be requested of the local

police by the case manager. If the member is not found in the home by the police, then the case manager must enter a critical incident in the WV IMS. All telephone contact must be documented on the Case Management Monthly Contact Form. At a minimum, the case manager must complete a six-month Service Assessment and Service Plan. This must be a face-to-face home visit with the members.

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

- Assuring financial eligibility remains current.
- Assuring the health and welfare of the members.
- Addressing a member's changing needs as reported by the member, personal attendant, or informal support.
- Addressing changing needs determined by monthly contact with the member.
- Referring to and procuring any additional services the member may need that are not services the personal attendant provider agency can provide.
- Coordinating with all current service providers to develop the six-month Service Plan and the Annual Service Plan (or more often as necessary). It is mandatory that the member, the case manager, and the personal attendant provider agency be present at the initial and six-month Service Plan meeting and the Annual Service Plan meeting.
- Providing the Service Plan to all applicable service providers that are providing services to the member within seven business days.
- Providing the HCBS Settings Rule brochure to the member and explaining the contents upon initial enrollment.
- Annually conducting the Member-Controlled Settings Rule Assessment.
- Uploading all required documents into the UMC web portal such as the Service Plans (initial and annual), Member-Controlled Settings Rule Assessment, prior authorizations, budgets, assessments, court-appointed legal guardian information, the Medical Power of Attorney (MPOA) and any other pertinent information.
- Evaluating social, environmental, service, risks and support needs of the member:
    - In collaboration with the member, develop and write a Person-Centered Service Plan which details all services that are to be provided including both formal and informal (if available), services that will assist the member to achieve optimum function.
- Coordinating the delivery of care, eliminating fragmentation of services, and assured appropriate use of resources.
- Proactively identifying problems and coordinating services that provide appropriate high-quality care to meet the individualized and often complex needs of the member.
- Providing advocacy on behalf of the member to ensure continuity of services, system flexibility, integrated services, proper utilization of services and resources, and accessibility to services.
- Ensuring that a member's wishes and preferences are reflected in the development of a Person-Centered Service Plan by working directly with the member and all service providers.
- Informing and assisting member of their rights, including information about grievance and Fair Hearing processes.
- Informing the member about their choices of service delivery models.
- Assuring that a member's legal and human rights are protected.
- Monitoring the members' risk management, safety and welfare and notifying the UMC of concerns.
- Ensuring a seamless transition between Traditional and *Personal Options* service delivery models.

- Reporting suspicion of A/N/E or exploitation to APS or CPS as applicable, case managers are mandatory reporters.
- Discussing whether a legal/non-legal representative is desired and/or needed by a member and informing the UMC and the *Personal Options* resource consultant (if applicable) of any changes in legal/non-legal representatives on the next business day that the case manager became aware of such a change.
- Providing or linking members with program materials in a format they can use and understand.
- Explaining person-centered planning and philosophy to members.
- Explaining to members the roles and supports that will be available through each service delivery model.
- Reviewing and discussing the members' budget, which is determined by individual needs documented in the member's Service Plan and authorized by the UMC.
- Ensuring that member knows how and when to notify the case manager about any operational or support concerns or questions.
- Notifying the UMC and the resource consultant (if applicable) of concerns regarding potential issues which could lead to a member's disenrollment.
- Following up with the member regarding additional services or support based on the submission of a critical incident.
- Notifying the Take Me Home Transition program's transition coordinators when members are re-institutionalized, die or have additional pre-transition service needs and the member continues to have available funds.

512.34.2 Case Manager Qualifications

A case manager must be fully licensed in West Virginia as a social worker, counselor, or registered nurse (RN), or have a four-year degree in an approved Human Services field.

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

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

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

Provisionally and temporarily licensed social workers must successfully complete and pass the BMS Case Management Certification training prior to billing for TBIW services. A provisional and temporary license does not qualify as being fully licensed.

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

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

512.34.3 Case Manager Initial and Annual Training Requirements

Initial:

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

Licensed professionals must maintain their professional licensure training requirements.

Annual:

- Recognizing and reporting abuse, neglect and exploitation training. Staff have the option to test out with 70% competency. If unsuccessful, entire training must be completed.
- HIPAA training. Staff have the option to test out with 70% competency. If unsuccessful, entire training must be completed.
- Training related to a person-centered planning approach.
- Training related to TBI.
- Recognizing Medicaid fraud and how to report.

Licensed professionals must maintain their professional licensure training requirements.

512.35 PERSONAL ATTENDANT AGENCIES RESPONSIBILITIES

The personal attendant agencies are responsible for acting on an agency assignment by either accepting or rejecting the assignment within two business days of notice by the UMC.

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

- Already at max capacity.
- Inappropriate referral.
- Temporarily unable to take on new members.

- Unable to meet member needs.
- Withdrawn by member request.
- Other provider explanation.

Qualified personal attendant staff must be working with the members within 30 calendar days from the completion of the Person-Centered Service Plan.

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

The personal attendant agency will send a designated staff person to the members' annual six-month Person-Centered Service Plan meetings. This person must be responsible for the personal attendant hiring and training.

If the member wishes their personal attendant to attend Service Plan meetings, the personal attendant can bill up to two hours under the personal attendant Service Code S5125 UB**.**

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

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

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

512.35.1 Personal Attendant Services

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

More than one personal attendant agency can provide personal attendant services to a member receiving services on the TBIW. Before a second personal attendant agency is contacted to provide services, the personal attendant agency must contact the UMC to explain why a second agency is necessary. The UMC must approve the second personal attendant agency before the process continues. The agency the members selected on their Freedom of Choice Personal Attendant form is the primary agency and is responsible for coordinating services. The Service Plan must indicate which agency is the primary agency. There cannot be a duplication of services.

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

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

Service Unit: 15 minutes
Ratio: 1:1
Site of Service: This service may be provided in the home of the member who receives services and/or the local public community. This service may not be provided in a personal attendant's home. This would exclude members who live with a family member/friend that is the paid personal attendant.
Service Limits: Personal attendant services are limited by the members' budget.
Prior Authorization: All units of service must be prior authorized before being provided.

