CHAPTER 501 AGED AND DISABLED WAIVER (ADW)

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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 program. This program, therefore, must also function within federally defined parameters. Any service, procedure, item, or situation not discussed in the BMS Provider Manual must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their certification utilizing professionally accepted best practices of care, and in accordance with all state and federal requirements. Enrolled providers are subject to review of services provided to people enrolled in Medicaid by the BMS whether the services require prior authorization or not. All providers of services must maintain current, accurate, legible, and completed documentation, including electronic documentation with electronic signatures and timestamps, 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 Aged and Disabled Waiver (ADW) program provided to eligible West Virginia Medicaid members. The policies and procedures set forth herein are promulgated as regulations governing the provision of ADW services by approved and enrolled ADW providers in the Medicaid program. Requirements and details for other West Virginia Medicaid services can be found in other chapters of the BMS Provider Manual.

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

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

PROGRAM DESCRIPTION

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

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

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

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

ADW services include:

- Case management
- Personal attendant services
- Skilled nursing
- Non-medical transportation services
- Personal Emergency Response System (PERS)
- Environmental Accessibility Adaptations (EAA)
  - Home
  - Vehicle
- Medical adult day care
- Pest eradication

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

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

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

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

501.1 HOME AND COMMUNITY BASED SETTINGS REQUIREMENTS

In January 2014, the Centers for Medicare & Medicaid Services promulgated a final federal rule (2014 Home and Community Based Services Final Rule CMS-2249-F and CMS 2296-F) to ensure that members receiving long-term services and supports through 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 members not receiving Medicaid HCBS.

The case manager must complete mandatory training on the West Virginia Medicaid HCBS Statewide Settings Transition Plan (STP) prior to completing the member-controlled assessments. The case manager training is available on the WV Learning Management System. Personal attendant staff must also receive mandatory training on the STP. 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 develop the competency-based training test and ensure the paid caregiver passes with 80% competency. Members will receive educational information on STP from their case manager in the form of the brochure and documented via a signed brochure.

Member-Controlled Settings

Member-controlled settings are defined as home or apartments owned or leased by a HCBS member or by one of their family members. The following services may be provided in a member-controlled setting: Personal attendant services (traditional or self-directed), case management, non-medical transportation (traditional or self-directed model), Skilled Nursing Annual Assessment, skilled nursing, Personal Emergency Response Unit (traditional or self-directed), community transition, and pest eradication (traditional or self-directed model).

The member's case manager must assess the setting initially and annually, up to 90 calendar days prior to the member's anchor date, to ascertain 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 as 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 services.
- The setting is selected by the member.
- 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 member choice regarding services and support, and who provides them.

If the setting does not meet the above-listed standards, 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 on the West Virginia STP webpage.

Provider-Owned/Controlled Settings

Provider-owned/controlled settings include: (1) a member residing in a home of a paid unrelated caregiver; (2) a member residing in a home that is owned or managed by a provider agency; and (3) an

adult medical day care facility. The following services may be provided in a provider-owned/controlled setting: Personal attendant services (traditional or self-directed model), case management, non-medical transportation (traditional or self-directed model), skilled nursing annual assessment, skilled nursing, skilled nursing, Personal Emergency Response Unit (traditional or self-directed), community transition, medical day care, and pest eradication (traditional or self-directed model).

All provider-owned/controlled settings shall be evaluated at least annually by the BMS, or its designee, the utilization management contractor (UMC) once identified by the case management agency. The case management agency is responsible for identifying provider-owned/controlled settings and determining when a provider-owned/ controlled setting assessment is required initially and annually. When an assessment is needed, the case management agency shall submit a request to the BMS or its designee, the UMC. Assessments must be requested no later than 90 calendar days prior to the annual anchor date, which occurs during the annual PAS assessment. The purpose of the assessment is to determine that the setting meets the standards as described below:

- The setting was selected by the members.
- The member participates in unscheduled and scheduled community activities in the same manner as individuals not receiving Medicaid HCBS.
- Members have opportunities to seek employment and work in competitively integrated settings and engage in community life.
- The member has their own bedroom or shares a room with an individual 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 support 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 member, 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, 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 member preferences.
- Staff communicate with members in a dignified manner.
- The members can have visitors of their choosing at any time.
- The member's home has an entrance door that is lockable by the member, with only appropriate staff having keys to doors.

Any provider-owned/controlled setting that does not meet these standards, the BMS and/or the appropriate UMC will alert the ADW Provider that remediation is needed.

The provider-owned/controlled setting assessment may be found under the Resource tab of the webpage. Adult medical day care settings will be surveyed for settings rule by the OA. Adult medical day care settings are required to notify the OA prior to making any changes to the setting. The OA will review changes to ensure they meet the HCBS settings requirements and provide technical assistance as needed to remediate any identified issues.

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

Transition of Members Overview

When a case manager or the BMS designee discovers a setting that no longer meets the standards of the Settings Rule, the provider will develop a remediation plan within 30 calendar days of this discovery. The provider will have 30 additional calendar days to complete the remediation plan, and the case manager will have an additional time period to include these changes in the service plan.

The BMS will review any remediation plans on a case-by-case basis to determine if further action is needed to ensure compliance.

501.2 BUREAU FOR MEDICAL SERVICES CONTRACTUAL RELATIONSHIPS

The BMS contracts with an OA. The OA acts as an agent of the BMS and administers the operation of the ADW program, both Traditional and *Personal Options* Models. The OA conducts education for ADW providers, members receiving ADW services, advocacy groups, and others as requested. The OA also certifies the provider agencies prior to them enrolling as a Medicaid provider.

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

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

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

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

501.3 PROVIDER AGENCY CERTIFICATION

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

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

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

Conflicts of Interest

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

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

Conflict-Free Case Management

Applicants/members are not permitted to select agencies that would place them in a conflicted relationship. In some cases, a conflicted relationship may be required due to no other case management agency being available within a 25-mile radius of the member’s home or due to other cultural/linguistic reasons. A Conflict-of-Interest Exception form is available for the member to apply for an exception (see process under enrollment section).

Safeguards

For providers granted an exception to the conflict-free requirements, the State has ensured conflict-of-

interest protections, certifying that case managers employed by that provider remain neutral during the development of the Person-Centered Service Plan (PCSP) and including the requirement that the provider separate direct-care services and case management into distinct functions, with separate oversight.

- Case management agencies must have an internal policy, that includes the following, 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 personal attendant supervisor(s) and the case management supervisor(s) describing how the agency maintains administrative separation of the two.
  - Explain how members are assigned as a case manager.
  - Explain how members are given a choice of personal attendant 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 organizational chart that includes position titles and names of staff.
- Attestation/Conflict-of-Interest Exception application for home and community-based waiver services by agency owner/administrator of the following:
  - The agency has administrative separation of supervision of case management and personal attendant services.
- An organization chart showing administrative separation of supervisors, one for case management and one for personal attendant, must be provided.
- Case management members are offered a choice for personal attendant services between and among available service providers.
- Case management members are not limited to personal attendant services provided only by this agency.
- Case management members are provided with a case manager within the agency selected.
- Disputes between case management and personal attendant agencies are resolved in a timely manner to eliminate disruption in member services.
- Members are free to choose or deny personal attendant services without influence from the case manager and personal attendant staff.
- Members choose how, when, and where to receive their approved personal attendant services.
- Members are free to communicate grievance(s) regarding case management and/or personal attendant 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 as indicated in Section 501.33, Grievance Process.

The BMS utilizes the following criteria to make determinations regarding geographical, cultural, linguistic exceptions:

- The number of conflict-free case managers could not meet the capacity for the number of members in the geographical area within a 25-mile radius to the member.
- The number of conflict-free case managers certified by waiver type could not meet the capacity to serve members by waiver type.

- Only one case management agency serves the geographical area within a 25-mile radius to the member, eliminating the member's opportunity for choice of case manager.
- There were no providers of case management services in a geographical area within a 25-mile radius to the member.

Members will be given the opportunity to submit a Conflict-of-Interest Exception form if there are any cultural, geographical, or linguistic exceptions. The case manager can assist the member in completing and submitting the request. Upon completion of the form, the case manager will submit the form to the OA for review. Once the OA reviews the form it will be submitted to the BMS program manager for a final decision. The OA approves applications for exceptions after thorough vetting, including requests for additional information, if needed. Exceptions are awarded for one year. During the exception period, the BMS or the appropriate UMC have the right to review agency policies and operations. If granted, the exception will be reviewed by the OA and the BMS annually thereafter to determine if the exception is still warranted.

Members will be given an opportunity to file a grievance/complaint if they disagree with the final decision. The OA oversees grievances/complaints by the members and providers. The BMS will monitor the conflict-free case management (CFCM) process via retro-reviews conducted by the state OA and may periodically request additional reports from the OA.

Becoming a Certified ADW Provider

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

- A business license issued by the State of West Virginia.
- A federal tax identification number (FEIN).
- A competency-based curriculum for required training areas for personal attendant staff.
- An organizational chart.
- A list of the Board of Directors (if applicable).
- A list of all agency staff, which includes their qualifications.
- A Quality Management Plan for the agency.
- Written policies and procedures for processing complaints and grievances, from staff or members that:
    - Addresses the process for submitting a complaint.
    - Provides steps for remediation of the complaint including who will be involved in the process.
    - Steps include the process for notifying the member of the findings and recommendations.
    - Provides steps for advancing the complaint if the member/staff does not feel the complaint has been resolved.
    - Ensures that a member or agency staff are not discharged, discriminated, or retaliated against in any way if they have been a complainant, on whose behalf a complaint has been submitted or who has participated in an investigation process that involves an ADW provider.
- Written policies and procedures for the use of personally and agency owned electronic devices which 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 use of secure Virtual Private Network (VPN) connection.
  - Informs agency employees that during an investigation, information on their personal cell phone is discoverable.
  - Requires all electronic devices to be encrypted.
- Written policies and procedures for people to transfer.
- Written policies and procedures for the discontinuation of a member's services.
- Written policies and procedures regarding the prohibition for personal attendants to subcontract their work responsibilities to another person.
- Written policies and procedures for contemporaneous documentation and reporting of incidents if/when a member presents an unsafe work environment for direct care workers.
- Written policies and procedures to ensure that members, staff, and family members are free from retaliation or adverse consequences because they reported incidents or allegations of Abuse/ Neglect/Exploitation (A/N/E) or other staff misconduct.
- Written policies and procedures to ensure that court-appointed guardians are informed of reported incidents as soon as possible after the agency learns of the incident and in all cases, within 72 hours of agency learning of an incident.
- Written policy and procedures outlining agency personal attendant staff actions when the member is not home/does not respond to calls and the personal attendant has arrived to provide scheduled services.
- Written policy and procedure outlining case manager's actions when the member is not responding to a home visit and/or call.
- Providers must comply with the Centers for Medicare and Medicaid Services (CMS) Settings Rule.
- Written policies regarding member's right to request their records.
- Written policies and procedures to avoid conflict of interest (if agency is providing both case management and personal attendant services) must include at a minimum:
  - Education of Case managers on general conflict of interest/professional ethics with verification.
  - Initially and annually signed Conflict of Interest Assurance form for all Case managers and the agency director.
  - Process for investigating reports on conflict-of-interest complaints.
  - Process for reporting to the BMS.
  - Process for complaints to professional licensing boards for ethics violations.
- Office space that allows for confidentiality of the member.
- An Agency Emergency Plan (for members receiving ADW services and office operations). This plan must include:
  - Office Emergency Backup Plan ensuring office staffing and facilities are in place during emergencies such as floods, fires, etc. However, the new temporary facilities must meet all requirements. The provider must notify the OA within 48 hours.
  - Providers must inform people receiving ADW services of their Emergency Backup Plan.
- The provider must accept referrals in the UMC's web portal within five business days or forfeit the referral.

- All providers are required to have and implement policies and procedures for people with limited English proficiency and/or accessible format needs that are culturally and linguistically appropriate, to ensure meaningful access to services.
- Computer(s) for staff with HIPAA secure email accounts, the UMC web portal software, internet access, and current (within the last five years) software for spreadsheets.
- Hire and retain a qualified workforce.
- Ensure that a member is not discharged unless a viable discharge/transfer plan is in place that effectively transfers all services that the member needs to another provider(s) and is agreed upon by the member and/or their legal representative and the receiving provider(s).
- Ensures that services are delivered, and documentation meets regulatory and professional standards before the claim is submitted.
- Participate in all BMS mandatory training sessions.
- Written policy and procedures for reporting Medicaid fraud to the BMS Office of Program Integrity (OPI) and the program manager)
- Written policy and procedures for documentation training for case managers and personal attendants, at the minimum, must include current program forms and proper documentation and processes for correction procedures.

Provider agencies will be reviewed by the OA within six calendar months of initially providing services and annually thereafter.

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

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

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

501.3.1 Criminal Background Checks

Refer *to* *Chapter 700 West Virginia Clearance for Access: Registry & Employment Screening* (WV CARES) and WV Cares for criminal background check information, forms, and program information. ADW

does not allow Provisional Employees as outlined in Chapter 700. The current length of time for Crime Identification Bureau (CIB) checks is every five years.

501.3.2 Office Criteria

ADW providers must designate and staff at least one physical office location within West Virginia. The office cannot be in or part of a private residence. A post office box or commercial mailbox will not suffice. Each designated office must meet the following criteria:

- Physically located in West Virginia.
- ADW providers wishing to make changes in the approved counties they serve may do so as needed but **must** make the request in writing before providing services in that county to the OA. The OA will review the request and inform the provider in writing. No changes in counties served can be made unless approved by the OA.
- Providers may discontinue serving a county at any time pending transfer of any current members being served, however, they can continue serving existing members only but not receive any more referrals if they choose to do so.
- Be readily identifiable to the public.
- Meet Americans with Disabilities Act (ADA) requirements for physical accessibility. (Refer to 28 CFR 36, as amended). These include but are not limited to:
    - Maintains an unobstructed pedestrian passage in the hallways, offices, lobbies, bathrooms, entrance and exits.
    - The entrance and exit have accessible handicapped curbs, sidewalks and/or ramps.
    - The restrooms have grab bars for convenience.
    - The telephone is accessible.
    - Drinking fountains and water are made available as needed.
- Maintain a primary telephone that is listed under the name and local address of the business. (Note: Exclusive use of a pager, answering service, a telephone line shared with another business/individual, facsimile machine, cell phone, or answering machine does not constitute a primary business telephone).
- Maintain an agency secure HIPAA compliant e-mail address for communication with others inside your agency, (unless communicating through a secure agency network), the BMS and the OA for all staff.
- At a minimum, must have an email address and access to a computer, fax, scanner, and internet.
- Utilize any database system, software, etc., compatible with/approved and/or mandated by the BMS.
- Be open to the public at least 40 hours per week. Observation of state, religious, and federal holidays is at the provider's discretion. Hours of operation must be clearly posted for the public to see.
- Agencies that provide electronic devices to their staff must ensure all personally identifiable information is secure.
- Contain space for securely maintaining program and personnel records. (Refer to *Chapter 100, General Information*, and *Chapter 300, Provider Participation Requirements*, for more information on maintenance of records). Provider agencies are responsible for ensuring records are safely secured in a location free from exposure to natural disasters and can be provided at any time they are requested. No waivers will be granted for damage to member files due to acts of nature.
- Maintain a 24-hour contact method.

- Change in agency location due to emergencies such as flood or fire for over 30 calendar days requires a site review by the OA.
- Any authentication method for electronic and stamped signatures must meet the following basic requirements:
  - Unique to the person
  - Capable of verification
  - Under the sole control of the person, and
  - Linked to the data in such a manner that if the data is changed, the signature is invalidated.
- Agencies applying to become an ADW provider cannot obtain certification via BMS for the sole purpose of serving Veteran Administration (VA) clients only. The BMS is not responsible for certifying VA agencies or their workers.

501.3.3 Quality Improvement System

The Quality Improvement System (QIS) is designed to:

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

501.3.3.1 Centers for Medicare and Medicaid Services Quality Assurances

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

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

501.3.3.2 Quality Improvement Advisory Council (QIA)

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

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

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

501.3.3.3 Initial/Continuing Certification of Provider Agencies

Following the receipt of a completed Certification Application, the OA will contact the applicant to provide technical assistance to ensure understanding of requirements. The OA will schedule an onsite review to verify that the potential provider meets the certification requirements outlined above. This requirement may be waived if the prospective provider is a current licensed behavioral health center (LBHC) or is enrolled as a Personal Care (PC) Services program, Traumatic Brain Injury Waiver (TBIW), or Intellectual/Developmental Disabilities Waiver (IDDW) provider at the time of application. The OA will ensure any requirements that may differ from program to program will be reviewed accordingly.

The OA will notify the BMS fiscal agent for claims, upon satisfactory completion of the onsite review or verification of LBHC, PC Services, TBIW, or IDDW status. The BMS fiscal agent will provide the applicant with an enrollment packet which includes the Provider Agreement. The applicant must return the Provider Agreement signed by an authorized representative, to the BMS fiscal agent. A letter informing the agency they may begin providing and billing ADW services will be sent to the agency, and the agency should forward that to the OA. Medicaid services cannot be provided from an office location that has not been certified by the OA prior to becoming an enrolled Medicaid provider.