Documentation Requirements: All services provided to a member must be legibly documented, member-specific and errors in documentation cannot be completely covered but must be indicated with a line through the error and noted/initialed by the person making the correction on the Personal Attendant Worksheet and maintained within the member's record. The use of the EVV documentation does not replace the required Personal Attendant Worksheet.

512.35.2 Personal Attendant Qualifications

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

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

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

CNAs and LPNs serving in the capacity of a personal attendant cannot provide any skilled nursing care or any formal assessments.

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

A TBIW member receiving TBIW services cannot be a paid personal attendant/direct-care worker through another HCBS program.

512.35.3 Personal Attendant Responsibilities

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

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

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

- Bathing
- Grooming
- Dressing
- Eating/meal preparation
- Toileting
- Transferring
- Mobility
- Prompt for self-administration of medications

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

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

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

Activities include the following types of IADLs for essential errands:

- Shopping for groceries and cleaning supplies or food pantries.
- Picking up prescriptions or over-the-counter medications at the pharmacy.
- Local payment of bills (utility bill(s), phone bill, etc.).
- Banking transactions such as deposits and withdrawals.
- Post Office to send/receive mail.
- Assistance with the West Virginia DoHS for benefits or financial eligibility.
- Laundromat.

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

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

The personal attendant may bill for the following:

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

Community Activities

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

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

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

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

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

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

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

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

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

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

- Care or change of sterile dressings.
- Colostomy irrigation.
- Gastric lavage or gavage.
- Care of tracheostomy tube.
- Suctioning.
- Vaginal irrigation.
- Give injections, including insulin.
- Perform catheterizations, apply external (condom type) catheter.
- Tube feedings of any kind.
- Make judgments or give advice on medical or nursing questions.
- Application of heat or cold.
- Nail trimming if the person is diabetic.
- Administer any medications, prescribed or over the counter. This would include placing medication in the member's mouth (Administration of a prescribed EpiPen would be allowed with training).

- Fill a member's daily/weekly/monthly pill container.

Personal attendant services cannot be billed when a TBIW member is staying out of state, i.e. vacation or visiting family.

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

512.35.4 Personal Attendant Initial and Annual Training Requirements

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

- CPR Training – Provided only by certified trainers of UMC-approved courses. (Refer to the BMS website for current list of approved CPR vendors). Additional CPR courses may be approved by the UMC. CPR must include an in-person demonstration. Documentation that each trainee successfully completed the course and is certified must be maintained by the agency and made available upon demand. If training is conducted by agency staff, documentation that each trainer has successfully completed and been certified by the certified entity must be maintained by the agency and made available upon demand. Documentation of proof of CPR certification for personal attendants must be the card issued by the certifying body.
- First Aid Training – Provided only by certified trainers of UMC-approved courses. Documentation that each trainee successfully completed the course and is certified by the agency. If training is conducted by agency staff, documentation that each trainer has successfully completed and been certified by the certified entity must be maintained by the agency and made available upon demand. Online First Aid courses are allowed, but it must be a UMC-approved course. An agency RN's education and skill set are sufficient to provide the First Aid Training.
- Universal Precautions Training – Must use the most current training material.
- Personal Attendant Skills – Training focused on assisting individuals with TBI with ADLs/IADLs must be provided by an RN, social worker/counselor, a documented specialist in this content area or an approved internet training provider.
- If applicable, one-hour training specific to children/adolescents with TBI.
- A/N/E Identification Training – Must be provided by an RN, social worker/counselor, a documented specialist in this content area, or an approved internet training provider.
- HIPAA Training – Must include agency staff responsibilities regarding securing protected health information. Training must be provided by an RN, social worker/counselor, a documented specialist in this content area, or an approved internet training provider.
- Personal Attendant Ethics Training – Ethics training such as promoting physical and emotional well-being, respect, integrity, responsibility, justice, fairness, equity and Medicaid fraud, waste and abuse. Training must include developing and maintaining working relationships and boundaries with the member (i.e. cannot take member to their own home and bill hours, discouraging after-work hours interaction to maintain a professional relationship. These trainings

must be provided by an RN, social worker/counselor, a documented specialist in this content area, or an approved internet training provider.
- Member Health and Welfare Training – Must include emergency plan response, fall prevention, home safety, seizure response and risk management must be provided by an RN, social worker/counselor, a documented specialist in this content area or an approved internet training provider.
- Member Rights and Responsibilities Training – Must include a review of the section of the West Virginia TBIW Member Handbook and other relevant provider specific policies and must be provided by a social worker/counselor/RN.
- Delivering Person-Centered Care Training (can use the training developed by the UMC) – Must be provided by a social worker/counselor/RN, a documented specialist in this content area, or an approved internet training provider.
- Personal Attendant Safety Training (how to keep safe in the workplace) – Must be provided by an RN, social worker/counselor, a documented specialist in this content area or an approved internet training provider.
- Training regarding proper documentation, correction requirements and forms.
- Settings Rule training and Member/Provider Controlled Assessment training. Staff can take the training found on the BMS LMS or the provider agency can develop competency-based training and test of their own (80% competency required).

Personal attendants are not required to have training in the administration of Narcan; however it is encouraged.

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

If a member uses a bed and/or door alarm, the personal attendant must have documented training on what needs to take place if the alarm has been activated.

Annual Training Requirements:

CPR, First Aid, universal precautions, member abuse, neglect, exploitation identification, Medicaid fraud, waste and abuse and how to report, and HIPAA trainings must be kept current.

- CPR is current as defined by the terms of the approved certifying agency (i.e., American Red Cross, American Heart Association. A list of approved agencies can be found on the TBIW website). CPR must include an in-person demonstration.
- First Aid is current as defined by the terms of the approved certifying agency (i.e., American Red Cross, American Heart Association. A list of approved agencies can be found on the BMS website.). Training provided by the agency RN (but not under a certifying agency such as American Red Cross), must be renewed within 12 months or less.
- Training will be considered current as defined by the time period on the card.
- Universal precautions training, abuse, neglect and exploitation (staff have the option to test out with 70% competency. If unsuccessful, entire training must be completed). Medicaid Fraud; waste and abuse and how to report, and HIPAA (staff have the option to test out with 70% competency. If unsuccessful, entire training must be completed). Training must be renewed every 12 months or less. Training will be determined current in the month it initially occurred.