When a provider is physically moving their agency to a new location or opens a satellite office, they must notify the OA 45 calendar days prior to the move. The OA will schedule an on-site or virtual review of the new location to verify the site meets certification requirements. The provider must submit a new Certification Application or complete the ADW Change Request form and submit it to the OA which includes information regarding the new location. Medicaid Services cannot be provided from an office location that has not been certified by the OA prior to becoming an enrolled Medicaid provider.
In addition, all providers of ADW 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, ADW providers must continue to meet the requirements listed in this chapter as well as the following:

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

501.3.3.4 Provider Quality Reviews

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

The OA performs annual on-site or remote reviews and desk documentation reviews as requested by the BMS to monitor program compliance. The OA also performs annual continuing certification reviews for agency and staff compliance. Targeted on-site ADW reviews and/or desk reviews may be conducted at the discretion of the BMS or its agents.

Quality Reviews

Quality reviews include a statewide representative sample of member records of those receiving ADW services along with the staff providing the services to those members. The OA will review program records using the BMS-approved Monitoring Tools. These tools are available on the ADW BMS Forms website. A proportionate random sample will also be implemented to ensure that at least two records from each provider site are reviewed.

Agencies are required to ensure staff possess required credentials and have completed all mandatory training initially and annually. If noncompliance is found for employees that were reviewed, the agency must complete and submit a self-audit to The OPI (refer to *Chapter 800, Program Integrity*) and a Corrective Action Plan (CAP), if required, to the OA within 30 calendar days. If the self-audit is not submitted to the OPI within 30 calendar days of the letter, a pay hold may be placed on the provider's claims until the self-audit is received. The OA will follow up on any CAPs within the next six months.

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

- Payment to the BMS, OPI, within 60 calendar days after the BMS notifies the provider of the over-payment, or

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

Additional information regarding repayment of disallowances can be found in *Chapter 800, Program Integrity*. Failure to provide written comments to the draft report will result in forfeiture of being able to request a document/desk review.

If the ADW provider disagrees with the final report, the ADW provider may request a document/desk review within 30 calendar days of receipt of the final report pursuant to the procedures in *Chapter 800, Program Integrity*, of the BMS Provider Manual. The ADW provider still must complete the written repayment agreement and enter a repayment arrangement within 30 calendar days of receipt of the Final Report. The request for a document/desk review must be in writing, signed and set forth in detail to the items in contention. Please note, the items of contention must have been noted on the draft report and addressed by the provider before requesting a document/desk review of the contended items. Requesting a document/desk review means that the provider and the OA could not reach an agreement on the contested items on the draft report, therefore a third party is asked to intervene. The letter must be addressed to:

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

Corrective Action Plan (CAP)

In addition to the draft report sent to the ADW providers, the OA will also send a draft CAP. The ADW providers are required to complete the CAP and submit it to the OA for approval within 30 calendar days of receipt of the draft report from the OA. The BMS may place a hold on claims if an approved CAP is not received by the OA within the specified time frame unless the provider requests and has been granted an extension. Requests for extensions must be made in writing to the OA detailing the reason for the request. The CAP must include:

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

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

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

501.3.3.5 Training and Technical Assistance

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

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

501.3.3.6 Self-Audit

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

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

ADW providers must use the approved format for submitting self-audits to the OPI. Failure to submit an assigned self-audit may result in the BMS withholding Medicaid payments until the self-audit is submitted. ADW providers are required to send completed Self Report and Standard Repayment Provision forms in an electronic format to the OPI. This information is not to be submitted to the program manager.

For information concerning other audit authorities relevant to services provided under this chapter or sanctions available to the BMS, please see *Chapter 800, Program Integrity*. Forms necessary to complete a self-audit can be found on the OPI webpage.

501.3.3.7 Record Requirements

Providers must fully complete all required ADW forms and follow published forms instructions. Forms with corrective fluid, tape or removable labels used on them will not be accepted. Documentation must be member-specific, legible, and errors in the 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 ADW website.

Providers must meet the following record requirements:

Program Records:

- The provider must keep a file on each member they serve.
- Files must contain all original and required documentation for services provided to the member by the provider responsible for development of the document including the Service Plan, PAS, the

complete Person-Centered Assessment, Contact Notes, Personal Attendant Log Worksheets, etc.

- Original documentation (which includes reproduced documentation, including scanned documentation, provided that the document is legible and capable of verification by the provider) on each member 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 is required to upload the following into the UMC web portal within 12 calendar days of completion:
    - PCSP.
    - Person-Centered Assessments.
    - Personal Attendant Log (PAL).
    - Service Plan Addendum.
    - EAA required documentation if applicable.
    - Residential Setting Rules required documentation.
    - Medical adult day care documentation if applicable.
    - Any legal documents pertaining to power of attorney, legal guardianship, conservatorship, etc.

Provider Personnel Records:

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

Certified ADW providers must agree to abide by all applicable federal and state laws, policy manuals, and other documents that govern the ADW program. Providers must also agree to make themselves, board members, their staff, and all records pertaining to services available for 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 safely maintained at the agency as required by state and federal regulations and is accessible for state and federal audits.

501.4 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 themself. 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 health care decisions. The ADW case manager must verify that a representative has the necessary authority and obtain copies of supporting documentation, e.g., court orders or power of attorney documents, for the member's file.

Legal representatives must always be consulted for decisions within their scope of authority. However, contact with or input from the legal representative should not replace contact and communication with the member. If the member can understand the situation and express a preference, the member should be kept informed, and 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 and sign the initial medical eligibility assessment,
- Attend and sign subsequent annual medical eligibility assessments,
- Sign the initial Medical Necessity Evaluation Request (MNER), and
- Attend the meetings to develop the Service Plan and sign the initial and annual Person-Centered Assessment.

Note: Adult Protective Services (APS), as the appointed guardian, is responsible for attending the meetings listed above. As the guardian they must approve and sign off on all decisions, except financial, relating to the protected person. Attending and participating in the scheduled meetings is a fiduciary obligation that ensures all services are in the client's best interest.

501.5 ELECTRONIC VISIT VERIFICATION

As required by the 21st Century Cures Act (Cures Act), the BMS has implemented an Electronic Visit Verification (EVV) system to verify home visits by personal attendant service providers. The EVV system verifies:

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

Services requiring EVV, such as personal attendant care, use the system to check-in at the beginning of the visit and after the visit. The member or authorized representative uses the system to verify the scheduled visit has been provided. The BMS has ensured the EVV solution is secure and does not constrain member selection of a caregiver or the manner of care delivery. Each agency will be responsible for ensuring that the appropriate staff are trained to use the agency's system. Personal attendants that live in the member's home will not be required to use EVV.

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

The personal attendant agency or case management agency staff may install the fixed object (FOB) device in the member's 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 to note the FOB was installed when applicable on the Monthly Contact form.

501.6 INCIDENT MANAGEMENT

ADW providers shall have policies and procedures for thoroughly reviewing, investigating, and tracking all incidents involving the risk or potential risk to the health and safety of the people they serve. Agencies should conduct trend analysis to assist in determining any implementation recommendations for any corrective actions.

All incidents must be reviewed by designated agency staff. Details must be objectively and factually documented during the review. The provider must ensure the health and safety of all involved (the members and/or the staff) during the review. In addition, all required entities must be notified as applicable (APS, Child Protective Services (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.

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

Anyone providing services to a member who suspects abuse, neglect, or exploitation must verbally report the incident to West Virginia Centralized Intake immediately by calling 1-800-352-6513, seven days a week, 24 hours a day. This initial referral must then be followed by a written report, submitted to the local West Virginia Department of Human Services (DoHS) in the county where the alleged victim resides, within 48 hours for APS and 24 hours for CPS following the verbal referral. An APS/CPS worker may be assigned to investigate the alleged abuse, neglect and/or exploitation. 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 health, 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 when appropriate. Any incident attributable to the failure of ADW provider staff to perform their responsibilities that compromise the health or safety of the member is considered to be neglected and must be reported to APS. Contact must be made with all provider agencies involved with the case. Any incidents the provider is made aware of that occurred during non-plan hours must also be reported. Incidents shall be classified by the provider as one of the following:

Critical Incidents

Critical incidents are occurrences with a high likelihood of producing real or potential harm to the health and welfare of the member or incidents which have caused harm or injury. It could also include any type of suspected criminal activity. These incidents may include, but are not limited to, the following:

- Attempted suicide, or suicidal threats or gestures.

- Suspected and/or observed criminal activity by the member, member's families, health care providers, concerned citizens, and public agencies that compromise the health or safety of the member.
- An unusual event such as a fall or injury of unknown origin requiring medical intervention or first aid.
- A significant interruption of a major utility, such as electricity or heat in the member's residence that compromises the health or safety of the member.
- Environmental/structural problems with the member's home, including inadequate sanitation or structural damage that compromises the health or safety of the member.
- Fire in the home resulting in relocation or property loss that compromises the health or safety of the member.
- Unsafe physical environment in which the personal attendant and/or other agency staff are threatened or abused, and the staff's welfare is in jeopardy.
- Disruption of the delivery of ADW services, due to involvement with law enforcement authorities by the member and/or others residing in the member's home, compromises the health or safety of the member.
- Medication errors by a member or their family caregiver that compromise the health or safety of the member, such as medication taken that was not prescribed or ordered for the member, and failure to follow directions for prescribed medication, including inappropriate dosages, missed doses, or doses administered at the wrong time.
- Disruption of planned services for any reason compromises the health or safety of the member, including failure of member's emergency backup plan.
- Any incident deemed to be restrictive in nature (i.e., restraint of any type).
- Any other incident judged to be significant and potentially have a serious negative impact on the member receiving ADW services.
- Any incident attributable to the failure of ADW provider staff to perform their responsibilities that compromises the member's health or safety is neglect and must be reported to APS.
- Death of a member.
- Any unplanned medical visit to an emergency room, health facility, or admission to a hospital.
- 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. (see functions/tasks that cannot be performed under Personal Attendant Responsibilities section)
- When a safety intervention that has been listed in a member's Service Plan has not been utilized (i.e. door alarm, if no one answers the door etc.) 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 or neglect. Examples of simple incidents include, but are not limited to, the following:

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

501.6.1 Reporting Requirements, Incident Management Documentation, and Investigation Procedures

Any incidents involving a member must be entered into the WV IMS within one business day of learning of the incident. The agency director or designated staff will immediately review each incident report. All critical incidents must be explored. All incidents involving A/N/E must be reported to APS but also must be noted in WV IMS.

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

If a death occurs, the worker of the provider agency who learned of the death first, this may be the case management agency or the personal attendant agency, must complete the report regarding the death in the IMS within one business day of learning of the death of a member.

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

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

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

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

The criteria utilized for a thorough review include, but is not limited to:

- The report was fully documented to include the date of the incident, date the agency learned of the incident, facts of the incident, type of incident, initial determination of the incident, and verification that an approved staff member conducted the review.
- All parties were interviewed, and incident facts were evaluated.
- Member was interviewed.

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

Agencies are responsible for adding new staff and removing staff within the WV IMS system who are no longer with the agency.

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

If a crisis occurs which results in a critical incident being substantiated, then a prevention plan will be created by the member and their case manager to support the Emergency Backup Plan and outline strategies that will ensure similar incidents do not occur in the future and that continuity of care is maintained for the member.

501.6.2 Incident Management Tracking and Reporting

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

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

501.6.3 Medicaid Fraud and Reporting Requirements

Providers are required to report all suspected fraud to the BMS. Providers must ensure that all staff are aware of the reporting requirements. 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 receive reimbursement for services never provided. Fraudulent activities include, but are not limited to, the following examples: falsifying documentation such as timesheets, certifications, medical records, submitting duplicative claims, or knowingly billing for medically unnecessary services. When a provider becomes aware of potentially fraudulent behavior, they must complete the fraud referral form available on the BMS website and submit the completed form to the OPI at DoHSBMSMedicaidOPI@wv.gov and to the ADW program manager.

501.7 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

General Requirements

- ADW program provider agencies must comply with the documentation and maintenance of records requirements described in *Chapter 100, General Information* and *Chapter 300, Provider Participation Requirements* of the BMS Provider Manual.
- ADW program provider agencies must comply with all documentation requirements listed in the ADW Manual.

- All required documentation must be safely and securely maintained by the ADW 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 member's file subject to review by authorized BMS personnel or contracted agents. In the event of a dispute concerning a service provided, documentation must be maintained until 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 safely and securely 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.
- 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.

Specific Requirements

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

- Each ADW provider who provides case management services is required to maintain all required ADW documentation for state and federal monitors.
- All ADW program forms as applicable to the policy requirement or service code requirement.
- Agencies may only use forms developed and published by the BMS (refer to *Chapter 300, Provider Participation Requirements*, for a description of general requirements for Medicaid record retention and documentation). .
- All providers of waiver services must maintain records to ensure the services were provided on the dates listed and were for the actual amount of time and number of units claimed.
- Day-to-day documentation for services by a provider agency is to be maintained by the provider agency that provides and bills for said service. Monitoring and review of services as related to the PCSP or monthly contact and quarterly face-to-face visit are to be maintained in the Case Management Provider Record.
- While monitoring the PCSP and services, the case manager may review or request specific day-to-day documentation. All documentation provided must meet the criteria for documentation as indicated in the policy manual such as date, actual time of service and number of units claimed.
- Required on-site documentation may be maintained in an electronic format if the documentation is accessible to individuals who may request it.
- Electronic health record and electronic signature requirements described in *Chapter 100, General Information* of the BMS Provider Manual.
- 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 other HCBS programs.

PROGRAM ELIGIBILITY AND ENROLLMENT

501.8 ADW PROGRAM ELIGIBILITY

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

- Be 18 years of age or older.
- Be a permanent resident of West Virginia. The individual may be discharged or transferred from a nursing home in any county of the state, or in another state, if their permanent residence is in West Virginia.
- 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.
- Be approved as medically eligible for nursing home level of care and in need of services.
- Choose to participate in the ADW program as an alternative to nursing home care.
- Members must be able to provide a safe working environment for ADW program staff and agency personal attendants, RNs, and case managers.

The applicant must first meet the financial eligibility requirements before a determination of the applicant's medical eligibility will be made. If an individual is medically and financially eligible, a slot must be available for them to participate in the program. If funded slots are not available, applicants determined financially and medically eligible for the Program will be placed on a Managed Enrollment List (MEL). As funded slots become available, applicants on the MEL will be notified and provided with detailed instructions on continuing the enrollment process. Placement on the MEL is determined by the date of the completed MNER. The BMS does not issue, or rank applicants' health care needs for emergency slots or to be placed higher on the MEL.

501.9 APPLICATION PROCESS

The ADW application process starts once an applicant applies to the ADW program by submitting the initial MNER form to the UMC.

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

501.10 FINANCIAL ELIGIBILITY

Once the applicant (includes Take Me Home (TMH), West Virginia 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.
- Applicant has 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 a PAS to determine medical eligibility.

Ineligible Applicants

An individual may be determined ineligible for various reasons:

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

If the applicant is over the income/asset guidelines, the West Virginia DoHS will send a letter to the applicant and notify them of the denial of financial eligibility along with informing them of their fair hearing rights. The referral will be closed by the UMC.

If the applicant did not complete and submit the paperwork within 60 calendar days and the white DHS-2 is not received, the OA will close the referral and notify the applicant the case has been closed. The letter will include the reason for the closure.

501.11 MEDICAL ELIGIBILITY

The UMC is the entity that is responsible for conducting original PAS assessments. The purpose of the medical eligibility review is to ensure the following:

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

501.11.1 Medical Criteria

An individual must have five deficits as described on the PAS to qualify medically for the ADW program. These deficits are derived from a combination of the following assessment elements on the PAS.

Section	Description of Deficits	
#24	Decubitus; Stage 3 or 4	
#25	In the event of an emergency, the individual is c) mentally unable or d) physically unable to vacate a building. a) Independently and b) With Supervision are not considered deficits	
#26	Functional abilities of individual in the home	
a.	Eating	Level 2 or higher (physical assistance for 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).

Section	Description of Deficits	
h.	Transfer	Level 3 or higher (one-person or two-person assistance in the home)
i.	Walking	Level 3 or higher (one-person or two-person assistance in the home)
j.	Wheeling	Level 3 or higher (must be Level 3 or 4 on walking in the home to use Level 3 or 4 for wheeling in the home. Do not count outside the home)
#27	Individual has skilled needs in one or more of these areas: (g) suctioning, (h) tracheostomy, (i) ventilator, (k) parenteral fluids, (l) sterile dressings, or (m) irrigations	
#28	Individual is not capable of administering their own medications	

501.11.1.2 Service Level Criteria

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

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

The total number of points possible is 44.

501.11.1.3 Service Level Range of Hours

Traditional Service Levels

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

The hours of service are determined by the service level and assessment results of the personal attendant agency RN assessment and F/EA Assessments (if applicable). Please note, the levels are a

range of hours and are to be used to meet everyone's daily needs. Maximum hours are not guaranteed if the need is not identified. If the minimum hours awarded are not being utilized, the reason must be documented in the Service Plan. If a member reports formal personal attendant services to assist with ADLs are not needed, a request for closure must be submitted.

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

501.11.1.4 Initial Medical Evaluation

Following is an outline of the initial medical evaluation process:

- An applicant shall initially apply for the ADW program by having their treating physician (Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), advanced practice registered nurse (APRN) or physician assistant (PA)) (referent) complete and sign a MNER form which includes International Classification of Diseases (ICD) diagnosis code(s). The referent, applicant, family member, advocate, or other interested party, may submit this form by fax, mail or electronically to the UMC. If information is missing from the MNER, the member will be notified that information is needed to further process the application. If additional information is not received, the case will be closed per UMC guidelines. TMH applicants/participants applying for the ADW program may have their nursing facility or hospital PAS (if it was conducted within a year) evaluated to determine medical eligibility thereby negating the need for an MNER.
- 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 contact person (if applicable) or legal representative. If no contact is made with the UMC within 10 business days, the referral will be closed. If the applicant chooses to have the evaluation after the referral is closed, a new referral may be required if the signature on the MNER is greater than 60 calendar days. The TMH Transition program applicants' transition coordinators will follow-up and will work closely with the UMC in cases where the UMC is unable to reach the applicant.
- If the MNER form indicates that the applicant has Alzheimer's, multi-infarct, senile dementia, or related condition; and/or if they have a guardian or legal representative, the assessment will not be scheduled without the guardian, contact person or legal representative present to assist the applicant.
- If the applicant is not financially eligible, the West Virginia DoHS office will notify the applicant of the denial of financial eligibility. The referral will be closed by the UMC. No letter will be sent by the UMC.
- The UMC RN 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.
- It is not the UMC's responsibility to extend invitations to any other participants and/or agency staff for this assessment. If the applicant wants others to attend, it is their responsibility to invite them.

501.11.1.5 Results of Initial Medical Evaluation

Approval

If the applicant is determined medically eligible and a slot is available, a notice of approved medical eligibility is sent to the applicant and/or legal representative/designated contact. The notice will be sent by mail to the applicant. If a TMH Transition program case, the TMH Transition program office will be notified. The UMC will email a white DHS-2 to the West Virginia DoHS.

The economic service worker will complete the white DHS2 and email it to the UMC. The applicant must be enrolled within 60 calendar days from the date the economic service worker signed the white DHS-2 form. The white DHS-2 form may not be accepted by the UMC if it is forwarded after the expiration date. If not enrolled, the applicant forfeits the slot and may need to reapply. The OA and the BMS will review all 60-calendar day closures to assess whether the enrollment delay was outside the applicant's control. If so, an extension may be granted. TMH applicants may also have some flexibility in the 60-day guidelines. Transition coordinators will monitor the need for an extension.

If the applicant is determined medically eligible and a slot is not available, a notice of approved medical eligibility will be sent to the applicant, legal representative/designated contact informing them a slot is not currently available, and they will be contacted when one becomes available. The applicant will be placed on the MEL. When a slot becomes available, the applicant, legal representative/designated contact will be sent a letter.

Denial

If it is determined that the applicant does not meet medical eligibility, the applicant, legal representative/ designated contact will be notified by a Potential Denial-Additional Information Needed letter. This letter will advise the applicant of the reason for the potential denial, listing the areas in which deficiencies were found. A copy of the PAS and ADW policy will also be included with the Potential Denial-Additional Information Needed letter. The applicant will be given 14 calendar days to submit supplemental medical information to the UMC. Information submitted after 14 calendar days will not be considered in the eligibility determination. However, it may be used during a pre-conference hearing or Medicaid Fair Hearing. Please note, a Potential Denial-Additional Information Needed letter is not a denial of service and a request for Fair Hearing should not be made at this time.

If the review of the supplemental information by the UMC determines the applicant is not medically eligible, the applicant, legal representative/designated contact will be notified by a Final Denial letter. If a TMH case, the TMH office will be notified. The Final Denial letter will provide the reason for the adverse decision. It will also include the applicable ADW policy manual section(s), a copy of the PAS, supplemental information documentation (if it has been supplied), notice of free legal services, and a Request for Hearing form to be completed if the applicant wishes to contest the decision.

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

Coming Off The MEL

If the applicant has been placed on the MEL, when a slot becomes available, the UMC will forward the

white DHS-2 to LTC economic service worker signifying that the applicant has been determined medically eligible and released from the MEL. The applicant will be notified by the UMC that their slot has been released. The economic service worker will reverify in a second review, the financial eligibility and forward the white DHS-2 back to the UMC within 60 calendar days of the date on the white DHS-2. If the LTC economic service worker needs additional documentation from the applicant, they will notify the applicant of the information needed including the deadline. If the applicant does not provide the information within the specified timeframes, the case may be closed.

If the applicant is determined financially eligible, the UMC will assign an anchor date notifying the OA that the enrollment process can begin. The OA will review all documentation to ensure that all required processes have been followed before enrolling the case.

After the second West Virginia DoHS review, if it is determined that the applicant is not financially eligible, the West Virginia DoHS will notify the applicant that they do not meet the financial eligibility criteria and inform the applicant of their hearing rights.

If the financial eligibility process and enrollment are not completed within 60 calendar days, the OA will close the referral and notify the applicant. The letter will include the reason for the closure (failure to complete the application process), the applicable ADW policy manual section(s), the TMH Transition program applicants/participants may be given flexibility if needed. The transition coordinator will provide follow-up and recommendations if additional time is needed.

If the applicant wants ADW services after the closure, a new MNER may need to be submitted to the UMC to begin the application process again.

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

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

501.11.1.6 Medical Re-evaluation

Annual re-evaluations for medical eligibility for each member must be conducted.

- The case manager must review the information from the UMC portal regarding the MNER.
- The case manager updates the MNER then submits it electronically within the UMC portal.
- Once submitted the UMC will receive an alert that the MNER was updated.
- The UMC contacts the ADW member and schedules the PAS 45-90 calendar days prior to the anchor date. A letter is sent to the member, legal representative/designated contact and notification is sent to the case management agency noting the date and time of the assessment.
- If the UMC is unable to contact the member, legal representative/designated contact within three attempts, a Potential Closure letter will be sent to the member, legal representative/designation contact. Notification is sent to the case management agency, *Personal Options* vendor, and the TMH office, as applicable.

- If no contact is made with the UMC within 10 business days of the date of the Potential Closure letter, the UMC will send the Final Denial letter to the member, legal representative/designated contact. The OA, case management agency, *Personal Options* vendor, and the TMH office will be notified. The OA will close the case.

501.11.1.7 Results of Medical Re-Evaluation

Approval

If the member meets the medical eligibility criteria, a Notice of Approved Continued Medical Eligibility is sent to the member, legal representative/designated contact. The case management agency, the personal attendant agency, and *Personal Options* vendor will be notified when applicable. For people enrolled in the Traditional model, this notice includes the approved Service Level and the range of hours of service per month. For people enrolled in *Personal Options*, this notice includes the approved Service Level and the maximum budget level. A notice of free legal services and a Request for Hearing form will also be sent.

The case management agency should follow up with the West Virginia DoHS to check in the Medicaid Management Information System (MMIS) that the member is still financially eligible.

Denial

If it is determined that the member does not meet medical eligibility the member, legal representative/designated contact. will receive a Potential Denial letter. The case management agency, the TMH office and the *Personal Options* vendor will be notified, if applicable. This letter will advise the member of the reason(s) for the potential denial, listing the areas in which deficiencies were found and notice that the medical eligibility standard has not been met. A copy of the PAS and ADW policy will also be included with the Potential Denial letter along with instructions on how to submit additional information to support medical eligibility. Information submitted after 14 calendar days will not be considered in the eligibility determination; however, it may be used during a pre-conference hearing or Medicaid Fair Hearing. Please note, a Potential Denial-Additional Information Needed letter is not a denial of service and a request for Fair Hearing should not be made at this time.

If the review of the supplemental information by the UMC determines that there is still no medical eligibility, the member, legal representative/designated contact. will be sent the Final Denial letter. The OA, case management agency, *Personal Options* vendor, and the TMH office will be notified as applicable. The Final Denial letter will provide the reason for the adverse decision. It will also include the applicable policy manual section(s), a copy of the PAS, supplemental information documentation (if it has been supplied), notice of free legal services, and a Request for Hearing form to be completed if the member wishes to contest the decision.

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

Service Level Determinations and Changes

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

Service Level Increase Determination

Upon re-evaluation, if the service level increases, the increase may happen immediately upon the case management agency/personal attendant agency notifying the UMC. If the member and/or the ADW provider(s) wish to start the higher service level prior to the end of the current authorization (prior to the anchor date), the ADW provider must submit a service level change request and supporting documentation electronically to the UMC. No physician signature is required in this situation, the only signatures required are the ADW provider submitting the request.

Service Level Change Request During Service Year

If the member and/or the ADW provider(s) wish to increase the service level during the current service year, they submit the service level change request electronically to the UMC.

To make a service level change request the form can be found on the BMS website, Aged and Disabled Waiver Request for Service Level Change.

501.12 ENROLLMENT

Although the applicant may be determined both financially and medically eligible, no Medicaid reimbursed ADW services can be provided until the member has been activated in the UMC web portal.

During the initial PAS assessment, the UMC notifies members of all available providers and services during the assessment. The member completes a Freedom of Choice form to identify their preferred provider, which will be forwarded to the provider of choice once applicant is determined medically eligible. The member is also informed that they may choose to receive services from a different provider of their choosing at any time while receiving services if it is not conflicted.

Once determined medically eligible upon completion of the PAS, the UMC releases the slot, sends the Notice of Decision letter, enters the agency/Service Delivery Model selections into the UMC portal, and sends the white DHS-2 to the local West Virginia DoHS office. This form signifies that the applicant's slot has been released. The West Virginia DoHS will then reconfirm financial eligibility and return the form to the UMC. The UMC will then enter the financial eligibility date into the UMC portal along with the anchor date. The OA will then review the applicants' file to ensure that coding for the correct program is present, and all agency selections and Service Delivery Models have accepted the case for service provision. When this is confirmed, the OA will then activate the case thereby enrolling it into the program.

Once enrolled, the case manager and the personal attendant agency RN will contact the member within seven business days and schedule the Case Management Assessment within 14 business days so the Service Plan can be developed. The expectation is for all agencies to meet at the same time with the member, this face-to-face meeting does not have to be completed with all provider agencies present due

to scheduling issues; however, all documentation must be shared within 14 business days. All timelines remain the same for the case management agency and the personal attendant agency; however, each ADW provider agency can schedule the face-to-face meeting at their convenience.

If *Personal Options* was the selected Service Delivery Model, the *Personal Options* vendor must make initial phone contact with the member within three business days of the enrollment date. If the member is unable to hire staff within 90 calendar days of enrollment, the resource consultant must inform the case manager to begin the process of an involuntary transfer to the Traditional Model for services.

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

501.13 DESCRIPTION OF SERVICE OPTIONS

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

1. Traditional service option
2. Participant-Directed Service Option (*Personal Options* financial management service)

A member who is receiving service may choose either service delivery model option at any time after enrollment by completing a Request to Transfer form and submitting it to their case manager.

501.13.1 Traditional Service Option, Traditional Model

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

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

- Personal attendant
- Case management
- Skilled nursing
- Non-medical transportation
- PERS
- EAA (Home and Vehicle)
- Adult medical daycare
- Pest eradication

The number of available monthly service hours is determined by the service level of care assessed during the personal attendant agency assessment or F/EA assessment, if applicable.

The hourly wage of agency staff employed by the ADW provider is determined by the agency that

employs the staff person, and must comply with all local, state, and federal employment requirements. All agency staff hired by the ADW provider must meet the requirements set forth in the ADW manual.

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

The Financial Management Service (FMS) model available to members to support their use of participant-directed services is *Personal Options*. Under *Personal Options*, the member is the common law employer of the personal attendants they hire directly. The FMS is not the employer. The member may appoint a representative to assist with these functions, but the member remains the common law employer. The members will also select a case management agency to provide case management services.

The following services are available via the *Personal Options* Service Delivery Model:

- Personal attendant
- Case management
- Non-medical transportation
- PERS
- EAA (Home and Vehicle)
- Adult medical daycare
- Pest eradication

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

All personal attendants hired by the member must meet the requirements listed in Personal Attendant Qualifications section of this manual.

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

People choosing *Personal Options* will develop a Spending Plan based on the services outlined in the Service Plan. The Spending Plan helps people determine how their budget will be used.
For members new to *Personal Options*, the first month's budget should be prorated to reflect the actual start date of services.

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

- Elect the member-directed option.
- Work with their resource consultant to become oriented and enrolled in the member-directed option, enroll personal attendants, develop a spending plan for the member-directed budget, and create an Emergency Personal Attendant Backup Plan to ensure staffing as needed.
- Recruit and hire their personal attendant(s).
- Provide required and member-specific training to personal attendant(s).
- Determine personal attendants' work schedule and how and when the personal attendant should perform the required tasks.

- Supervise personal attendant's daily activities.
- Evaluate their personal attendant's performance.
- Review, sign, and submit personal attendant's time sheets to the *Personal Options* FE/A.
- Maintain documentation in a secure location and ensure employee confidentiality.
- Discharge their personal attendant, when necessary.
- Notify their case manager and resource consultant of any changes in service need.
- Maintain a safe environment for all employees.

Personal Options F/EA is responsible for:

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

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

Personal Options makes available information and assistance services to common law employers to support their use of member-directed services and to perform effectively as the common law employer of their personal attendants. Information and assistance services provided by *Personal Options* include:

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

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

When *Personal Options* is selected by the member, the resource consultant provides information and assistance service that includes:

- Providing or linking common law employers with program materials in a format that they can use and understand.
- Providing and assisting with the completion of enrollment packets for common law employers.
- Discussing and/or helping determine the member-directed budget with the common law employer.
- Presenting the common law employer with the *Personal Options* F/EA's role regarding payment for services.
- Assisting common law employers with determining member-directed budget expenditures.
- Assisting with the development of an individualized spending plan based upon the members' annual member-directed budget.

- Making available to the member/representative a process for voicing complaints/grievances pertaining to the *Personal Options* F/EA's performance.
- Providing additional oversight to the common law employer as requested or needed.
- Monitoring and reporting information about the member's utilization of the member-directed budget to the member, representative, case manager and the BMS.
- Explaining all costs/fees associated with the member directing their own services.

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

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

Program Representative

Members may appoint a program representative to assist them with the responsibilities of self-direction. This may be a family member or friend. They cannot be paid for being the program representative to the member that they are assisting with their employer responsibilities, nor can they be the paid personal attendant to the member. The program representative must be 18 years of age. The F/EA will provide training and information to the person the member has chosen to be their program representative. The program representative can choose to accept or decline the appointment at any time. If the program representative no longer wants to perform this function, the member will need to choose another representative or change service delivery models if a Program representative is required. All program representatives, especially those providing this service to more than one ADW member, will be monitored and may at any given time be asked to produce documentation and/or explanation of duties they are providing.

Involuntary Transfers

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

If after 30 calendar days from when the additional training (for each area needed) has taken place and the member is still having difficulty managing their services, the F/EA resource consultant will make a request to the case manager to require the member to appoint a program representative to assist with the employer responsibilities. If the member refuses to choose a program representative, the member will be required to transition to the Traditional Service model following the Involuntary Transfer process. Information will be presented to BMS from the resource consultant and case manager. The BMS will make the final decision. If the member is required to transfer to the Traditional Service model, the case manager will contact the member to facilitate the transfer.

Reasons for Involuntary Transfer of service delivery model:

- Non-compliance with the Self-Direction program requirements.
- Non-compliance with the ADW program requirements.
- Demonstrated inability to supervise their employee(s).

- Demonstrated inability to complete and keep track of employee paperwork.
- Inability to hire and/or maintain an employee (within 90 calendar days of enrollment).
- Program representative is needed, and members refuse to choose or cannot locate a person for this role.

It is possible for a member to transition back to *the Personal Options* model from the Traditional Service model after an involuntary transfer has taken place. The BMS will consider if the members' circumstances surrounding the reason for the Involuntary Transfer have changed. The case manager will facilitate the transfer if deemed appropriate.

Involuntary Transfers for the reasons listed above would require case review to determine if circumstances have changed before being able to transfer back to self-direction.

501.14 PERSON-CENTERED ASSESSMENT

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

1. Person-Centered Case Management Assessment, and
2. Person-Centered RN or F/EA Assessment.

Once enrollment has been completed with the OA, in the Traditional Model, the case manager and the RN will contact the member within seven business days to schedule the Initial Person-Centered Case Management and RN Assessments. The contact to schedule the home visit must be completed within seven business days, however, agencies have up to 14 calendar days to complete their Person-Centered Assessments. The expectation is for all agencies to meet at the same time with the member, however, when not possible the case management agency, personal attendant agency RN, and resource consultant when applicable, do not have to attend the meetings together. The agencies must communicate when they are meeting with the member, provide the documentation to each other and the member, and upload into the UMC portal within seven business days from completion of the assessment.

The Person-Centered Assessment must be completed at least every six months from the member's anchor date and annually up to 45 calendar days prior to the anchor date.

See ADW Person Centered Assessment Chart on forms page on the ADW website.

All providers are required to maintain a copy of the entire Person-Centered Assessment in the member's UMC portal and agency files.
The member in the *Personal Options* Model will be contacted by the case manager to schedule a home visit within seven business days to complete the Person-Centered Case Management Assessment. The resource consultant will assist with the Person-Centered F/EA Assessment with information from the PAS. The case manager will coordinate with the resource consultant to ensure that the Person-Centered F/EA Assessment information has been forwarded prior to the service plan meeting.

When a member has a substantial change such as a health change that prompts the need for a new

service plan, a new assessment or Service Plan Addendum must be completed. These Person-Centered Assessments will determine the number of hours that the member is eligible for each month. No member is guaranteed the maximum number of hours within the full-service level as that is only a range of potential hours based on a member's assessed needs.

A copy of all Person-Centered Assessments must be provided to the member (or legal representative), case manager, RN, and resource consultant. The personal attendant agency, case management agency and F/EA will be responsible for uploading all Person-Centered Assessments and any other related documents into the UMC portal.

501.15 PERSON-CENTERED SERVICE PLAN (PCSP) DEVELOPMENT

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

For the Traditional Model, it is mandatory for the case manager, the RN, and the resource consultant to meet with the member (legal representative, if applicable) at the Initial, six-month and Annual PCSP meeting. Agency staff can meet at different times with the member however all meetings must be scheduled within seven business days, and the service plan must be completed within 14 calendar days. Documentation must then be uploaded into the UMC portal within seven business days upon completion of the document.