In addition, two hours of training focused on enhancing personal attendant service delivery knowledge, skills and additional person-centeredness must be provided annually. Member-specific on-the-job training can be counted toward this requirement. It is recommended that the same training not be repeated from year to year. It is suggested that providers evaluate and identify trends at their agencies when identifying potential training topics. Internet training courses can be found on the BMS website if the agency chooses to use those, or they can provide their own training(s) for the two hours. The additional two-hour training(s) is not required to have competency-based testing. The training(s) can be listed on the training log or a certificate to show the training was completed.

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

If a personal attendant leaves an agency to work for another agency, the provider agency hiring the personal attendant has the option to accept the certifications from the past TBIW agency if it is still current. Failure to meet training requirements for staff may result in disallowances. Certification cards for CPR and First Aid belong to the individual that took the course, not the agency. These cards should be made available to the employee.

512.36 NON-MEDICAL TRANSPORTATION SERVICES

Non-medical transportation provides reimbursement for personal attendants that perform essential errands for or with a member receiving TBIW services or community activities with a member. Non-medical transportation must be utilized for the member's needs and cannot be for the benefit of the personal attendant, member's family or member's friends. Family, neighbors, friends, or community agencies that can provide this service, without charge, must be utilized first. To gain access to incidental services and activities as specified in the Service Plan, the member may be transported by the personal attendant. Mileage can be charged for essential errands and community activities related to the Service Plan. Essential errands should be completed before mileage is used for community activities to ensure the members' needs are met.

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

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

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

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

Non-medical transportation services may be provided within 30 miles of the West Virginia border only to members residing in another state county border.

Traditional Model Procedure Code: A0160 UB
***Personal Options* Model Procedure Code:** A0160 U2
Service Unit: 1 unit = 1 mile
Service Limit: 3600 units annually
Prior Authorization: All units of service must be prior authorized before being provided.

Documentation Requirements: All transportation with, or on behalf of, the member must be included in the Service Plan and include the date, miles driven, travel time, destination, purpose of travel and type of travel (essential errand or community activity). The Service Plan must document the purpose of the travel and the destination. The personal attendant must document on the Personal Attendant Worksheet accurate miles traveled, exact location of the beginning and ending destination and reason for the travel.

512.36.1 Non-Medical Transportation Services Qualifications

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

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

512.37 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

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

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

PERS Vendor Qualification

The PERS provider must provide an emergency response center with fully trained operators who can receive signals for help from a member's PERS equipment 24 hours a day, 365, or 366 days per year as appropriate, of determining whether an emergency exists, and of notifying an emergency response organization or an emergency responder that the PERS service member needs emergency help.
Traditional Model Procedure Code: S5161 U5
Personal Options Model Procedure Code: S5161 U5 UK
Service Unit: 1 unit = 1 month
Service Limit: 12 Months
Prior Authorization: All units of service must be prior authorized before being provided.

Documentation Requirements: The TBIW personal attendant provider will choose a PERS vendor(s) to provide the service for the members that they are servicing who desire or need the service. The service provision will be documented in the Service Plan by the case manager. In the case where a member transfers to another personal attendant agency, they will be required to use the PERS vendor of the

agency they are transferring to. The personal attendant agency will need to work together to determine a transfer date of the service so PERS billing will not conflict with each other.

PERS cannot be used for TBIW members under the age of 13.

512.38 ENVIRONMENTAL ACCESSIBILITY ADAPTATION

EAA-Home are physical adaptations to the private residence of the member who receives services or the family in which the member resides and receives services which maximize physical accessibility to the home and within the home. EAA-Home must be documented in the Service Plan by the case manager. Additionally, these adaptations enable the member who receive services to function with greater independence in the home.
EAA-Vehicle are physical adaptations to the vehicle including paying for accessibility adaptations if the member who receives services has the capacity to drive or needs regular transportation from a family member. EAA-Vehicle must be documented in the members Service Plan by the case manager. The purpose of this service is to maximize accessibility to the vehicle only.

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

Traditional Model Procedure Code: Home-S5165 U2 Vehicle-T2039 U2
Personal Options Model Procedure Code: Home- S5165 U3 Vehicle-T2039 U3
Service Unit: $1.00
Service Limit: $1,000 total per Service Plan year
Prior Authorization: All units of service must be prior authorized before being provided.

Documentation Requirements: The case management agency or personal attendant agency must submit the West Virginia TBIW EAA Home/Vehicle form and additional required supporting documentation. Additional required documentation is a contractor's [vendor's] business license when applicable.

EAA - Home

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

- Cleaning
- Painting

- Repair/replacement of roof
- Windows (unless a modified window is needed that is large enough for an adult/child to use to exit in case of fire)
- Flooring
- Structural repairs
- Air purifiers, humidifiers or air conditioners (unless the person has a documented respiratory/allergy condition or diagnosis)
- Heating equipment or furnaces
- Generators unless used for specific medical equipment (cannot be for the entire house)
- Plumbing and electrical maintenance
- Fences, gates or half-doors
- Security systems
- Adaptations that add to the square footage of the home except when necessary to complete an approved adaptation, (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair)
- Computers, communication devices, tablets, and other technologies
- Landline telephones or cell phones
- Swimming pools, hot tubs or spas or any accessories, repairs or supplies for these items
- Railing for decks or porches (railing for a ramp is permitted)
- Appliances that are not adapted/modified
- Yard work
- Household cleaning supplies
- Utility payments
- Household furnishings such as comforters, linens, drapes, etc.
- Furniture unless it is a lift chair for someone with documented* mobility issues
- Outdoor recreational equipment unless specifically adapted for the member's needs
- Driveway or walkway repairs or supplies unless specifically to exit or enter home to and from vehicle
- Covered awnings
- Adaptations made to rental residences must be portable.
- $1,000 available per Service Plan year in combination with Traditional and Self-Directed EEA.

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

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

*For Lift Chair EAA applications the member must first meet the requirements to apply for a lift chair, and the information must be attached to the application. Refer to the instructions found on the BMS website.

Limits:

If additional funding is needed, the member will be responsible for determining an additional funding source and arranging payment for the balance.

If for some reason the balance cannot be obtained, the payment will need to be returned to the BMS.

If there is a change in the estimate submitted resulting in an overpayment, the overpayment amount will need to be returned to the BMS and not spent on another item.

EAA - Vehicle

- The amount of service is limited by the individualized budget of the member who receives services.
- $1,000 available per Service Plan year in combination with Traditional and Self-Directed EEA.
- This service may not be used for adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the member who receives services.
- This service may not be used to purchase or lease a vehicle.
- This service may not be used for regularly scheduled upkeep, maintenance, or repairs of a vehicle except for upkeep and maintenance of the modifications.
- This service may not be used for running boards, insurance, or gas money.
- Car seats, unless specifically adapted/modified for the member are not covered.

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

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

EAA is not used for the purchase of durable medical equipment (DME).

512.39 PEST ERADICATION

Procedure Code Traditional: S5121 U2
Procedure Code *Personal Options*: S5121 U3
Service Unit: $1.00
Service Limit: $1,700 per Service Plan Year
Prior Authorization Required: All units of service must be prior authorized before being provided.
Service Definition: Pest eradication services are services that suppress or eradicate pest infestation that, if not treated, would prevent the member from remaining in the community due to a risk of health and safety. Pest eradication services are intended to aid in maintaining an environment free of insects, rodents and other potential disease carriers to enhance safety, sanitation and cleanliness of the member's residence. This service can be made available on an ongoing basis to prevent reinfestation only when reinfestation is likely to occur, and the case manager determines the reinfestation would negatively impact on the member's health and safety. The case manager must consult the pest control provider to determine the likelihood of reinfestation. Documentation must include the amount, duration,

and scope of services as determined by the case manager (based on the vendor's recommendation). The justification for ongoing services must be documented in the Person-Centered Service Plan.

Pest eradication services are only permissible for members residing in their own home (they own or are renting a free-standing single dwelling unit). The service cannot be made available as a preference of the member to remove something on a property that has no impact on the member living there. Case managers are responsible for ensuring that no other resource is available to have this service done. Case managers must ensure that local health departments or other available resources cannot provide this service. Case managers must also determine if landlords are required to provide this service to make the rental property habitable. This can be done by reviewing the lease to determine the landlord's responsibility. Case managers will contact landlords to convey the importance of maintaining and treating adjourning properties once the member's property is treated for pests. This is to ensure that pests do not return to the member's residence.

Limits: Pest eradication services may not be used solely as a preventative measure; there must be documentation of a need for the service either through case manager direct observation or member reports that a pest is causing or is expected to cause harm that would prevent a member from safely remaining in the community. Case managers must provide the affected member with educational materials or locate appropriate training on pests to aid in keeping a treated residence pest free in the future. When pest eradication is needed, case managers must also review the affected member's Person-Centered Service Plan to assess infestation risks and develop a Risk Mitigation Plan (using a Service Plan Addendum).

Case managers must have reasonable assurance that the member plans to live on the property for the foreseeable future if a pest control service is provided. This needs to be documented in the Addendum. The case managers will also determine from the member if they have any health conditions that need to be considered by the pest control provider. Such health conditions need to be considered in determining the method of pest control used to not adversely affect the health of the member.

Documentation: The case management agency must submit a service plan addendum documenting the amount, duration, and scope of pest eradication service. The Service Plan Addendum must also document that all the listed requirements are met. The case management or personal attendant agency must submit a copy of (or verify) a contractor's/vendor's business license. A vendor's business license can be verified at the Secretary of State's website.

Qualifications: If an individual will be contracted out (for hire) to make pesticide applications, the business that the individual works for will be required to be licensed with the West Virginia Department of Agriculture as a Licensed Pesticide Application Business and any employees making pesticide applications for the business will be required to become licensed with West Virginia state agency as a commercial applicator or as a registered technician (one licensed to make pesticide applications under the supervision of a Commercial Applicator).

Pesticide vendors must comply with Title 61 Legislative Rule West Virginia Department of Agriculture Series 12 A Certified Pesticide Applicator Rules, Series 12 B Licensing of Pesticide Businesses and Chapter 19 Agriculture Article 16A West Virginia Pesticide Control Act. Case management agency and/or personal attendant agency can verify qualifications. These two agencies may work together to determine a qualified vendor to provide the service.

Case managers are not expected to go into a member's home for home visits, service planning and assessments when infestations have been identified. A phone meeting must be conducted to complete an Addendum to the members' Service Plan to develop a plan to address the infestation. The addendum outlining the plan must be submitted to the UMC for approval. The addendum would need to reflect changes in the personal attendant services provided and shared with the personal attendant agency. Services the personal attendant could continue to provide would be essential errands for groceries and/or pharmacy. The plan should also include any informal support that could assist the member until the infestation is eliminated. The case management and personal attendant services cannot be altered indefinitely. The goal is to return all services to the member prior to the infestation. If the member does not follow the plan for pest eradication, a request for discontinuation of services may be made.

TAKE ME HOME (TMH) TRANSITION SERVICES

Transition services support individuals transitioning from long-term care facilities to the community who often face obstacles including lack of basic household items (i.e., furniture, bedding, etc.), limited community support and no one to help develop comprehensive plans to transition home. The TMH Transition program staff, nursing facility staff and other individuals identified by the member to participate in the process to help address many of these barriers by providing a variety of services and support to program members to promote a successful and safe transition to the community. Transition services and other waiver, as well as non-waiver services and support, are incorporated into a transition plan, and approved by the transition manager. The TMH Transition program applicants are not subject to the same MEL requirements which require a TBIW slot to be available.

The TMH Transition program staff work in teams consisting of a transition coordinator, housing specialist and a community liaison specialist. The teams, located in five areas around the state, work together to support their participants to transition safely and successfully to the community. The TMH Transition program staff work one-on-one with members and their transition teams to:

- Accept and follow up with referrals.
- Conduct intake interviews to share information about options for returning to the community, including the availability of waiver transition services.
- Assess residents' transition support needs, including risk factors that may jeopardize a safe and successful transition to the community.
- Assess and verify residents' readiness to begin transition assessment and planning.
- Facilitate the development of a transition team consisting of the resident, the transition coordinator, the waiver case manager, the facility social worker and other appropriate staff, and anyone else the resident chooses to include in the transition process.
- Work with the TMH participant and their transition team to develop a written transition plan which incorporates specific services and supports to meet identified transition needs.
- Conduct a Risk Analysis and develop a written Risk Mitigation Plan to address and monitor all identified risks that may jeopardize the TMH participant's successful transition.
- Arrange and facilitate the procurement and delivery of needed transition services and supports, including waiver transition services prior to transition.
- Participate in all required training including the State Transition Plan training.
- Reviews residential settings to ensure it is following the Residential Settings Rule.