For those choosing *Personal Options*, the resource consultant may or may not be present for the initial meeting, however, they will forward the PAL information to the case manager. The member (or legal representative) may choose to have whomever else they wish to participate in the process (other service providers, informal supports, etc.). The resource consultant will conduct the initial assessment, complete the FEIN forms, and develop the budget and PAL in a separate meeting however the PAL will be forwarded to the case manager, and the resource consultant will be responsible to upload the document into the UMC portal upon completion and within seven business days.

The PCSP must detail all services (service type, provider of service, amount, frequency, and duration) the member is receiving, including any informal supports that provide assistance (family, friends, etc.), dual services if applicable, and any other agency services such as Veteran's Administration (VA), home health, and Hospice, regardless of the source of payment. The PCSP must include all needs and risks identified in the PAS, the Person-Centered case management assessment, the Person-Centered personal attendant agency RN assessment, and the Person-Centered F/EA Assessment where applicable. The PCSP must address the members' preferences, goals, home and community-based living arrangements, personal strengths, Emergency Backup Plan(s) and outcomes. The PCSP must include a risk plan, service(s) plan (service, amount, frequency, and duration) and resource plan with referral

source. It is the case manager's responsibility to ensure that all assessments are reviewed with the member and considered in the development of the Service Plan.

It is the case manager's responsibility to send a copy of the PCSP to the member and/or their legal representative, if applicable, the personal attendant agency, and resource consultant, if applicable, within seven business days from the service plan meeting. The case management agency must have the original document in the member's file and uploaded into the UMC portal.

When the member has a change in needs, a Service Plan Addendum must be developed and attached to the current PCSP or an update to the current PCSP must be made to document any permanent Plan changes (i.e., change in service hours, types of assistance with the activity, frequency of the activity, destination for community activity or essential errands, etc.).

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

For those choosing *Personal Options*, the resource consultant is responsible for all duties related to the PAL. Each agency involved with the member is responsible for uploading documents in the UMC portal within seven business days upon completion of the document.

All participant signatures must be on the Service Plan and all participants at the Service Plan meeting must sign the Service Plan.

PCSP Disagreement

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

Risk Analysis and Mitigation Plan

A critical step in the assessment process is the comprehensive analysis of risk. A risk analysis is not a one-time exercise, but rather a process by which the analysis of risk and the development of risk mitigation strategies are continually revisited. The PCSP must address any identification of risk and the plan for mitigation strategies.

24-Hour Emergency Backup Plan

The purpose of the 24-hour emergency backup plan is to ensure that critical services and support are provided to safeguard the member's health and safety whenever there is a breakdown of delivery of planned services. The ADW provider agency-approved 24-hour Emergency Backup Plan must be used and be a part of the PCSP.

Responsibility Agreement

A Responsibility Agreement is between the ADW program member and the provider agency. The Agreement must address the specific actions/outcomes that are expected by the members for their services to continue. Some examples of when a Responsibility Agreement should be developed can include the following: noted pattern of the member's noncompliance with program policies such as non-attendance for required service planning meetings, refusal to allow the case manager to conduct home visits in the member's residence, not permitting personal attendant staff to perform services or asking personal attendant staff to perform services not outlined in the member's Service Plan. Safety concerns in the member's home should be addressed promptly when first displayed or noticed and addressed in a Responsibility Agreement. The case manager will develop the Responsibility Agreement and attach it to the PCSP.

The Responsibility Agreement must be updated each time that a PCSP is reviewed if necessary.

501.15.1 Annual and Six-Month Service Plan Development

The Annual assessment will always be completed up to 45 calendar days prior to the anchor date month. The Six-Month Assessment is due six months following the anchor date (refer to ADW Person Centered Assessment Chart).

Participation in the six-month and Annual PCSP development are mandatory for the member (or legal representative), the case manager, the RN (Traditional Model) and/or the resource consultant (*Personal Options*) or Personal Care RN (dual services cases) as applicable. The member (or legal representative) may choose to have whomever else they wish to participate in the process (direct-care staff, family members, other service providers, informal support, etc.) It is mandatory that the case manager, the RN, and the resource consultant meet with the member (legal representative if applicable) at the-Initial, six-month and Annual PCSP meeting. Agency staff can meet at different times with the member however all meetings must be scheduled within seven business days upon acceptance of the referral, and the Service Plan must be completed within 14 calendar days. Documentation must then be uploaded into the UMC portal within seven business days upon completion of the document.

Service Plan Addendum

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

An addendum can also be utilized if a new service available under the ADW program is added prior to the Anchor or six-month planning meeting. The Service Plan Addendum must be uploaded into the UMC portal along with any other required documents.

501.15.2 Interim Service Plan Development

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

developed.

If the case management agency develops an Interim Service Plan, the personal attendant agency must initiate services within three business days. This is only available through the Traditional Service Model and the TMH Transition program.

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

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

501.16 ASSISTED LIVING RESIDENCES AND GROUP RESIDENTIAL FACILITIES

ADW services may not be provided in assisted/independent living residences or group residential facilities.

All settings where ADW services are provided must be integrated into the community per the CMS Final Rule on Home and Community-Based Settings. Further settings requirements can be found in Section 501.1 of this Chapter.

501.17 COVERED SERVICES

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

- Case management
- Personal attendant
- Skilled nursing annual assessment
- Skilled nursing services
- Non-medical transportation
- PERS
- EAA:
    - Home
    - Vehicle
- Adult medical day care
- Pest eradication

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

Prior to using another internet provider that is not the one utilized/approved by the state for training purposes, ADW providers must submit the name, web address, and course name(s) to the OA for review. The OA will respond in writing whether this internet training meets the training criteria.

Members choosing *Personal Options* and their personal attendant employees may access a resource consultant for OA training materials and assistance. The member and/or the worker are responsible for the costs of the training.

All training must use a competency-based training curriculum defined as a training program which is designed to give staff the skills needed to perform certain tasks and/or activities. The curriculum should have goals, objectives, and an evaluation system to demonstrate competency in training areas. Competency is defined as passing a graded posttest at no less than 70% except for Case Management Certification and West Virginia STP training which requires 80%.

501.17.1 Case Management Services

Procedure Code: G9002 U1
Service Unit: 1 unit per month
Service Limit: 12 units per calendar year
Reimbursed at a monthly rate.
Prior Authorization Required: No

Documentation Requirements: All contacts with, or on behalf of a member, must be legibly documented within the member's record, including date and time of contact, a description of the contact, and the signature of the case manager. The case manager must contact the member (or legal representative if the member is unable to respond to questions), once per month via call, face-to-face quarterly, and document the contact on the Case Management Monthly/Quarterly Contact form. Case management agencies may not bill for transportation services. The case manager must complete the Initial Contact form for a member new to the program and the Monthly/Quarterly Contact form for documentation of required monthly contact and quarterly visits with the member. The case manager may utilize the ADW Member Notes for documentation of contact needed outside of the Initial Contact form and the Monthly Contact form. Errors in documentation cannot be completely erased but must be indicated with a line through the error and noted/initialed by the person making the corrections.

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

Description: Case management activities are indirect services that assist the member in obtaining access to needed ADW services, other State Plan services, as well as medical, social, educational, and other services, regardless of the funding source.

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

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

501.17.2 Case Manager Qualifications

A case manager can be licensed in West Virginia as a social worker, licensed professional counselor, RN, or they may also possess a four-year degree in an approved Human Services field.

Licensure documentation must be maintained in the employees' file. Provisionally and temporarily licensed social workers must successfully complete and pass the BMS Case Management Certification training prior to billing for ADW services as a provisional and temporary license does not qualify as being fully licensed.

Case managers possessing a four-year degree in an approved Human Services field (if the degree in question is not on the approved list, transcripts, curriculum information must be submitted to the BMS program manager for approval) who successfully complete and pass the BMS Case Management Certification training prior to billing for ADW services will also qualify. Documentation that covers all the employee's employment period must be present (example: If an employee has been with your agency for three years, the documentation of licensure must be present for all three years). All documented evidence of staff qualifications such as licenses, certificates, signed confidentiality agreements (Refer to *Chapter 100, General Information*), and references shall be maintained on file by the provider. The provider shall have an internal review process to ensure that employees providing ADW services meet the minimum qualifications.

Resource consultants under the *Personal Options* Model for the F/EA are not case managers.
The ADW program does not allow interns to operate independently as these "paraprofessionals" are not qualified yet to provide the service(s). Providers will not be reimbursed for services provided by unqualified professionals.

501.17.3 Case Manager Initial and Annual Training Requirements

Initial Training:

- CFCM training (including a signed Conflict-of-Interest Statement signed initially and annually thereafter). Training can be found on the OA Learning Management System (LMS).
- The BMS Case Management Certification- (DoHS110 – DoHS114) Required for all Non- licensed case managers and those with a Four-Year Human Services degree (initial only). Training can be found on the State's LMS.
- *Personal Options* Service Delivery Model training.
- Person-Centered Planning/Service Plan development.
- A/N/E identification training that includes recognizing and reporting A/N/E.
- HIPAA training.
- West Virginia STP Rules and Member/Provider-Controlled Assessment training found on the BMS LMS (80% competency required).

Annual Training:

- Signed Conflict of Interest Statement form (training is required only initially upon hire).
- Person-Centered Planning/Service Plan development.
- ANE identification training that includes recognizing and reporting ANE (staff have the option to test out with 70% competency. If unsuccessful, entire training must be completed).

- HIPAA(staff have the option to test out with 70% competency. If unsuccessful, entire training must be completed).

Case managers who are licensed must maintain any professional license renewal training year-round to maintain license.

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

Case managers must complete and pass with 80% competency mandatory training on the Settings Rule prior to completing the member-controlled setting assessment. The case manager training is available on the LMS. Members will receive educational information on the Settings Rule from their case manager in the form of a brochure. The members will need to provide their signature on the brochure and placed in the member's file for verification of training.

Providers must use training modules provided on the LMS when applicable.

501.17.4 Case Management Responsibilities

The case manager is responsible for follow-up with the members to ensure that services are provided as described in the Service Plan. Initial contact, via telephone or face-to-face, must be made within seven calendar days after personal attendant services have begun. At a minimum, monthly telephone contact and a quarterly face-to-face home visit must be conducted to ensure services are being provided and to identify any potential issues. Monthly telephone contacts must be documented on the Case Management Monthly Contact form and include detailed information on the status of the member in the comment section. Quarterly home visits must be documented on the monthly contact forms but marking the form as being a face-to-face quarterly visit.

If a member (or legal representative) cannot be reached by telephone for the monthly contact, the case manager must attempt to reach the individual(s) listed on the member's 24-Hour Emergency Backup Plan within one business day of not being able to reach the member.

If the case manager is unable to reach the member or listed individual on backup plan, the case manager will contact the personal attendant agency or the F/EA resource consultant to see if there has been any disruption of services. If the member has not had an interruption in services, the case manager will document the contact with the personal attendant agency verifying that the member is safe and is still receiving services. The case manager shall continue to try to call the member (or legal representative) to ensure the member's health and safety.

If no contact has been made with the member or legal representative within three calendar days of the initial attempt, a home visit is required. If there is no answer at the member's home, the case manager shall request a well person/welfare/wellness check from local law enforcement. All steps taken should be documented by the case manager.

If the member is not found in the home by law enforcement, then the case manager must enter a critical incident in the WV IMS.

Monthly contact should, at a minimum, confirm that the member is receiving services as required by their Service Plan and ensure the member's health and safety. In addition to quarterly face-to-face visits, the case manager must complete a six-month Person-Centered Case Management Assessment and Service Plan. There must also be a face-to-face home visit with the members.

Specific activities to ensure that needs are being met include, but are not limited to:

- Assure financial eligibility remains current.
- Annually update the MNER.
- Assure the health and welfare of the members.
- Address changing needs of the members as reported by them (or legal representative), personal attendant staff and/or RN, resource consultant, if applicable or informal supports.
- Address changing needs determined by the monthly contact and/or quarterly face-to-face visit.
- Refer and procure any additional services or resources needed.
- Coordinate with all current service providers to develop the six-month PCSP and the Annual PCSP (or more often as necessary). It is mandatory that the case manager, the RN, and the resource consultant meet with the member (legal representative, if applicable) at the six-month Annual PCSP meeting. Agency staff can meet at different times with the members; however, all documentation must be made available to all agencies involved within the guidelines indicated.
- Provide the PCSP to all applicable service providers that are providing services to the members, including TMH transition navigators, if applicable and *Personal options* resource consultant, if applicable within seven business days.
- Provide copies of all necessary documents to the members and the personal attendant service provider agency or *Personal Options* resource consultant.
- Coordinate and process all transfers requested or required due to agency closure, and/or emergency transfers.
- At a minimum, upload the following documents into the UMC web portal: PCSP, Person-Centered Case Management Assessment, legal representative information, Service Plan Addendum and any other pertinent information.
- Assist with filing grievances, complaints, and fair hearing requests.
- Make fraud and abuse/neglect referrals as needed.
- Assist with obtaining legal representation when needed, such as medical power of attorney, health care surrogate, etc.
- Ensure services were provided in accordance with the PCSP.
- Evaluate social, environmental, service, risks, and support needs of the member.
- Develop and write an individualized PCSP which details all services that are to be provided including both formal, informal (if available) and State Plan or other agency services that will assist the member to achieve optimum function.
- Ensure no duplication of services.
- Coordinate the delivery of care, eliminate fragmentation of services, and assure appropriate use of resources.
- Proactively identify problems and coordinate services that provide appropriate high-quality care to meet the individualized and often complex needs of the members.
- Provide advocacy on behalf of the members to ensure continuity of services, system flexibility, integrated services, proper utilization of facilities and resources, and accessibility to services.

- Ensure that a member's (or legal representative) wishes, and preferences are reflected in the development of the PCSP by working directly with the member (or legal representative) and all service providers.
- Assure that a member's legal and human rights are protected.
- Follow up on all service delivery concerns within two business days and document in the WV IMS.
- Monitor the members' risk management, safety, and welfare. Notify the OA, personal attendant agency, and resource consultant, if applicable, of concerns.
- Explain person centered planning along with the roles and supports that will be available through each service delivery model.
- Ensure that the member knows how and when to notify the case manager about any operational and support concerns or questions.
- Notify the personal attendant agency, resource consultant, if applicable, of concerns regarding potential issues which could lead to a member disenrollment.
- Request a service level change if applicable.
- Notify the local West Virginia DoHS that the member is no longer medically eligible when applicable.
- Provide the HCBS Settings Rule Brochure to the member and explain the contents upon initial enrollment.
- Conduct Member controlled assessment.
- Provide recipient user guide and obtain signature page initially to new members.
- Coordinate with RN regarding service level changes.

501.17.5 Case Management Caseloads

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

501.18 PERSONAL ATTENDANT SERVICES

Traditional Model Procedure Code (personal attendant not living in home with member): S5130
Traditional Model Procedure Code (personal attendant living in home with member): S5130 UK
***Personal Options* Model Procedure Code (personal attendant not living in home with member):** S5130 U1
***Personal Options* Model Procedure Code (personal attendant living in home with member):** S5130 U1 UK

Ratio:	1:1
Service Unit:	15 minutes
Service Limits:	Determined by Service Level Criteria and Service Level Limits, cannot bill for personal attendant services for any member that is temporarily or semi-permanently staying out of state, for example but not limited to while vacationing, visiting family, etc.
Prior Authorization Required:	Yes

Documentation Requirements: All services provided to a member must be legibly documented on the PCSP and maintained in the members' record. Errors in documentation cannot be completely erased but must be indicated with a line through the error and noted/initialed by the person making the correction on any of the documents.

Personal attendants will also participate in EVV requirements and will therefore require individual NPI numbers.

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

More than one personal attendant agency can provide direct care services to a member when a member does not have services due to a limitation in access to staff. Therefore, before a second personal attendant agency is contacted to provide services, the personal attendant agency must contact the OA to explain why a second agency is necessary. The OA must approve the second personal attendant agency before the process continues. The agency the members selected on their Freedom of Choice Personal Attendant form is the primary agency and is responsible for coordinating services. The PCSP must indicate which agency is the primary agency. The primary agency must coordinate the billable nursing units. There cannot be a duplication of services.

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

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

Any changes in scheduled services must be approved in advance by the RN who then notifies the case manager in the traditional model. In the *Personal Options* Model, services not provided as planned may not be carried over into a new month. The resource consultant will need to inform the case manager when and if there are issues with service provision.

A copy of all original PALs must be maintained in the member's file and uploaded by the agency that created the form into the UMC portal to verify services provided.

501.18.1 Personal Attendant Qualifications

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

Medicaid prohibits legally responsible persons from providing ADW services for purposes of reimbursement. Legally responsible persons include the spouse. Court-appointed legal guardians are also prohibited from being paid caregivers. A Medical Power of Attorney (MPOA), Power of Attorney (POA), healthcare surrogate or any other legal representative may provide services, however, if an

MPOA, personal attendant, healthcare surrogate, or any other legal representative is providing services they must:

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

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

All documented evidence of personal attendant qualifications such as licenses, transcripts, certificates, fingerprint-based background checks, First Aid, Cardiopulmonary resuscitation (CPR) training, signed confidentiality statements and references may be issued by the provider agency or obtained from another provider agency, and shall be maintained on file by the provider. The provider must have an internal review process to ensure that the personal attendant providing ADW services meets the minimum qualifications required by policy.

Certified nursing assistants (CNA) who can provide documentation of current Certification, can be hired immediately with their CNA credential once they have completed First Aid, CPR training, finger printing requirements, and STP training. 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 ADW related personal attendant trainings (First Aid, CPR training, and two additional hours of ADW-related training).