TMH Transition Services

There are two services available to assist individuals in transitioning back to the community:

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

512.40 PRE-TRANSITION CASE MANAGEMENT

Procedure Code: T1016 U2
Service Unit: 15 minutes
Service Limit: 24 units
Prior Authorization Required: Yes
Service Definition: The purpose of the pre-transition case management service is to ensure that waiver services are in place on the first day of the members' transition to the community. Prior to the member's transition from the facility, pre-transition case managers will:

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

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

Limits: Individuals eligible to receive this service:

- Live in a nursing facility, hospital, Institution for Mental Disease (IMD), or a combination of any of the three for at least 60 consecutive days; and
- Have been determined medically and financially eligible for the TBIW program; and
- Wish to transition from facility-based living to their own homes or apartments in the community consistent with the CMS Settings Rule (1915(I)); and
- Have a home or apartment in the community to return to upon leaving the facility that is consistent with the CMS Settings Rule (1915(I); and

- Require waiver transition services to safely and successfully transition to community living; and
- Can reasonably be expected to transition safely to the community within 180 days of the initial date of transition service.

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

Pre-transition case management qualifications are the same as case manager qualifications.

512.41 Community Transition Services

Procedure Code: T2028 U2
Service Unit: $1.00
Service Limit: $4,000 units
Prior Authorization Required: Yes
Service Definition: The community transition service is the primary waiver service available to support qualifying applicants with a safe and successful transition from facility-based living to the community. Community transition services are one-time expenses necessary to support applicants wishing to transition from a nursing facility, hospital or IMD to their own home or apartment in the community. Allowable expenses are those necessary to address barriers to a safe and successful transition identified through a comprehensive Transition Needs Assessment and included in an approved individualized Transition Plan. Community transition services are furnished only to the extent that they are reasonable and necessary as determined through the Service Plan development process, clearly identified in the service plan and the applicant is unable to meet such expense or when the services cannot be obtained from other services. Community Transition Services do not include monthly rental or mortgage expenses; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes. The components of the community transition service include:

- Home Accessibility Adaptation Modification - Assistance to applicants requiring physical adaptations to a qualified residence. This service covers basic modifications such as ramps, widening of doorways, purchase and installation of grab-bars and bathroom modifications needed to ensure health, welfare and safety and/or to improve independence.
- Home Furnishings and Essential Household Items - Assistance to applicants requiring basic household furnishings to help them transition back into the community. This service is intended to help with the initial set-up of a qualifying residence.
- Moving Expenses - Includes rental of a moving van/truck or the use of a moving or delivery service to move an applicant's goods to a qualified residence. Although this service is intended as a one-time set-up service to help establish a qualified residence, under certain circumstances it may be used throughout the transition period to relocate a member.
- Security Deposit - Used to cover rental security deposit.
- Utility Deposits - Used to assist applicants with required utility deposits for a qualifying residence.
- Transition Support - Services necessary for the member's health and safety such as pest eradication and one-time cleaning prior to occupancy. All transition services must be reasonable

and necessary, not available to the member through other means, and clearly specified in the waiver member's Service Plan.

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

Limits to Community Transition Services: The total expenditure on services cannot exceed $4,000 per transition period. Community transition services cannot be used to cover the following items. Please note that this is not intended to be an all-inclusive list of exclusions:

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

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

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

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

512.42 PRIOR AUTHORIZATIONS

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

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

512.43 BILLING PROCEDURES

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

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

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

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

512.44 PAYMENTS AND PAYMENT LIMITATIONS

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

No TBIW services may be charged while a member is inpatient in a nursing home, hospital, rehabilitation facility, or other inpatient medical facility, except for personal attendant services on the day of admission and day of discharge.

For active TBIW members, 30 days prior to discharge from one of these programs, case management services may be billed to plan the member's discharge to ensure services are in place.

This section refers to non-TMH Transition program members.

512.45 SERVICE LIMITATIONS, SERVICE EXCLUSIONS AND RESTRICTIONS

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

TBIW services are made available with the following limitations:

- All members must live in West Virginia and be available for required services.
- All TBIW regulations and policies must be followed in the provision of the services. This includes the requirement that all TBIW providers obtain a business license in the State of West Virginia, be certified by the UMC and enroll in the West Virginia Medicaid program.
- The services provided must match the goals and objectives of the member's Person-Centered Service Plan.
- Members' budgets and limitations described in this manual must be followed.
- No duplication of services assisting the member with ADLs or ancillary tasks that are being provided by another program such as, but not limited to, Medicare, Medicaid, Veterans Administration, Worker's Compensation, some private long-term care insurances, or private pay.
- TBIW members cannot be a paid care giver in another waiver program or the Personal Care Services program for another program member or family member.
- Any setting where the provider of HCBS also owns and operates an individual's residential service is considered provider-controlled and therefore not in alliance with the CMS HCBS Settings Rule unless the provider operating the residential setting can produce a signed agreement indicating that the member can maintain their freedom of choice regarding personal attendant services.
- TBIW services cannot be provided in the following settings, an adult family care, a group home or assisted living facility.
- TBIW service hours not provided that are listed on the Personal Attendant Worksheet can be made up on a different day within the same two-week period on the Personal Attendant Worksheet but cannot be carried over into a new month. This applies to both Traditional and Self-directed service models. Permanent or long-term changes in the services/service hours listed on the Personal Attendant Worksheet must be made through an Addendum to the Service Plan by the case manager for both Traditional and *Personal Options* models.

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

Restrictive Intervention

The TBIW prohibits intentional restrictive interventions of a member's movement or behavior. Restrictive interventions that are prohibited include but are not limited to: physical restraints such as ropes, handcuffs, bungee cords, phone cords, electrical cords, zip ties, tape of any kinds, gags, locking in a room, blocking an emergency fire exit, physical four-point restraint and other extreme forms of restraint. Physical Interventions may be utilized when a member is physically aggressive in an unsafe environment.