Licensed practical nurses (LPNs) who can provide documentation of their current license, can be hired immediately with their LPN credential once they have completed CPR training, finger printing requirements, and West Virginia STP training. 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 ADW-related personal attendant training (CPR and two additional hours of ADW-related training)

CNAs and LPNs will be serving in the capacity of a Personal Attendant and cannot provide any skilled nursing care.

Personal attendant staff must also receive mandatory training on the Settings Rule. This training can be the same training available to the case manager, or it 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 with 80% competency.

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

An ADW member receiving ADW services also cannot be a paid personal attendant/direct-care worker through another HCBS program.

EVV requires all personal attendant workers, who do not reside in the home with the member, to have their own NPI number to link the worker to the member.

501.18.2 Personal Attendant Initial and Annual Training Requirements

Initial

- CPR training - Provided only by certified trainers of OA approved courses. Additional CPR courses may be approved by the OA. All CPR courses must include a return skills-based demonstration. Documentation that each trainee successfully completed the course (possession of CPR card) must be maintained by the agency and made available upon request. If training is conducted by agency staff, documentation that each trainer has successfully completed and been certified by the certified entity must be maintained by the agency and made available upon request.
- First Aid Training – Documentation that each trainee successfully completed the course and is certified must be maintained by the agency. If training is conducted by agency staff, documentation that each trainer has successfully completed and been certified by the certified entity must be maintained by the agency and made available upon demand. Online First Aid courses are allowed, but it must be an OA approved course. The agency's RN education and skill set are sufficient to provide the First Aid Training.
- Competency-Based Universal Precautions training.
- Competency-Based Personal Attendant Skills – Training on assisting people with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Must be provided by an RN, social worker/counselor, a documented specialist in this content area, or a qualified internet training provider.
- A/N/E identification training to include recognizing and reporting A/N/E.
- HIPAA training.
- Competency-Based Direct-Care Ethics – Training on ethics such as promoting physical and emotional well-being, respect, integrity and responsibility, justice, fairness, equity and Medicaid fraud, waste and abuse. Training must also include developing and maintaining professional working relationships and boundaries with the members. Must be provided by an RN, social worker/counselor, a documented specialist in this content area, or a qualified internet training provider.
- Member Health and Welfare – Training must include emergency plan response (signs of heart attack, stroke, infection, confusion), fall prevention, home safety and risk management- must be provided by an RN, social worker/counselor, a documented specialist in this content area, or a qualified internet training provider.
- Person-Centered Planning.
- Personal attendant safety training (Extreme Situations Guide).
- West Virginia STP training Rules and Member/Provider-Controlled Assessment training. Staff can take the training found on the LMS system or the provider agency can develop a competency-based training program and test (80% competency required).

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

Provider may use the training provided on the LMS.

Note: If a personal attendant transitions employment from one OA certified ADW provider agency to another, the receiving provider agency may accept training previously completed, provided documentation meets the standards outlined.

Annual

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

- CPR is current as defined by the terms of the approved certifying agency.
- First Aid, if provided by the American Heart Association, American Red Cross, or other qualified provider, is current as defined by the terms of that entity. Training provided by the agency RN (but not under a certifying agency such as American Red Cross), must be renewed within 12 months or less.
- Universal Precautions - Staff have the option to test out with 70% competency. If unsuccessful entire training must be repeated.
- A/N/E Identification and Reporting - Staff have the option to test out with 70% competency. If unsuccessful entire training must be repeated.
- HIPAA training Staff have the option to test out with 70% competency. If unsuccessful, the entire training must be completed.

Training will be determined current in the month it initially occurred. (example: If First Aid training was conducted May 10, 2025, it will be valid through May 31, 2026).

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

In addition, two hours of training focusing on enhancing direct-care service delivery knowledge and skills must be provided annually. Member-specific on-the-job training can be counted toward this requirement. It is recommended that the same training is not be repeated from year to year. It is suggested that providers evaluate and identify trends at their agencies when identifying potential training topics. Competency-based training curriculum is defined as 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 posttest at no less than 70%. If a member of staff fails to meet competency requirements, the provider agency must conduct additional training and retest the staff (until a score of at least 70% is obtained) before the staff can work with members.

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 ADW 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.

501.18.3 Personal Attendant Responsibilities

The personal attendant's primary function is to provide hands-on personal care assistance outlined in the PCSP. Such assistance also may include the supervision of members as provided in the PCSP. As time permits, personal attendants may also provide other incidental services such as changing linens, meal preparation and light housekeeping such as sweeping, mopping, washing dishes and dusting. All incidental services are intended to maintain the member in their home. The scope of personal attendant service may include performing incidental services however, such activities may not comprise the entirety of the service. Personal attendants may also assist the members to complete essential errands and community activities and supervision of health and welfare risk factors in the home and community. The members must accompany the personal attendant on all community activities. All services provided must appear on the PCSP and must be fully documented on required forms and comply with the BMS documentation standards, including form instructions. The personal attendant must inform the RN of any changes in the member's health, safety, or welfare.

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

Personal attendant services may include but are not limited to direct-care assistance with the following types of ADL:

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

Personal attendants may provide supervision to the member if they require prompting and observation for safety reasons for ADLs/Instrumental IADLs. Supervision may also cover communication and cognitive exercises. Personal attendants may also prompt members for self-administration of medications.

Essential Errands: Essential errands are activities that are essential for the member 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 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 available, before personal attendant services. The informal support availability must be addressed in the service plan. Special caution is advised for those people who live with their personal attendant, or their personal attendant is a relative to ensure services are for the sole benefit of the eligible member to avoid disallowances. Travel must be conducted in the members' immediate community unless a need is otherwise identified and documented on the Service Plan. The essential errand must be fully documented per the PAL.

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

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

A paid family member personal attendant will not be able to take the member to family events as a formal support i.e., billable service. This would be considered informal support provided by the family.

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

The personal attendant may bill for the following:

- Accompanying the member to a medical appointment and the member is using non-emergency medical transportation (NEMT).
- Aiding the member with an ADL while at an outpatient medical appointment.
- Waiting with the member while at a medical appointment.
- If the personal attendant will be paid as the friend/family under the NEMT program, they can also bill the ADW for the time riding with the 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 the member to have the opportunity to interact with others in their immediate community, utilize community resources, and engage in community life. The member's immediate community is a reasonable proximity to the member's home.

The member must accompany the personal attendant on the community activity. These activities are not intended for the benefit of the personal attendant, family, friends, or others. If informal support, family friends or other resources are available, these resources should be utilized if willing and able before personal attendant services. The PCSP should address informal support availability for such activities. Special caution is advised for those people who live with their personal attendant, or their personal attendant is a relative to ensure services are for the sole benefit of the eligible member. Community activities may not exceed 20 hours per month. The community activity must be fully documented per the PAL.

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

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

All personal care needs as outlined on the PCSP must take precedence before essential errands or community activities can occur.

The personal attendant must also document on the PAL the time and the services that were provided. Any deviations from the PAL must be documented on the PAL.

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

Personal attendant staff cannot perform any service that is considered a professional skilled service or any service that is not on the Service Plan.

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

- Care or change of sterile dressings.
- Colostomy irrigation.
- Gastric lavage or gavage.
- Care of tracheostomy tube.
- Suctioning.
- Vaginal irrigation.
- Injection of any medication including insulin.
- Administer any medications – prescribed or over the counter. This would include placing medication in the member's mouth (this would exclude the use/administration of an epi-pen as this would be allowed).
- Perform catheterizations, apply external (condom type) catheter.
- Tube feedings of any kind.
- Make judgments or give medical advice.
- Application of heat or cold.
- Nail trimming if the member is a diabetic.
- Fill a member's daily, weekly, and/or monthly pill container.

If at any time a personal attendant is witnessed to being, or suspected of, performing any prohibited tasks, the personal attendant RN, ADW case manager, and the *Personal Options* vendor (if applicable) must be notified immediately. This would require an incident entry into the WV IMS.

Personal attendants will also participate in the EVV requirements, therefore, will be required to have an NPI number.

501.19 SKILLED NURSING ANNUAL ASSESSMENT/NURSING SERVICES

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

Documentation Requirements: The RN Initial and Annual (up to 45 calendar days prior to the Anchor Date month) Person-Centered Assessment for development of the Person-Centered Plan

501.19.1 Skilled Nursing Services

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

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

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

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

Description: Skilled nursing services consists of nursing staff (RN) assessing, managing, observing, and evaluating care. Skilled nursing services are not the provision of nursing care.

501.19.2 Registered Nurse Qualifications

An RN must be employed by a certified personal attendant agency and have a current West Virginia RN license. Licensure documentation must be maintained in the employees' file. Documentation that shows the RN was licensed for the employee's entire employment period must be present (for example – if an employee has been with the agency for three years – documentation of licensure must be present for all three years). All documented evidence of staff qualifications such as licenses, certificates, signed confidentiality agreements (Refer to *Chapter 100, General Information*) and references shall be maintained on file by the provider. The provider shall have an internal review process to ensure that employees providing ADW services meet the minimum qualifications.

501.19.3 Registered Nurse Initial and Annual Training Requirements

Initial Training:

- Person-Centered planning/Service Plan development
- A/N/E identification and reporting training
- HIPAA training
- CPR

Annual Training:

- *Person Centered planning/Service Plan development.
- *ANE identification and reporting - 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
- CPR as due.

RNs must maintain professional license training requirements.

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

RN Responsibilities: Listing includes, but may not be limited to the following:

- Assure financial eligibility remains current.
- Attend the Initial, six-month, and Annual (45 calendar days prior to anchor date) PCSP meeting and upload documents into the UMC portal within seven business days upon completion of the document.
- If requested by the member (or legal representative), attend the member's ADW medical eligibility appointments with the UMC. It is the member's responsibility to invite the personal attendant agency RN.
- Initiate services within three business days if the case management agency develops an Interim Service Plan.
- Make a home face-to-face visit with the ADW recipient and personal attendant within 30 calendar days after personal attendant services begin.
- Complete a Person-Centered RN Assessment within six months from the annual anchor date month and upload documents into the UMC portal within seven business days upon completion of the document.
- Based on discharge orders from an acute care hospital, nursing facility, or other residential setting indicating a change in member's condition, complete a RN Assessment, to determine the needed changes to address the discharge orders in the Service Plan. The RN must notify the case manager if additional services or changes in services are needed (notification of the case manager is an administrative duty and is not billable) so the case manager can amend the plan if necessary.
- Review and approval of the PALs to ensure services were provided as described in the PCSP and completed per policy before submitting billing under approved personal attendant allowable codes.
- Provide member-specific training to personal attendants as needed. This training may be counted under the additional two hours of training requirement.
- Pre-fill the member's medication box monthly if ordered by a physician, PA, or APRN per written prescription. Documentation to support the need for this service must be included in the PCSP and Assessment to substantiate the need. Example: The ADW recipient has Rheumatoid Arthritis in left and right hand/fingers and unable to open a medication bottle. No pharmacy prepackaging services available. No family, friends, or other informal support to assist.
- Compile, prepare, and submit material that can be used to assess an ADW member's need for an increase in their Service Level.

- Service level changes can only be requested for members at Service Level A, B, or C, and only when there is a substantial change in the member's medical condition. A Request for Service Level Change must be completed and submitted to the UMC with clinical documentation sufficient to support the request, which may include applicable test results from the physician, PA, APRN, or hospital discharge summary. These documents must be on the professional's letterhead and/or dated no later than one month prior to, or one month following, the request for an increased service level. Any verbal or telephonic statements; or letters from family, neighbors, friends, or case management and personal attendant staff will not be considered without attached physician documentation or a facility discharge summary. The Service Level Request form must be signed by the RN or the case manager and the ADW recipient (or legal representative). Original signatures are required, i.e., "signature of member on file" is not acceptable. This request may or may not result in a change in the Service Level. The final determination will be made by the UMC.

- Notice of the determination will be sent to the ADW recipient (or legal representative), case manager and RN if applicable. Case managers need to be notified of the request.
- People receiving ADW services who are appealing a denial of medical eligibility will remain at their current Service Level pending a Fair Hearing decision if the request was made within 13 calendar days of the denial letter date. The UMC will not review a request for an increased Service Level for ADW recipients appealing a denial of medical eligibility.

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

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

Administrative duties are not billable. Duties include, but are not limited to:

- Sending copies of any assessments to the members receiving ADW services (or legal representative) or the case management agency.
- Notifying the case management agency of any changes regarding the ADW member, such as admission or discharge from an acute care hospital, nursing home, or other residential facility, change in service level, etc.
- Being available to the personal attendant for consultation and assistance at any time when the personal attendant is providing services.
- Completing and submitting required program reports to the BMS, the OA, or the UMC.
- Telephone calls.
- Uploading RN assessments and paperwork into the UMC or any other required portal.

501.19.4 Training Documentation

Documentation for training conducted by the agency RN, social worker/counselor, or a documented specialist in the content area must include the training topic, date, location of the training and the signature of the instructor and the trainee or, for *Personal Options*, the member (or legal representative).

Training documentation for internet-based training must include the person's name, the name of the internet training provider, credit hours (time spent) and either a certificate or other documentation proving successful completion of the training.

A card or certificate from the American Heart Association, the American Red Cross or other training entity is acceptable documentation for CPR and First Aid.

Providers can use the approved ADW form to document training found on the BMS website or they can provide training certificates with the above documented information. Either tracking method will be accepted.

CPR/First Aid Documentation

Personal attendant workers must have a CPR/First Aid card. While an agency is waiting for the card, BMS will accept the training log in each personal attendant's personnel file as evidence. Once the agency is in receipt of the card, a copy should be placed in the employee's personnel file within 30 calendar days, and the original card should be distributed to the employee. The training log/sign in sheet documentation is valid for 30 calendar days from the date of the class.

Personal Options

Personal attendant workers must have a CPR/First Aid card. The BMS will accept a letter on the certifying agencies' letterhead stating that training meets the policy requirements for documentation of training. The letter is valid for 30 calendar days from the date of the class. The card must be secured and copied onto the staff record after 30 calendar days.

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

501.20 NON-MEDICAL TRANSPORTATION SERVICES

Traditional Model Procedure Code:	A0160 U5
***Personal Options Model* Procedure Code:**	A0160 U4
Service Unit:	One unit - One mile
Service Limit:	300 units per calendar month
Prior Authorization:	No

Documentation Requirements: All transportation with, or on behalf of the member, must be included in the Service Plan and include the date, miles driven, travel time, destination, purpose of travel and type of travel (essential errand or community activity). The Service Plan and PAL must document the purpose of the travel and the destination. The personal attendant must document on the PAL accurate miles traveled, exact location of the destination and reason for the travel. Those using *Personal Options* will submit and invoice the *Personal Options* vendor.

Description: Non-medical transportation provides reimbursement for personal attendants that perform essential errands and/or community activities for/or 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, should be utilized first. The member may be transported by the personal attendant to gain access to incidental services and activities as specified in the Service Plan, this would include transportation to work if the member is employed or school if the member is enrolled in courses. 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.

The case manager must document on the Service Plan the availability/willingness of the member's family, friends, or other community agencies to provide transportation first. 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.

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

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

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

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

501.20.1 Non-Medical Transportation Services Qualifications

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

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

501.21 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS) SERVICES

Traditional Model Procedure Code: S5161 U6
***Personal Options Model* Procedure Code**: S5161 U6 UK
Service Unit: 1 unit – 1 per month
Service Limit: 12 Month Calendar Year
Prior Authorization: No

Documentation Requirements: The ADW personal attendant agency or the F/EA, when applicable will choose the PERS vendor(s) to provide the service for the member that has indicated or needs the service to remain safe in the community. The service provision will be documented in the service plan by the case

manager and the personal attendant agency and F/EA when applicable will submit billing. Any calls requiring WV IMS documentation or follow-up, will become the responsibility of the personal attendant agency. In the case where members transfer, members will be required to use the PERS vendor of the agency they are transferring to. The personal attendant agencies will need to work together to determine a transfer date of the service so PERS billing will not conflict with each other.

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

PERS Vendor Qualifications: The PERS vendor must provide an emergency response center with fully trained operators who can receive signals for help from a member's PERS equipment 24 hours a day, 365 or 366 days per year as appropriate, determining whether an emergency exists, and of notifying an emergency response organization or an emergency responder that the PERS service member needs emergency help.

501.22 ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS (HOME AND VEHICLE) SERVICES

Home

Traditional Model Procedure Code: S5165 U7
***Personal Options* Model Procedure Code:** S5165 U7 UK
Service Unit: $1 per unit
Service Limit: $1,000.00 per service plan year
Prior Authorization: No
Site of Service: This service may be provided in the members' residence.

Limitations:

- If a member has a documented change in need after the Annual Service Planning/Assessment has been conducted, then a Service Plan Addendum must occur to discuss the need for the EAA which may or may not be authorized.
- EAA-Home is not intended to replace the members', member's family, or landlord's responsibility for routine maintenance and upkeep of the home.
- Adaptations made to rental residences must be portable.
- $1000 available per member's annual Service Plan year in combination with Traditional and *Personal Options* and EAA-Vehicle.
- The personal attendant agency must not pay EAA funds to the members, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA supplies or service.
- If additional funding is needed (above the $1,000 per member, per service year), the member will

be responsible for determining an additional funding source and arranging payment for the balance.
- Activities, goods, and services not covered under this service are noted in the Exclusion List below.

Exclusion Lists: Activities, goods, and services not allowed 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 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
- Appliances that are not adapted/modified to meet the members' needs (appliances compliant with the ADA are sufficient to meet this requirement).
- 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 person's needs
- Driveway or walkway repairs or supplies unless specifically to exit or enter home to and from vehicle
- Covered awnings

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

Documentation: The case management agency must maintain all the following documentation in the members' file and upload the following documents into the UMC portal, if available:

- Any assessments detailing the need for the EAA.