Door alarms and Global Positioning System (GPS) trackers used by families for members who wander off would not be considered a restraint, however, must be reflected on the member's Service Plan.

Emergency Safety Intervention

The BMS allows limited interventions when the member may be confused or agitated in relation to one or more of the following diagnoses:

- Dementia
- Alzheimer's Disease

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

When a member experiences confusion, agitation, wandering or behavior that may create an emergency risk to the member's safety, emergency safety interventions covered may include alarms for doors, GPS identification or monitoring devices, PERS and other methods of locating or warning of emergency safety incidents and bed rails. The case manager must document in the Assessment and the Service Plan the rationale for the use of an emergency safety intervention. The UMC monitoring staff will review the use of emergency safety interventions during the provider onsite review.

Emergency safety interventions are not to be used for the convenience of the caregiver. When a safety intervention that has been listed in a member's Service Plan is utilized (i.e. door alarm) an incident must be reported in the WV IMS.

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

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

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

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

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

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

PC services must not duplicate activities/services in another service/program and are not for respite, monitoring/supervision, or companion care. PC activities that will be performed outside the daily routine must have a rationale on the Personal Care RN Assessment explaining the need for the personal care activity at that time of day. Example: A second bath in the evening for a member who is incontinent. Members enrolled in TBIW who wish to request additional services through the PC Services program and who meet the TBIW/PC Dual requirements may apply for PC as indicated below:

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

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

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

512.47 PROVISION OF TBIW AND HOME HEALTH AGENCY SERVICES

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

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

512.48 VOLUNTARY AGENCY CLOSURE

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

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

The agency terminating participation must ensure that the transfer of the member is accomplished as safely, orderly and expeditiously as possible. Agency services must continue to be provided until all transfers are completed. It is the agency's responsibility to maintain and/or destroy all agency records according to the BMS common chapters.

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

512.49 INVOLUNTARY AGENCY CLOSURE

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

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

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

512.50 ADDITIONAL SANCTIONS

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

Failure to meet policy requirements will prompt the BMS to issue a letter notifying the provider of the specific areas of non-compliance. A Plan of Correction will be requested from the provider to address each area of non-compliance. The provider will have 15 days to develop a provisional Plan of Correction and submit it to the BMS. If the Plan of Correction has not been implemented by the provider, the BMS may begin the process of progressive remediation. For each step of progressive remediation, a non-compliance notification letter will be issued by the BMS to the provider. However, the BMS can escalate the remediation process (per provider/per case) to any step of the overall process.

Progressive remediation steps:

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

512.51 MEMBER RIGHTS AND RESPONSIBILITIES

Case management agencies must confirm receipt of the TBIW Program Member Handbook from the UMC and review the contents with each member initially and annually thereafter. The discussion will include the following:

Their rights to:

- Transfer to a different provider agency, from Traditional services to Self-Direction through *Personal Options*, or from Self-Direction through *Personal Options* to Traditional services.

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

And their responsibility to:

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

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

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

512.52 GRIEVANCE PROCESS

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

A member may bypass the level one grievance and file a level two grievance with the UMC if they choose. The grievance process is not utilized to address decisions regarding medical or financial eligibility, a reduction in services or case closure. These issues must be addressed through the Medicaid Fair Hearing process.

The grievance procedure consists of two levels:

Level One, TBIW provider:

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

Level Two, UMC:

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

512.53 MEDICAL ELIGIBILITY APPEALS

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

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

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

If the Request for Hearing form is not submitted to the Board of Review within 13 days of the date of the Notice of Decision letter, reimbursement for all TBIW services will cease. TBIW services will cease at close of business on the 13th day after the date of the Notice of Decision letter if the member/legal guardian does not submit a Request for Hearing form.

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

If the denial of medical eligibility is upheld by the hearing officer, services that were continued during the appeal process must cease on the date of the hearing decision. If the member/applicant is eligible financially for Medicaid services without the TBIW program, other services may be available for the individual. If the termination based on medical eligibility is reversed by the hearing officer, the members' services will continue with no interruption.

The Medicaid Fair Hearing process is limited to hearings involving the following:

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

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

If the member is still determined to not be medically eligible, the UMC will notify the LTC Unit of the findings.

Due to the nature of Unsafe Environment closures a member would not be eligible for the option to continue existing services during the fair hearing process.

512.54 TRANSFERS TO ANOTHER AGENCY OR SELF-DIRECTION THROUGH *PERSONAL OPTIONS*

A member utilizing the TBIW program may request a transfer to another provider agency or *Personal Options* at any time. If a member wishes to transfer to a different provider agency, a Request to Transfer form must be completed and signed by the member and/or their legal representative (if applicable). The form may be obtained from the current provider agency, the new provider agency, or the UMC. Once

completed and signed by the member, the form must be submitted to the UMC. The UMC will then coordinate the transfer and set an effective date based on when required transfer documents are received. The effective date of transfers will be 30 days from receipt of a correct and completed Request to Transfer form by the UMC. For case management transfers, the effective date of transfer will be the first day of the next month if the transfer is received by the 17th of the month.

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

Transferring agency responsibilities:

- To continue to provide case management/personal attendant services until the effective date of transfer documented on the Notice of TBIW Transfer form.
- If it is a case management agency transfer, the receiving case manager will have access to the member's eligibility assessment and other pertinent documentation in the UMC web portal prior to the date of transfer.
- If it is a personal attendant service agency transfer, the receiving personal attendant agency will have access to the member's eligibility assessment and other pertinent documentation in the UMC web portal.
- To maintain all original documents for monitoring purposes.

Receiving agency responsibilities:

- Personal attendant service agencies must meet with the members within seven business days to review the Service Plan.
- If it is a case management agency transfer, a Service Plan Addendum must be conducted within seven business days of the transfer effective date.
- Provide copies of the Service Plan addendum to the member, personal attendant agency, resource consultant (if applicable) and to the UMC within seven business days.