- Written physician statement.
- The member's PCSP or Service Plan/Assessment Addendum which details the need for the EAA.
- Copy of the approved application for EAA services (This application may be completed by the case management agency or personal attendant agency, but it must be provided to the case management agency if completed by the personal attendant agency).
- Proof of purchases including any receipts or invoices pertinent to the EAA (will need to be provided by the personal attendant agency as they will process the claim).
- Verification by the case management agency that the contracted entity services were completed as approved.

Description: EAA-Home are physical adaptations to the private residence of the member or the member's family home which maximize the member's physical accessibility to the home and within the home. EAA-Home must be documented in the member's PCSP and must include the specific item(s) requested and how these adaptations will enable the member to function with greater independence in the home. This service is used only after all other funding sources have been exhausted.

Vehicle

Traditional Model Procedure Code:	T2039 U8
***Personal Options* Model Procedure Code:**	T2039 U8 UK
Service Unit:	$1 per unit
Service Limit:	$1,000.00 per service plan year
Prior Authorization:	No

Site of Service: This service may be provided to a vehicle owned by the member or the member's family. The vehicle must be the member's primary means of transportation and the adaptations are to maximize the member's accessibility to and in the vehicle.

Limitations:

- If a member has a documented change in need after the annual Service Planning/Assessment has been conducted, then a Service Plan Addendum to the Service Plan must occur to discuss the need for EAA which may or may not be authorized.
- $1000 available per member's annual PCSP year in combination with Traditional and *Personal Options* and EAA Home.
- 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.
- This service may not be used to purchase or lease a vehicle.
- This service may not be used to adapt a vehicle owned or leased by the Waiver provider agency.
- This service may not be used for regularly scheduled upkeep, maintenance, and repairs of a vehicle except for upkeep and maintenance of the modifications.
- The personal attendant agency must not pay EAA funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service.

Exclusions: Activities, goods, and services not allowed include, but are not limited to:

- 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.
- Purchasing or leasing a vehicle.

- Regularly scheduled upkeep, maintenance, or repairs of a vehicle except upkeep and maintenance of the modifications.
- Running boards, insurance, or gas money.
- Car seats unless specifically adapted/modified for the person.

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

Documentation: The case management agency must maintain all the following documentation in the members' file and upload the documents into the UMC portal:

- Any assessments detailing the need for the EAA.
- The member's PCSP and/or Service Plan Addendum which details the need for the EAA.
- Copy of the approved application for EAA services (This document may be completed by the case management agency or personal attendant agency but must be made available to the case manager if completed by the personal attendant agency).
- Proof of purchase, including any receipts or invoices pertinent to the EAA services (which will need to be provided by the personal attendant agency as they process the claim).
- Verification by the case management agency that the approved EAA service was completed as approved.

Description: EAA-Vehicle are physical adaptations to a vehicle owned by the member or the member's family which is the member's primary mode of transportation. The purpose of EAA-Vehicle is to maximize the members' accessibility to and within the vehicle. EAA-Vehicle is documented on the member's PCSP and must specify the item(s) being requested. This service is used only after all other funding sources have been exhausted.

501.22.1 Environmental Accessibility Adaptations Qualifications Home and Vehicle Process

EAA applications may be completed by the member, case manager, personal attendant agency, or F/EA vendor. Completed applications must be submitted by the case manager who is responsible for adding the EAA service to the member's PCSP. The case manager will submit the EAA application, estimate or invoice which specifies the vendor, and any other supporting documentation to the OA for approval.

The OA will notify the case manager and the personal attendant agency of the determination. If approved, the personal attendant agency is responsible for claiming the EAA service, issuing payment to the vendor, and obtaining receipt(s). The case manager will confirm the adaptations are completed as specified in the member's PCSP. If the adaptations are not completed as planned, the case manager will assist the member to remediate the issue.

If the application is not approved, the OA will notify the case manager and provide justification for the denial. The case manager is responsible for notifying the members. If appropriate, the existing application may be corrected and resubmitted or the member may choose to submit a new application.

The maximum of $1,000.00 per service plan year applies to EAA-Home and Vehicle combined. The $1,000.00 maximum is available per service plan year for either Traditional or Self-Directed Model, but not both, should the member change Service Delivery Model within a Service Plan year.

501.23 ADULT MEDICAL DAYCARE SERVICES

Procedure Code/Service Unit: Full Day: T2021 U4
Half Day: T2021 U8
Service Limit: Full Day: Minimum of 7 hours
Half Day: Minimum of 4 hours
Prior Authorization Required: Yes

Description: Medical adult daycare centers are an ambulatory healthcare facility that provide an organized day program of therapeutic, social, health maintenance, and restorative services and whose general goal is to provide an alternative to 24-hour long-term institutional care to elderly or disabled adults who need such services by virtue of physical or mental impairment. This service provides individuals with chronic physical or cognitive impairments the care they need. A highly cost-effective long-term care alternative, medical adult day health centers administer nursing care, meals, and therapeutic activities in a safe, structured, and homelike environment.

501.23.1 Adult Medical Daycare Qualifications

Providers of adult medical daycare centers are required to be a licensed facility via the Office of Health Facility Licensure and Certification (OHFLAC). Providers must follow guidelines set forth in 64 CSR 2 Title 64 Legislative Rule Series 2 Licensure of Medical Adult Daycare Center in West Virginia. Agency must be enrolled with a West Virginia ADW Medicaid provider. Staff must follow the West Virginia Clearance for Access: Registry & Employment Screening (WV CARES) requirements and possess an acceptable federal Office of the Inspector General (OIG) Medicaid exclusion list check, be able to perform the tasks, and meet training requirements as mandated by the OHFLAC. Agency licensure and staff training are verified annually by the OHFLAC.
The OA will certify and monitor the agency to ensure that the program is following the HCBS Setting Rule. Agency must be an enrolled West Virginia ADW Medicaid provider. Agency licensure is verified annually by the OHFLAC. Agency staff's credentials/training are verified initially and annually by the OHFLAC with exception of the state and federal fingerprint-based checks which are checked every five years and the OIG which is checked monthly by WV CARES.

Approved providers can bill NEMT to and from the member's place of residence and the facility. The licensee shall establish regular hours of operation of not less than four hours per day and a minimum of five days per week. The center's hours of operation should be during times that encompass a normal work week or the member's caregivers. Services are specified in the members' Service Plan. The services must be provided in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the member. Meals provided as part of these services shall not constitute a full nutritional regimen, i.e., three meals per day.

501.24 PEST ERADICATION

Traditional Model Procedure Code: S5121 U7
***Personal Options* Procedure Code:** S5121 U7 UK
Service Unit: $1 per unit
Service Limit: $1,700 per service plan year in total not for each Service Delivery Model
Prior Authorization Required: No

Limits: This service can be made available on an ongoing basis to prevent reinfestation only when reinfestation is likely to occur, and the case manager (with personal attendant agency's RN input if necessary) determines the reinfestation would negatively impact the member's health and safety. The case manager must consult the pest control provider to determine the likelihood of reinfestation. The justification for ongoing services must be documented in the Service Plan or Service Plan Addendum. Pest eradication services are only permissible for members residing in their own home. This also includes a home that the members may own or are renting as 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 will document that no other resource is available to provide this service in the notes.

If a lease exists, case managers must determine the landlord's responsibility to make the rental property habitable.

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 individual report that a pest is causing or is expected to cause harm that would prevent a participant from safely remaining in the community.

Case managers must provide the affected member with education material 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 PCSP to assess infestation risks and develop a risk mitigation plan.

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 Service plan. The case managers will also determine from the member (and the personal attendant agency RN if necessary) 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.

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 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. Case manager and personal attendant services cannot be altered indefinitely. The goal is to return to services the member had prior to the infestation. If the member is not following the plan for pest eradication, they place themselves at risk of losing services.

Documentation Requirements: Documentation must include the amount, duration, and scope of services as determined by the case manager. Documentation must also document that all above requirements were confirmed as indicated i.e. licensed vendor, no other payment source etc. in the member's Service Plan or Service Plan Addendum.

All requests for pest eradication services must be submitted by the case manager using the "Request for Pest Eradication" form to the OA for approval. Applications will be considered complete only when all required documentation is included. The completed application must contain the following:

- A description of the requested service, including the amount, duration, and scope (e.g., one time treatment; quarterly treatments for one year).
- Verification that the vendor is licensed with the West Virginia Department of Agriculture (WVDA) as a Licensed Pesticide Application Business.
- A copy of the member's PCSP and/or Service Plan Addendum documenting the need for pest eradication.
- Documentation that no alternative resource is available to provide the service (may be documented in the Service Plan or Addendum).
- A case manager statement confirming reasonable assurance that the member intends to reside in the property for the foreseeable future (may be documented in the Service Plan or Addendum).
- A case manager statement confirming the member has received pest prevention education or training to support maintaining a pest free residence following treatment (may be documented in the Service Plan or Addendum).

Description: 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.

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 WVDA as a licensed pesticide application business. 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). The case management agency must check for available licensed entities on the WVDA website to identify eligible Pest Eradication contractors. A licensed Pest Eradication contractor/vendor is an entity holding valid and current licensure through the WVDA.

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 in determining a qualified vendor to provide the service.

TAKE ME HOME TRANSITION PROGRAM OVERVIEW AND SERVICES

Individuals wishing to transition from long-term care facilities to the community often face numerous obstacles, including lack of basic household items, limited community support, and no one to help develop comprehensive plans to transition home. The TMH community liaison specialists, housing specialists, and transition coordinators help address many of these barriers by providing a variety of services and supports to the TMH Transition program participants to promote a successful and safe transition to the community.

The TMH field staff work in teams consisting of a transition coordinator, housing specialist and a community liaison specialist. The teams, which are in five areas around the state, work together to support the TMH participants' transition, safely and successfully to the community. TMH staff work one-on-one with participants 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,
- Facilitate the development of a transition team consisting of the resident, the transition coordinator, the waiver case manager, the facility social worker and other appropriate staff, and anyone else the participant chooses to include in the transition process,
- Work with the TMH participant and their transition team to develop a written Transition Plan which incorporates specific services and supports that 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 support including waiver transition services prior to transition,
- Participate in all required training including the West Virginia STP training,
- Review residential settings to ensure it is following the Residential Settings Rule.

501.25 TMH TRANSITION PROGRAM SERVICES

Transition services support individuals transitioning from nursing facilities, hospitals, and Institutions for Mental Diseases (IMD) to their own home or apartment in the community. The provision of transition services is individualized, based on a comprehensive transition needs assessment conducted by a transition coordinator in collaboration with the individual, TMH staff, nursing facility staff, and other individuals identified by the member to participate in the transition process. Transition services and other waiver, as well as non-waiver services and support, are incorporated into a transition plan, and approved by the transition manager. In addition to the two waiver transition services there are several Money Follows the Person (MFP) demonstration and supplemental services available to assist MFP-eligible individuals in transitioning back to the community.

The waiver transition services include:

- Pre-Transition Case Management: To develop a Waiver Participant Interim Service Plan and ensure that the needed community services and supports are in place the first day the participant returns to the community; and
- Community Transition Services: One-time expenses that address identified barriers to a safe and successful transition from facility-based living to the community.

501.25.1 Pre-Transition Case Management

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

Limits: Individuals eligible to receive this service:

- Live in a nursing facility, hospital, IMD, or a combination of any of the three for at least 60 consecutive days; and
- Have been determined medically and financially eligible for the ADW program; and
- Wish to transition from facility-based living to their own homes or apartments in the community consistent with the CMS Settings Rule (1915(I)); and
- Have a home or apartment in the community to return to upon leaving the facility that is consistent with the CMS Settings Rule (1915(I)); and
- Require waiver transition services to transition to community living safely and successfully; and
- Can reasonably be expected to transition safely to the community within 180 continuous 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 one-time following transition to the community. This service is not available once the resident transitions to the community and enrolls in the waiver. The case management agency will receive authorization for this service via the Pre-Transition Case Management Services Authorization letter that will be sent from the TMH transition manager, or the designee, to the case management agency provider.

Description: The purpose of the pre-transition case management service is to ensure that waiver services are in place on the first day of the participants' transition to the community. Prior to the participant's transition from the facility, pre-transition case managers will:

- Participate in the transition assessment and planning process to help ensure that home and community-based services and supports needs are thoroughly considered in transition planning,
- Conduct the person-centered assessment as required by waiver policy,
- Complete the required Waiver Interim Service Plan,
- Facilitate the development of the assessment for those eligible for and planning to enroll in the ADW program when returning to the community,
- Facilitate the development of the service plan by the selected waiver personal attendant agency,
- Coordinate with the personal attendant agency to ensure that direct-care services are in place the first day the resident returns home,
- Residents of nursing homes may apply and be determined eligible but are not enrolled in the waiver program until they have been discharged from the facility (transitioned) and begin waiver services. The transition manager notifies the OA and the UMC of the transition of a TMH participant and the OA will enroll the individual on the date of the transition.

Qualifications: Pre-transition case management qualifications are the same as case manager qualifications listed in the ADW case management qualifications section.

501.25.2 Community Transition Services

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

Limits: The total expenditure for services cannot exceed $4000 per transition period. Community

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

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

Any service or support that does not address an identified need in the Transitional Plan, decrease the need for other Medicaid services, increase the member's safety in the home, or improve and maintain the member's opportunities for full membership in the community is excluded. For individuals ages 22-64 transitioning from an IMD, the individuals will not receive community transition services because federal financial participation is not permitted for services rendered to individuals in this age range while they are in an IMD.

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

Description: 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 resources. Community transition services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

The components of the community transition service include:

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

All transition services must be reasonable and necessary, not available to the member through other means, and clearly specified in the waiver member's service plan. Members will be directly responsible for their own living expenses post transition.

501.26 BILLING PROCEDURES

When 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 determine the number of units to be billed. Claims cannot be processed for less than a full unit of service. Rounding of units is allowed once per billing period (i.e., for a 15-minute unit, at least eight minutes of service must be provided and documented to "round up" to the next whole unit). If less than eight minutes of service is provided, the unit of service is "rounded down" to the next whole unit (ex. 37 minutes would be billed as two 15-minute units). **The billing period on a claim cannot overlap calendar months:**

- Medicaid is the payor of last resort. Provider agencies must bill all third-party liabilities such as a member's private insurance for those services that are covered by both private insurance and the Medicaid waiver program prior to billing Medicaid. Medicaid is considered a secondary insurance to an individual's private insurance. The case manager must inform the member, their family, and/or legal representative of this requirement.
- Claims for services may not be dated after the date of a member's death. Services must be provided and dated prior to the member's discharge date to be billed.
- Claims will not be honored for services regardless of the service code definition, provided outside of the scope of *Chapter 501, Aged and Disabled Waiver* policy manual or outside the scope of federal regulations.
- It is the providers' responsibility to check the member's Medicaid eligibility via the MMIS vendor's portal prior to providing services and then monthly thereafter.

501.27 PAYMENTS AND PAYMENT LIMITATIONS

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

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

For active ADW members, 30 calendar 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.

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

Note: This section refers to non-TMH members.

501.28 SERVICE LIMITATIONS AND SERVICE EXCLUSIONS

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

ADW services are made available with the following limitations:

- The member must live in West Virginia and be available for planned services.
- All ADW regulations and policies must be followed in the provision of the services. This includes the requirement that all ADW providers be certified by the OA in the State of West Virginia and enrolled in the West Virginia Medicaid program.
- The services provided must conform with the stated goals and objectives of the member's PCSP.
- Members' budgets (*Personal Options*) and limitations described in this manual must be followed.
- No duplication of services assisting members with ADLs or ancillary tasks that are being provided by another program such as, but not limited to, Medicare, Medicaid, VA, Worker's Compensation, some private long-term care insurances, or private pay.
- ADW members cannot be the documented unpaid or paid caregivers in another waiver program, the Personal Care Services program for another program participant, or in any other capacity for a family member (children, grandchildren, spouses, etc.) during service plan time.
- Any setting where the provider of the HCBS also owns and operates a member's residential setting is considered a conflict of interest and therefore not in compliance with the CMS HCBS

setting rule unless the provider operating the residential setting can produce a signed agreement indicating that the member can maintain their freedom of choice regarding personal attendant services.
- Adult family care, group home, and assisted living facilities are not approved settings for ADW services.

Restrictive Intervention

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

Emergency Safety Intervention

The BMS allows limited physical 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,
- Traumatic brain injury (TBI),
- Other brain disease or injury,
- Cognitive impairment and/or behaviors that create memory loss with difficulties in thinking, problem-solving or language, agitation, anxiety, irritability, and motor restlessness that often led to such behaviors as wandering, pacing and night-time disturbances.

When a member experiences confusion, agitation, wandering or behavior that may create an emergency risk to the member's safety, emergency safety interventions may include alarms for doors, Global Positioning System (GPS) identification or monitoring devices, personal emergency response systems and other methods of locating or warning of emergency safety incidents and bed rails. The case manager must document in the Person-Centered Assessment and the Risk Mitigation Plan the rationale for the use of an emergency safety intervention. Emergency safety interventions are not to be used for the convenience of the caregiver.

501.28.1 Dual Service Requests for ADW and Personal Care (PC) Services

PC services are to be used as additional services to supplement the ADW services when the member's needs exceed what the waiver can provide.

The case manager must ensure that the member meets the ADW criteria for dual services before applying for PC services and documents the need for additional services in the member's Service Plan or Service Plan Addendum.

This should be done at the initial, six month or annual Service Plan. If the need is identified outside of Service Planning meetings, the Service Plan addendum can 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. Personal care activities that will be performed outside the routine of the day must have a rationale on the PC 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 ADW who wish to request additional services through the PC Services program and who meet the ADW/PC Dual requirements may apply for PC as indicated below:

- For initial PC requests, the PC applicant, ADW case manager, personal attendant agency, resource consultant or referent will submit an Initial PC-MNER to the UMC via fax or mail. If Waiver requirements are met (member assessed at a level D), the UMC will key the ADW 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 personal care agency will receive an annual eligibility alert 90 calendar days prior to the anchor date through the UMC web portal. After receipt of the alert the personal care agency should update any member demographics, diagnosis, or significant information then submit within the web portal. The UMC will utilize the ADW PAS for annual redetermination. If Waiver requirements are met (member assessed at a level D), the UMC will key the ADW PAS previously completed (by the UMC) into the PC web portal for determination of PC eligibility. If waiver requirements are not met, the PC member will be discharged.
- If an existing PC member becomes eligible for ADW and is offered a slot, but does not meet ADW requirements for dual services, the member must choose between ADW or PC services, however, the PC services are to remain in place until the ADW service begins.
- For members approved for dual services, the PC agency will utilize the medical eligibility ADW anchor date.

Once dual services are approved for an ADW/PC member, the ADW Person-Centered Assessments (case manager and RN) and the ADW PAL will be used when developing the PC Plan of Care:

- The PC RN is responsible for submitting the PC Plan of Care within three calendar days of the initial request for the documents to the case manager and uploading it in the UMC's personal care web portal.
- The ADW case manager is responsible for providing a copy of the PC Plan of Care to the ADW personal attendant agency within seven business days.
- Case management agencies also cannot 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 approval of dual services, the ADW personal attendant agency is unable to provide the maximum level of services identified for dual services due to staffing issues, the PC direct-care worker services can continue for 30 calendar days.
- The ADW Service Plan should reflect the assessed service hours for the members regardless of whether staffing is available to provide these hours at any time.

- If for any reason the assessed service hours for a member cannot be provided, the reason should be documented in the members' file.
- If the ADW agency is unable to provide an ADW personal attendant for 140-155 hours per month due to staffing issues, PC services can continue to allow the ADW agency time to hire/train new staff. PC agencies must follow the PC manual requirements and allowable timelines regarding requesting this extension.

501.28.2 Dual Provision of ADW and Home Health Agency Services

Members who have been determined eligible for and are enrolled in the ADW program may receive services from a home health agency that does not duplicate ADW services. Once the case manager is aware of home health agency services provided to the ADW member, the case manager must work with the home health agency to ensure no duplication of services occurs. In general, services may only include skilled nursing care or therapy services for post-hospitalization stays or acute episodes of chronic conditions. The provision of case management via home health agencies is considered duplication of services and should not occur. The need for home health services must be documented in the members' Service Plan and/or Service Plan Addendum. Documentation of the referral from the member's attending physician is the responsibility of the home health agency. If a copy is available, it may be maintained in the member's ADW file. The need for home health services must be documented on the ADW Person Centered Plan or the Service Plan Addendum and must be maintained in the members' record of both the ADW agency and home health agency. Please refer to *Chapter 508, Home Health Services* for additional information.

501.29 VOLUNTARY AGENCY CLOSURE

A provider may terminate participation in the ADW program with 60 calendar day's written notification of voluntary termination. The written termination notification must be submitted to the BMS fiscal agent and to the OA. For a personal attendant agency closure, the provider must provide the OA with the complete list of all current members and must notify each member's case management agency to initiate a transfer. For a case management agency closure, the case management agency must provide the OA with the complete list of all current members and must initiate transfer.

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

Services must continue to be provided by the current agency provider until all transfers are completed by the case management agencies involved.

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

501.30 INVOLUNTARY AGENCY CLOSURE

The BMS may administratively terminate a provider from participation in the ADW program for violation of the rules, regulations, or for the conviction of any crime related to healthcare delivery. If the provider is a corporation, its owners, officers, or employees who have violated said rules and/or regulations or have

been convicted of a crime related to health care delivery, may likewise be excluded from further participation in the ADW program. After notice of intention to suspend or terminate enrollment under their authority, the provider may request a document/desk review. Refer to *Chapter 100, General Information*, for more information on this procedure.

Prior to closure, the provider will be required to provide the OA with a complete list of all people and the case management agencies currently, on the ADW that will need to be transferred. The case manager (if applicable and not the closing agency) will provide selection forms to each of the people on the agency's list that they are providing services to, along with a cover letter explaining the reason for a new selection must be made. The case manager along with any assistance needed of the OA will ensure that the transfer of all people is accomplished as safely, orderly, and expeditiously as possible. It is the agency's responsibility to maintain and/or destroy all agency records according to the BMS common chapters.

501.31 ADDITIONAL SANCTIONS

If the BMS or the OA receives information that clearly indicates a provider is unable to serve new people due to staffing issues, health, and safety risk, etc., or has a demonstrated inability to meet recertification requirements, the BMS may remove the agency from the Provider Selection forms and from the provider information on the OA website until the issue(s) are addressed to the satisfaction of the BMS. Health and safety deficiencies deemed critical may include other sanctions including involuntary agency closure.

Failure to meet policy requirements will prompt the BMS to issue a letter notifying the provider of the specific areas of noncompliance. A CAP will be requested from the provider to address each area of noncompliance. The provider will have 15 calendar days to develop a provisional CAP and submit it to the OA and the BMS. For each step of progressive remediation, a noncompliance 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

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

- **Census Reduction:** If the provider continues to be non-compliant, then a census reduction of up to 10% will be placed on the provider. The provider must submit an amended CAP to the OA and the BMS.
- **Census Hold:** The next step in the remediation process is a census hold.
- **30-Day Pay Hold:** If the provider continues to be non-compliant, a 30-day pay hold may be placed on the provider.
- **Termination of ADW Provider Status:** The BMS may either accept the amended CAP or issue a final noncompliance notification and termination of the ADW provider status.

501.32 MEMBER RIGHTS AND RESPONSIBILITIES

Case management agencies along with resource consultants, as applicable, must communicate to each member initially, and annually (must also obtain the member's signature on the acknowledgement of

training form out of the ADW Recipient User Guide located on the BMS website) the following, their right to:

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

It is their responsibility to:

- Notify the ADW personal attendant agency within 24 hours prior to the day services are to be provided if services are not needed.
- To notify case manager, personal attendant agency and/or resource consultant promptly of changes in Medicaid coverage.
- Comply with the agreed upon PCSP and responsibility agreement (if applicable).
- Cooperate with all scheduled in-home visits.
- Notify the case manager, personal attendant agency, and/or resource consultant of a change in residence or an admission to a hospital, nursing home or other facility.
- Notify the case manager, personal attendant agency, and/or resource consultant of any change of medical status or direct-care need.
- Maintain a safe home environment for all service providers required to be in the home.
- Verify services were provided by initialing and signing the PAL.
- Communicate any problems with services to the case manager, personal attendant provider agency and/or the resource consultant for *Personal Options*.
- Report any suspected Medicaid fraud to the case manager, personal attendant provider agency, resource consultant, or the OPI Unit at (304) 558-1700. Reports can also be emailed to DoHSBMSMedicaidOPI@wv.gov.
- Report any incidents of abuse, neglect, or exploitation to the case manager, personal attendant provider agency, the resource consultant, or the WV Centralized Intake hotline at 1-800-352-6513.
- Report any suspected illegal activity of staff to their local police department or appropriate authority as well as the case manager, personal attendant provider agency and/or resource consultant.
- Notify case manager and resource consultant, if applicable, of any changes in their legal representation and/or guardianship and provide copies of the appropriate documentation.
- Utilize non-medical transportation support when available from family, friends, neighbors, and community agencies that can provide transportation.
- Not ask personal attendants to provide services that are excluded by policy or not on their Service Plan.

- Notify their resource consultant (if utilizing the *Personal Options* model) within 24 hours when they terminate an employee.
- If a member is being investigated for or is in the process of being closed by an agency for noncompliance 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 ADW or other HCBS programs, the unsafe environment closure information will be shared with the selected providers.

The ADW Recipient User Guide is available for use when conducting this conversation. It can be found on the ADW website under the forms and policy tab.

501.33 GRIEVANCE PROCESS

Members who are dissatisfied with the services they receive from a provider agency have a right to file a grievance. All ADW agencies will have a written grievance procedure. The UMC RN will explain the grievance procedure to all applicants/people receiving ADW services at the time of initial application/ reevaluation. Applicants/members will be provided with an ADW Grievance form at that time. Service providers will only afford people a grievance procedure for services that fall under the service provider's authority; for example, a case management agency will not conduct a grievance procedure for personal attendant agency activities, nor will a personal attendant agency conduct a grievance procedure for case management agency activities. ADW providers will also not conduct a grievance procedure for ADW contractor activities.

A member may bypass the level one grievance and file a level two grievance with the OA if they choose, especially if the grievance is related to service provision dissatisfaction for a particular ADW provider agency. The grievance process is not utilized to address decisions regarding medical or financial eligibility, a reduction in services or case closure. These issues must be addressed through the Medicaid Fair Hearing process.

The grievance procedure consists of two levels:

- **Level One: ADW Provider**
  - An ADW provider has 10 business days from the date they receive an ADW Grievance Form to hold a meeting, in person or by telephone. The meeting will be conducted by the agency Director or their designee with the member. The agency has five business days from the date of the meeting to respond in writing to the grievance. If the member is dissatisfied with the agency's decision, they may request that the grievance be submitted to the OA for a Level Two review and decision.
- **Level Two: OA**
  - If an ADW provider is not able to address the grievance in a manner satisfactory to the member and the member requests a Level Two review, the OA will, within 10 business days of the receipt of the ADW Grievance form, contact the member and the ADW provider to review the Level One decision. Level Two decisions will be based on Medicaid policy and/or health and safety issues.

501.34 MEDICAL ELIGIBILITY APPEALS

If a member/applicant is determined not to be medically eligible, a written Notice of Decision, a Request for Hearing form and the results of the functional/medical assessment are sent by mail by the UMC to the

member/applicant or their legal representative. A notice is also sent to the member's case manager via the UMC's web-based system.

The termination may be appealed through the Medicaid Fair hearing process if the Request for Hearing form is submitted to the Board of Review within 90 calendar days of receipt of the Notice of Decision.

If the member or legal representative wishes to continue existing services throughout the appeal process, the Request for Hearing form must be submitted to the Board of Review within 13 calendar days of the date on the notice of decision letter. If the Request for Hearing form is not submitted within 13 calendar days of the date of notice of decision letter, reimbursement for all ADW services will cease.
ADW services will cease at close of business on the thirteenth day after the date of the written Notice of Decision letter if the member or their legal guardian does not submit a Request for Hearing form.

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

If the denial of medical eligibility is upheld by the hearing officer, services that were continued during the appeal process must cease on the date of the hearing decision. If the member is eligible financially for Medicaid services without the ADW program, other services may be available. If the termination based on medical eligibility is reversed by the hearing officer, the member's services continue with no interruption. In addition, the West Virginia 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, Member Eligibility, Section 400.1.9, Member Fair Hearings and Appeals* for additional information.

If the member is still determined to not be medically eligible, the case manager will notify the economic service worker of the findings.

Note: Due to the nature of unsafe environment closures, a member would not be eligible for the option to continue existing services during the fair hearing process.

501.35 TRANSFER TO ANOTHER AGENCY OR TO *PERSONAL OPTIONS*

A member may request a transfer to another agency or to *Personal Options* and vice versa at any time. If a member wishes to transfer to a different agency, a Request to Transfer form must be completed and signed by the member or legal representative. In certain situations, a verbal request will be accepted. The form may be obtained from the case manager, personal attendant provider, the new providers, the OA, or other interested parties. Once completed and signed by the member, the form must be uploaded into the

UMC's web portal by the case manager. The member's case manager will coordinate the transfer with the receiving agency, including setting an effective date and entering the transfer into the UMC web portal, with assistance from the OA if necessary.

For case management transfers, the effective date of transfer will be the first date of the next month if the transfer is received by the 17th of the month. At no time should the transfer take more than 45 calendar days from the date that the member's signed, correct, and complete transfer request is received by the case manager, unless there is an extended delay caused by the member in returning necessary documents or if it is a situation in which there is difficulty finding an agency able and willing to serve the member. Services must continue to be provided by the agency currently, assigned to the member until the effective date of the transfer.

Transferring Agency Responsibilities:

- Continue providing services until the effective date of the transfer
- For all transfers, the following documents should be uploaded into the UMC web portal at a minimum of three business days prior to the effective date of transfer:
    - PCSP
    - Case Manager Assessment
    - Personal attendant agency RN Assessment
    - PAL
    - Any other pertinent documentation
    - Service Plan Addendum, if applicable
- Maintain all original documents for monitoring purposes if available.

Receiving Agency Responsibilities:

- If it is a personal attendant agency transfer, the Person-Centered RN Assessment must be scheduled within seven business days and agencies have up to 14 calendar days from the transfer effective date to complete the RN Person-Centered Assessment and Personal Attendant Log (PAL). The RN Person-Centered Assessment for the member transfer may be done over the phone. In addition, updates may be made to the existing Assessment and PAL for the member until the next Annual or Six-month Assessment is due. When a member transfers to another agency, the receiving personal attendant agency cannot bill for an Initial Assessment (billing code T1001, Modifier UD) if one has been completed within the calendar year). They can bill for an RN Assessment (T1002).
- If it is a case management transfer, the Person-Centered Case Management Assessment must be scheduled within seven business days of the transfer effective date and agencies have up to 14 calendar days of the transfer effective date to complete the assessment and Service Plan. The Case Management Person-Centered Assessment for a member transfer may be done over the phone. In addition, updates may be made to the existing Assessment, and a Service Plan Addendum must be completed for the members until the next Annual or Six-month Assessment is due.
- Provide a copy of the newly developed PCSP to the member and/or legal representative, and upload copy into the UMC web portal within seven business days of completion of the document.

The existing PCSP from the transferring agency must continue to be implemented until such a time that the receiving agency can develop and implement a new Person-Centered Plan or Service Plan

Addendum to prevent a gap in services. A provider may not request a transfer for unsafe or non-compliance.

501.35.1 Emergency Transfers to Another Agency or to Personal Options

A request to transfer that is considered an emergency, such as when a member suffers abuse, neglect, exploitation, harm, or a health and welfare risk, including inability to provide services, will be reviewed by the OA, and the case manager will take appropriate action. The case management agency, personal attendant agency, or the *Personal Options* resource consultant must notify the OA to request the emergency transfer and upload supporting documentation into the UMC portal. The case manager will then expedite the request as necessary, coordinating with the members and agencies involved.

501.36 DISCONTINUATION OF SERVICES

The following require a Request for Discontinuation of Services form:

- No personal attendant services have been provided for 180 continuous days – for example, an extended placement in a LTC or rehabilitation facility or incarceration.
- Unsafe Environment – An unsafe environment is one in which the personal attendant and/or other agency staff are threatened or abused, and the staff's welfare is in jeopardy. This may include, but is not limited to, the following circumstances:
    - The member or other household members demonstrate sexually inappropriate behavior; display verbally and/or physically abusive behavior; and/or threaten a personal attendant or other agency staff with guns, knives, or other potentially dangerous weapons, including menacing animals or verbal threats to harm the personal attendant and/or other agency staff.
    - The member or other household members display an abusive use of alcohol and/or drugs and/or illegal activities in the home.
    - The ADW provider agency has been forewarned by a mental health professional/law enforcement of harm or ideations of harm by the member.
    - The physical environment of the member's home is either hazardous or unsafe.
- An unsafe environment may also include where a member can no longer be safely maintained in the community with ADW program services. This may include, but are not limited to the following circumstances:
    - Member requires more than 1:1 personal attendant service.
    - Member requires 24-hour care.
- The provider must follow the steps in the ADW Procedural Guidelines for Non-Compliance and Unsafe Closures. This can be found on the ADW website.
- The member is non-compliant with the Service Plan, the responsibility agreement (if applicable), the program requirements by policy, and the Member Rights and Responsibility Guide.
- The member no longer desires or requires services.
- The applicant/member has received a slot but does not accept the required case management services and/or will not allow a service plan to be developed.

The Request for Discontinuation of Services form and supporting documentation must be uploaded into the UMC's web portal by the case manager and a notification is sent to the OA that it has been uploaded. The OA will review all requests for a discontinuation of services. If it is an appropriate request, and the OA approves the discontinuation, the OA will send notification of discontinuation of services to the

member (or legal representative) with a copy to the case management agency or F/EA. Fair hearing rights will also be provided except if the member (or legal representative) no longer desires services. The effective date for the discontinuation of services is 13 calendar days after the date of the OA notification letter if the member (or legal representative) does not request a hearing.

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

When the OA receives an unsafe closure request, they will review and make a recommendation to BMS based upon the evidence submitted. Documentation to support the unsafe environment should come from multiple sources, if possible, i.e., the personal attendant agency and the case management agency. Agencies will be required to provide adequate supporting documentation to support the discontinuation of services request. If a fair hearing is requested, the agency submitting the discontinuation of services request will be required to attend the fair hearing. Repeated nonparticipation in the fair hearing process may result in requests no longer being approved.

Recommendations include:

- Suspend services for up to 90 calendar days to allow the member time to remedy the situation. The case manager will reassess at 30, 60, and 90 calendar days and make a recommendation to the OA at any time during the 90 days suspension to reinstate services.(If services are suspended, the personal attendant agency can allow a personal attendant to continue to provide essential errands during the suspension i.e. groceries/pharmacy
- Immediate closure.