The Service Plan for the transferring case management and/or personal attendant service agency must continue to be implemented, with any changes reflected in the Service Plan Addendum held because of the transfer. A provider may not request a transfer for an unsafe environment or member non-compliance. If there is an unsafe environment or member noncompliant issue, the provider must follow the process outlined in the Section 512.56, Discontinuation of Services.

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

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

Transfers that occur because of Conflict-Free Case Management situations are granted 90 days to ensure a smooth transition. The BMS cannot permit waiver members to remain in conflict based on choice. If the member does not qualify for geographic, or cultural/linguistic exceptions and/or refuses to make a selection that removes the existing conflict of providers, BMS will make the selection for the

member and the UMC will assist in the transfer to resolve the conflict. If the member disagrees with the BMS agency selection, then the member will be given the opportunity to file a grievance of complaint.

512.55 EMERGENCY TRANSFERS TO ANOTHER AGENCY OR *PERSONAL OPTIONS*

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

512.56 DISCONTINUATION OF SERVICES

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

- No personal attendant services have been provided for 180 continuous days, for example, an extended placement in a long-term, rehabilitation facility or incarceration.
- Unsafe Environment. Members must be able to provide a safe working environment for TBIW case manager and personal attendant staff and/or other agency staff including, but not limited to, (this includes the member and/or persons in the member's home):
    - Yelling, verbal abuse, or cussing the personal attendant.
    - Touching the personal attendant inappropriately or talking about touching the personal attendant inappropriately.
    - Home is full of debris and clutter, and the member prevents the personal attendant from cleaning the area as described in member's Service Plan.
    - Animals that are dangerous to or that could harm the personal attendant or any TBIW staff are unconfined during service hours and visits.
    - People in member's home during service time who pose a problem to the personal attendant staff doing services, including anyone with a history of harassing, touching or threatening the personal attendant staff.
    - Members or others in or around the member's home threaten the personal attendant.
    - Members or others in or around the member's home participating in any criminal activity or allowing it to occur in the member's home during personal attendant service time.
    - The agency has been forewarned by a mental health professional/law enforcement of harm or ideations of harm by the member.
    - The member or other household members repeatedly demonstrate sexually inappropriate behavior; display verbally and/or physically abusive behavior; and/or threaten a personal attendant or other agency staff with guns, knives, or other potentially dangerous weapons, including menacing animals.
    - The member or other household members display an abusive use of alcohol and/or drugs or engages in the manufacture, buying and/or selling of illegal substances.
- The member is non-compliant with the Service Plan, the responsibility agreement (if applicable), the program requirements by policy, the TBIW Member Handbook, or the member rights and responsibilities, etc.
- Member no longer desires services.

- Member no longer require services.
- Member care needs can no longer be sufficiently met, and they can no longer be safely maintained in their home and community with TBIW services.
- The member requires more than 1:1 personal attendant service
- Member requires 24-hour care

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

If a member has had a closure due to an unsafe environment and reapplies for the TBIW program or other HBCS (such as the PC Services program or other waivers), the unsafe environment closure information will be shared with the providers.

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

The Request for Discontinuation of Services form and supporting documentation must be submitted to the UMC. Documentation to support the unsafe environment should come from multiple sources, if possible, i.e., the personal attendant agency, case management agency and F/EA if applicable.

The UMC will review all submitted documentation for a discontinuation of services then submit the request to the BMS for review and decision. If the BMS approves the discontinuation, the UMC will send notification of discontinuation services to the member with a copy to the case management agency, personal attendant agency and/or F/EA.

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

Requests for Discontinuation of Services for Unsafe Environments fall into one of two categories:

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

It is the case management agency's responsibility to conduct the 30-, 60- and 90-day assessments to ensure the health and safety of the member during any time that services are suspended. The personal attendant agency can allow the personal attendant to continue to provide essential errands during the suspension. (i.e. groceries/pharmacy)

The following do not require a Request for Discontinuation of Services form.

- Death
- Moved out of state

- Medically ineligible
- Financially ineligible

512.57 HOW TO OBTAIN INFORMATION

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

GLOSSARY

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

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

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

Activities of Daily Living (ADL): Activities that a person ordinarily performs during the ordinary course of a day, such as mobility, personal hygiene, bathing, dressing, eating, and skills required for community living.

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

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

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

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

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

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

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

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

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

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

Cueing: Giving a signal or reminder to do something.

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

Days: Calendar days unless otherwise specified.

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

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

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

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

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

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

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

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

Environmental Accessibility Adaptations – Home: Physical adaptations to the private residence of the member who receives services or the family in which the member resides and receives services which maximize physical accessibility to the home and within the home.

Environmental Accessibility Adaptations - Vehicle: Physical adaptations to the vehicle including paying for accessibility adaptations. The purpose of this service is to maximize accessibility to the vehicle.

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

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

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

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

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

Home and Community-Based Services (HCBS) Settings Rule: In January 2014, the federal CMS issued a new federal rule (CMS-2249-F/CMS-2296-F) impacting sections of Medicaid law under which states may use federal funds to pay for HCBS. The rule supports enhanced quality in HCBS programs and adds protections for individuals receiving services. In addition, this rule reflects the CMS intent to ensure that individuals receiving services and support through Medicaid's HCBS programs have full

access to the benefits of community living and can receive services in the most integrated setting. An adult family care setting would not be an approved setting.

Home and Community-Based Services (HCBS): Services which enable individuals to remain in the community setting rather than being admitted to a long-term care facility.

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

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

Incidental Services: Secondary activities performed by the personal attendant such as light housecleaning, making, and changing the bed, dishwashing, and laundry for the sole benefit of the person receiving TBIW services.
Informal Supports/Informal's: Family, friends, neighbors, or anyone who provides a service to a person and not reimbursed.

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

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

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

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

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

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

Minor Child: A child under the age of 18.

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

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

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

Person Centered Discovery Tools: Tools used by the case manager to give structure to conversations with program members. It is a way to capture information that directs the Service Plan Development as well as improving understanding, communication, and relationships.

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

Personal Attendant: The individual who provides day-to-day care to people on the TBIW including both Traditional and *Personal Options*/*Self-Direction* models.

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

Personal Emergency Response System (PERS): A small device that is used to request help from a 24-hour monitoring center in the event of an emergency. Monitoring can alert emergency medical services to help the individual.

Physician's Assistant: An individual who meets the credentials described in West Virginia Code Annotated, §30-3-13 and §30-3-5. A graduate of an approved program of instruction in primary health care or surgery who has attained a baccalaureate or master's degree, has passed the national certification exam, and is qualified to perform direct patient care services under the supervision of a physician.

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

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

Program Representative: An individual selected by a person receiving TBIW services using the *Personal Options/Self-direction* Model, to assist them with the responsibilities of self-direction.

Qualified Residence: Take Me Home (TMH) Transition Program defines as a person's own home, a person's family's home, and/or a person's own apartment.

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

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

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

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

Room and Board: (Bureau for Social Services' Specialized Family Care Program Policy definition 8/26/2015) Room and Board Services are defined as the provision of food and shelter including private and common living space; linen, bedding, **laundering** and laundry supplies; **housekeeping duties** and common lavatory supplies (i.e., Hand soap, towels, toilet paper); maintenance and operation of home and grounds, including all utility costs.

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

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

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

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

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

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

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

Transition Coordinator: An individual with the TMH Transition program's services who works one-on-one with eligible participants and their transition teams to plan and facilitate the transition process.

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

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

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

CHANGE LOG

SECTION NUMBER	CHANGE	EFFECTIVE DATE
Entire Chapter	Traumatic Brain Injury Waiver (TBIW)	October 1, 2015
Entire Chapter	Updated Sections on Take Me Home; Overview; Pre-Transition Case Management; and Community Transition	January 1, 2019
	Take Me Home (TMH) Transition Program - Name change from Take Me Home West Virginia 512.2 Added Conflict-Free Case Management Added service provision, settings rule, member rights to records, agency policies, and requirement to notify guardians of critical incidents.	April 1, 2021

	512.2.4 Added WVCARES website. 512.2.5 Added restrictions on subcontracting services and BMS not being responsible for certification of agencies that provide Veterans services. 512.2.6.4 Name change of reviews 512.3 Added Electronic Visit Verification (EVV) requirement 512.4 Added a description 512.5 Added requirement for NPI numbers for service providers/workers 512.5.1 Added BA Human Service Degree to Case Management qualifications 512.5.2 Added Case Management Certification Training requirements 512.5.4 and 512.5.5 Added training requirements for personal attendants 512.5.6 Added detail for CPR and First Aid qualifications 512.10.1 Added continuous oxygen 512.11 Added timelines for enrollment and hiring staff 512.14 Added details regarding Risk Analysis and Mitigation; 24hr. backup plan; and Responsibility Agreements 512.10 Added Personal Emergency Response System (PERS) units 512.17 Added service limitations and notifications to Take Me Home Transition Coordinators. 512.18 Added detail regarding personal attendant services and responsibilities; service code and unit limit 512.19 Added to billing practices 512.25 Added TBIW members cannot be paid workers for other programs; settings information; Restrictive Intervention and Emergency Intervention information 512.28 Additional requirements added 512.30 Added progressive remediation 512.31 Added requirement to provide safe working environment 512.36 Added information regarding member not being served safely in the community and member not accepting case management services 512.21.2 Addition/change to services	
Entire Chapter	512.1 New Section-HCBS Settings Requirements 512.3 Added Exceptions Application, Attestation, policy/procedure to report Medicaid Fraud and documentation training 512.4 Clarified case manager not required to use EVV 512.6 Removed 8 contiguous counties/notice, cannot become a TBIW Provider for the benefit of serving other programs	Aug. 1, 2023

	512.7 Clarified “calendar” days 51.14 Added Documentation, length to keep employee documentation, what must be uploaded into the web portal 512.16.1 Added Human Service degree with BMS Certification 512.16.2 Added Trainings-Medicaid Fraud, Settings Rule, documentation 512.16.3 Added CAN training, member on a HCBS program cannot be paid caregiver for a HCBS program 512.16.4 Allowing online CPR, Medicaid Fraud. Clarified who can provide trainings 512.16.5 Medicaid Fraud, CPR must have demo, Person Centeredness 512.16.6 Removed time on logs, Use of certificates as proof of training 512.17 Added requirement of policy/procedure, suspected sexual abuse, assault/abuse language 512.17.1 E-files, Agency responsible for adding/deleting staff in IMS within timelines 512.17.2 Expanded Abuse/Neglect/Exploitation details 512.18 New section added Medicaid Fraud and Reporting Requirements 512.19 Employee File retention, PAs living in member home not required to have NPI# 512.22 Process changed 512.23.2.1 Uploading documentation in the web portal 512.23.2.3 View Documents in the web portal 512.25.1 Added Environmental Accessibility Adaptions (EAA) Home and vehicle 512.25.2 Clarified CMs required, added PERS and EAA, timeline to hire Pas, enrollment home visit 512.26 Changed “calendar days to “business” day 512.27 Added Discovery tools, changed “calendar” day to “business” day, list school environment, TMH Assessment and Service Plan development timeline changed 512.27.1 Using an Addendum 512.28 resource consultants will upload Spending Plans into the web portal for members who self-direct their services 512.29 Changed from 5 days to 15 days 512.30 Added EAA 512.31 Change in required contacts 512.31.1 HCBS Settings Rule info to members 512.32 Number of days to have staff working 512.32.1 Documentation Training	

	512.32.2 Add to functions personal attendants cannot perform 512.34 Added definition of service 512.35 New covered service added 512.36 Removed Interim Service Plans 512.39 Added other BMS Chapter numbers 512.41 Added statement about door alarms and GPS trackers, statement about Targeted Case Management 512.42 Removed the annual MNER and use of new form 512.47 Choice of case management agency must meet CFCM criteria 512.50 Removed limits to transfer, access to records, transfer require an addendum to the Service Plan rather than a full new Service Plan development 512.52 Conflict-Free Case Management statement, added/reworded items in list Glossary - Added definition for Medicaid Fraud	
Entire Chapter	512.3 Added allowing an agency to be in an emergency site for 30 days. If there any longer the site must meet office criteria and be certified. 512.25 Modified DSH-2 process and enrollment 512.31 Increase maximum available TBIW budget 512.35.3 Added LPNs as Pas 512.39 Added pest eradication	February 1, 2025