It is the case management agency's responsibility to monitor the health and safety of the member during any time that services are suspended. In all cases, the member must be provided with their right to a Fair Hearing by the OA. However, due to the nature of unsafe environment closure, the member is not eligible for the option to continue existing services during the fair hearing process.

The following do not require a Request for Discontinuation of Services form but must be reported to the OA and a discharge request in the UMC's web-based portal:

- Death
- Moved out-of-state
- Medically ineligible
- Financially ineligible

501.37 HOW TO OBTAIN INFORMATION

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

GLOSSARY

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

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

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

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

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

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

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

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

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

Common Law Employer: The entity that is viewed by the IRS, United States Customs and Immigration Service, state tax and labor departments as the employer. In the Personal Options FMS model, the member is the common law employer.

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

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

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

work with members. A 70% competency rate is required for all training requirements except for Case Management Certification and West Virginia STP training as these required 80%.

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

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

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

Days: Calendar days unless otherwise specified.

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

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

Dual Services: When a member is receiving Medicaid waiver services and PC services at the same time.

Duplication of services: ADW services are one-to-one staff-to-member ratio services. No single personal attendant can bill for more than one member during a single fifteen-minute period. A personal attendant and direct-care worker from another program cannot bill for the same tasks for the same member (i.e., environmental tasks shared across multiple Medicaid members or funding sources).

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

Electronic Visit Verification (EVV): an electronic monitoring system used to verify a personal attendant for the following: type of service performed, member receiving service, date of service, location of service delivery, individual providing service, time services begin and end.

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

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.

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

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

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

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

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

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

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

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

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

Instrumental Activities of Daily Living (IADL): Skills necessary to live independently, such as abilities used to shop for groceries, handle finances, perform housekeeping tasks, prepare meals, and take medications.

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

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

Legally Responsible Person: A spouse who is legally responsible for providing supports that they are ordinarily obligated to provide.

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

Medical Adult Day Care: Day care centers that are an ambulatory healthcare facility which provides an organized day program of therapeutic, social, and health maintenance and restorative services and whose general goal is to provide an alternative to 24-hour long-term institutional care to elderly or disabled adults who need such services.

Money Follows the Person: The purpose of MFP is to support state Medicaid programs in providing people with long-term care needs a greater choice of where to live and receive needed services and support. Each state MFP initiative consists of two parts: A transition program to identify Medicaid members living in long-term care facilities who wish to live in the community and help them do so; and a rebalancing program through which states make system-wide changes that provide Medicaid members with long-term care systems to enhance home and community-based service options for members. West Virginia's Money Follows the Person program is called Take Me Home, West Virginia.

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

National Provider Identifier (NPI): A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered providers must share their NPI with any entity that may need it for billing purposes.

Nurse: A Registered Nurse (RN), unless otherwise indicated.

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

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

Person-Centered Service Plan (PCSP): The PCSP outlines the services and supports members need to improve their quality of life and achieve their goals. The PCSP details all services the member receives including informal supports. It also includes all needs and risks identified and addresses the members’

goals, home and community-based living arrangements, personal strengths, emergency back-up plan(s) and outcomes.

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

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

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

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

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

Qualified Residence: ADW and the Take Me Home (TMH) Transition Program define a "Qualified Residence" as:

- A home that is owned or leased by a non-family member that is not a paid caregiver.
- A home or an apartment that is owned or leased by the member.
- A member's family's home.
- A home or an apartment that is leased by the member's family.

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

Remediation: the act of correcting an error or fault.

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

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

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

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

Room and Board: Room and board services are defined as provision of food and shelter including private and common living space: linen, bedding, laundering, and laundry supplies, housekeeping duties and common lavatory supplies (hand soap, towels, toilet paper), maintenance and operation of home and grounds including all utility costs.

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

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

Sexual Exploitation: When an individual, whether for financial gain or not, persuades, induces, entices, or coerces an incapacitated adult 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: A social worker is a helping professional that focuses on both the individual and his or her environment. To work in the ADW program, a social worker must hold a regular Social Work License. For more information, please visit the WV Board of Social Work Licensure website.

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

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

Transition Coordinator: An individual with the Take Me Home administrative services who works one-on-one with eligible participants and their Transition Teams to plan and facilitate the transition process.

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

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

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

CHANGE LOG

SECTION	DESCRIPTION	EFFECTIVE DATE
Entire Chapter	Aged and Disabled Waiver (ADW)	December 1, 2015
Entire Chapter	Take Me Home Overview Pre-Transition Case Management Community Transition	January 1, 2019
Entire Chapter	501.4 and 501.5 Addition of Electronic Visit Verification (EVV) as required by 21st Century CURES Act. 501.2 Addition of requirement for Conflict-Free Case Management (CFCM) 501.23 Addition of Personal Emergency Response System service for Traditional and Personal Options members 501.22.1 Addition of modifier to Transportation service code 501.19.1 Addition of modifier to Case Management service code 501.19.2 Removal of Case Management case load limit requirement 501.20.1 Addition of Traditional and Personal Options service codes with UK Personal Attendant 501.27 Addition of limitation on restrictive interventions Entire manual - Changed "person" to "member" throughout manual. 501.19.1 Addition of requirement for case manager to conduct quarterly visits in member's home 501.21 Removal of Personal Options Skilled Nursing services 501.20.2 Addition of member supervision as a billable personal attendant service 501.31 Addition of progressive sanctions for agencies cited for failure to comply with policies	April 1, 2021

	501.2 Clarification of requirements when a certified agency is sold. 501.14 Addition of case manager's responsibility to coordinate development of member's service plan and member transfers to new provider agencies 501.13.2 Addition of requirement for Personal Options members to receive Case Management services 501.32 Addition of member's responsibility to provide a safe environment for workers 501.5.1 Addition of four-year degree in Human Services field as qualification for case manager 501.2 Addition of Conflict-Free Case Management safeguards 501.24 Addition of service limitations and restrictions for Community Transition Services 501.16 Addition of group homes and assisted living homes restriction to service locations	
Entire Chapter	Program Description - Added Environmental Accessibility Adaptations (home and vehicle) and Medical Adult Day Care (will be available June 2023) 501.1 Added Home and Community-Based Settings Requirements 501.2 Moved and clarified the Conflict Free Case Management exceptions process to enrollment. 501.3 Provider Agency Certification Section: Removed: Recent audit indicting six months of payroll dollars available in budget, recent business plan, and providers cannot require personal attendants to sign any type of freedom of choice that limits employment opportunities that would affect member choice of provider agency or worker. Added: Written policy and procedures for reporting Medicaid Fraud to the BMS (OPI and program manager, written policy and procedures for documentation training for case manager and personal attendant that at the minimum must include current program forms and proper documentation and processes for correction procedures 501.3.1 Criminal Background Checks: Added length of time for CIB checks is every five years. 501.3.2 Office Criteria: Clarified records being safely secured in a location freedom from exposure to natural disasters and no waivers for required documents will be granted for damage to member files due to acts of nature, removed contiguous county requirements, allow provider to add and delate counties as needed, if an agency discontinues accepting referrals for a particular county, they can keep existing members if the agency requests. 501.3.3.4 Program Reviews: Changed how employees are selected for reviewing staff associated with member files	May 1, 2023

	selected for provider reviews rather than a 10 percent sample of employees. Added: Failure to respond in writing to draft reports from provider reviews will result in forfeiture of being able to request a documentation/desk review, repayments will begin before or after DDR requests, if ruling in agency favor, agency is paid back 501.3.3.6 Self-Audit: Added reference to General Manual Section 800 501.3.3.7 Program Records: Added required to upload Service Plan Addendum, EAA (home and vehicle) required documentation, Residential Settings rules documentation, and Medical Adult Day Care documentation. 501.5 Electronic Visit Verification: Removed case manager requirement, added 85% compliance, and NPI number requirements. 501.6 Staff Qualifications and training requirements: Added State Transition Plan training requirements, changed competency % to 70% from 75% 501.6.1 Case Management Initial and annual training requirements: Initial: added STP training. Annual: allow testing out of Abuse Neglect and Exploitation and HIPAA 501.6.3 Personal Attendant Qualification: Added: Certified Nursing Assistant Certification as trained PA only requiring CPR, First Aid and CIB before employment 501.6.4 Personal Attendant Training Requirements: Added STP for initial. Annual: Allow testing out of ANE and HIPAA 501.6.4 Personal Attendant Annual Training: Allow agencies to accept existing certifications from other agencies if within one year and not expired, encourage agencies to distribute CPR cards 501.6.7 RN Training Requirements: Initial: Added Abuse Neglect and Exploitation, HIPAA Annual: Added Person Centered Planning/Service Plan Development, and can test out of ANE and HIPAA 501.6.8 Training Documentation: ADW provider agencies can use the approved ADW form to document training or copies of certificates for monitoring purposes. 501.6.8 CPR/FA Documentation: Added: Cards belong to worker and encouraged agency provide worker with a copy 501.6.10 Added EAA Vendor Qualifications for home and vehicle 501.6.11 Added Adult Medical Day Care Qualifications for provider agencies. OA will monitor Residential Settings Rule	

	501.7 Incident Management: Removed requirement for person investigating incidents to be a licensed professional since we now allow Human Services Degrees and certified credentials. Updated reporting to APS guidelines as agencies needs to call and report along with also submitting report. Better defined serious physical abuse Added death of a member and any unplanned visit to an ER, health facility, or admission to a hospital as a critical incident 501.11 Financial Eligibility: Returning to FE first then ME, DHS2 forms going directly from UMC to DoHS and DoHS to UMC. UMC mailing out LTC Applications to applicants 501.12.2.3 Initial Medical Evaluation: DHS2 forms will be sent directly to DoHS from UMC and DoHS will return DHS2 forms directly to UMC 501.12.2.5 Medical Re-evaluation: MNER will just be updated in UMC portal and will no longer require a new MNER with a physician signature 501.12.2.5 Added section with clarification for Service Level decreases, increases, and changes. 501.13 Enrollment: Added how to apply for an exception if necessary for a conflicted relationship with an agency due to no agency within a 25-mile radius of the member 501.14.1 Traditional Service Option, Traditional model: Added EAA (home and vehicle) and Adult Medical Day Care 501.15 Person Centered Assessment: Provided clarification of the 7 – 14-day requirements, added Anchor Date to be used as the annual date to keep consistency with dates, SP planning can happen up to 45 days prior to Anchor date, added Service Plan Addendum as way to update SP and reflect any needed changes, all agencies are responsible for uploading their own documents into the UMC portal 501.16.1 Annual and Six-Month Service Plan Development: Added annual assessment will be completed up to 45 days prior to Anchor Date 501.16.1 Service Plan Addendum: Expanded and encouraged use of this document for changes in the service prior to annual and six-month reviews 501.17 Assisted Living Residences, Group Residential facilities, and provider owned settings: Added that provider owned settings are not an approved setting 501.21.3 Case Management Responsibilities: Simplified/clarified case management actions to be taken if they are not able to reach a member, removed complete and submit annual MNER 501.19.4 (prior manual section) Case Management Reporting: Removed this as it is no longer being done	

	501.22.1 Personal Attendant Services: Added NPI requirement 501.22.2 Essential Errands: Added laundry 501.22.2 Community Activities: Added visiting family members/friend in a long-term care facility or hospital or visiting a cemetery are not community activities reimbursable by Medicaid 501.23 Skilled Nursing: Revised definition as old definition indicates actual nursing is allowable in the program, it is not 501.23.1 Skilled Nursing Annual Assessment: Added Anchor Date and up to 45 days planning for annual assessment 501.23.2 Skilled Nursing Services: Added Anchor Date and up to 45 days planning for annual assessment, must upload documents into UMC portal 501.25 PERS: Personal attendant agency required to do any IMS reports for calls made by member, if member transfers, they need to use PERS vendor of the personal attendant agency that is providing personal attendant services 501.26 Added EAA section for home and vehicle that defines the service, explains the process, fees, and the limitations associated with the service 501.27 Added Adult Medical Day Care section that defines the service, explains the process and fees (effective June 2023) 501.28.2 Community Transition Services: Added to limitations PERS, Equipment, Specialized Medical supplies, and transportation 501.29 Payments and Payment limitations: Moved into this section areas that reimbursement for ADW cannot be made 501.30.1 Dual Service Requests for ADW and Personal Care (PC) Services: Provided clarification for this and removed need for all providers to initially meet to get the PC services started, discussed ability to use service plan addendum 501.30.1 Dual Service Requests for ADW and Personal Care (PC) Services: Provided clarification for this and removed need for all providers to initially meet to get the PC services started, discussed ability to use service plan addendum 501.30.2 Dual Provision of ADW and Home Health Agency Services: Discussed ability to use Service Plan Addendum 501.31 Voluntary Agency closure: Added it is the agency's responsibility to maintain and/or destroy all agency records according to BMS common chapters 501.32 Involuntary Agency Closures: Added it is the agency responsibility to maintain and/or destroy all agency records according to BMS common chapters 501.34 Member Rights and Responsibilities: Requiring the case manager review the Rights and Responsibilities document and obtain signature from member for member file	

	Glossary Definitions: Added new services definitions and clarified existing definitions	
Entire Chapter	Program Description -Added Pest Eradication Moved TMH Transition Program Overview to TMH Services section 501.1 HCBS Settings requirements – Removed background activities per CMS recommendation in application, added UMC as the BMS representative 501.3 Provider Agency Certification – relocated CFCM exceptions process to this section. 501.3.3.3 Initial/Continuing Certification of Provider Agency – Added if applying agency is already identified HCBS/PC/LBHC provider, they will be approved. 501.3.3.4 Provider Quality Review – Removed punitive actions and changed it to an on-site visit will be made. 501.3.3.7 Record Requirements – provided additional clarification of definition of original document 501.6 Staff Qualification and Training Requirements section relocated to section 501.16 covered services in the back of the manual under Covered Services. Added pest eradication 501.6.1 Reporting Requirements – Added agencies must add and delete staff as needed in the IMS system. 501.11.1.1.6 Results of initial medical evaluation clarification were added to the process 501.12 Enrollment – provided better clarification 501.12.1 Traditional Services added Pest Eradication 501.12.2 Participant Directed Service Option, Personal Option model added listing of available services to include new Pest eradication 501.13 Person Centered Assessment added timelines for sharing member information between personal attendant agency, case management agency and F/EA and removed requirement for case management agency and personal attendant agency RN to attend meeting together. 501.14 Person-Centered Service Plan Development – removed requirement for case management agency, personal attendant agency RN to attend meeting together. 501.14.1 Annual and Six- Month Service Plan Development the ADW Person Centered Assessment Chart is referred to and provided in documents grid on BMS website, removed requirement for case management agency and personal attendant agency RN to attend meeting together. Initiation of Personal Attendant Services – relocated this section to 501.17 Personal Attendant Services section. 501.16 Covered Services section added, and each service has all information together under one section within the service listed.	March 1, 2024

	501.17.1 Personal Attendant Qualifications, added LPN as allowed qualifications for personal attendant, under personal attendant annual training decreased the four additional hours of training to two 501.18 Skilled Nursing Annual Assessment/Nursing Services updated definition to indicate the service to be assessing, managing, observing, and evaluating care not providing it. 501.20 EAA Home and Vehicle, removed business license and qualified, removed verifying business license and qualified, under codes and documentation added application and OA review to the process of requesting services 501.21 Adult Medical Day Care under qualifications added OA will certify and monitor HCBS settings rule 501.22 Added the service of Pest Eradication 501.23 Moved TMH Transition Overview to TMH services sections 501.24 Billing Procedures removed billing must take place on the last date in the service range 501.26 Service Limitations and Service Exclusions provided additional clarification, under restrictive interventions made language consistent and removed OA monitoring staff references. 501.26.1 Dual Service Request for ADW and PC Services clarification and timelines were provided 501.27 Voluntary Agency Closure removed requirement to submit final continuing certification to reconcile outstanding corrective action plans 501.28 Involuntary Agency Closure removed requirement to submit final continuing certification to reconcile outstanding corrective action plans 501.33 Transfer to Another Agency or to *Personal Options* had clarification and timeless added under receiving agency 501.34 Discontinuation of Services additional unsafe environment definition with examples was provided with explanation of documentation and attendance to requested Fair Hearing process if applicable Glossary added definition of NPI number, removed Felony and Misdemeanor as they no longer appear in this policy	
Entire Chapter	501.1 Home and Community Based Settings Requirements included provider owned settings 501.1 Home and Community Based Settings Requirements updated verbiage on notification when a provider-owned/controlled setting no longer meets the standards of the Settings Rule 501.1 Home and Community Based Settings Requirements updated verbiage on transition of members protocol when a setting no longer meets the standards of the Integrated Settings Rule	June 1, 2026

	501.3 Provider Agency Certification added the Conflict-of-Interest Assurance form must be signed initially in addition to annually and agencies must have an internal policy related to conflict of interest, removed provider agency/personal attendant from geographical, cultural, linguistic exceptions requirements 501.3.3.4 Provider Quality Reviews removed section on Agency Continuing Certification Reviews and updated Quality Review language 501.6.1 Reporting Requirements, Incident Management Documentation, and Investigation Procedures added details on using a prevention plan in the event of a substantiated critical incident and clarified the process for submitting A Notification of Death form 501.11 Medical Eligibility removed details on PAS types 501.11.1.4 Initial Medical Evaluation changed Nurse Practitioner to Advanced Practice Registered Nurse 501.11.1.5 Results of Initial Medical Evaluation clarified that the UMC should receive the DHS-2 within 60 calendar days 501.11.1.6 Medical Re-Evaluation clarified that the MNER is to be submitted electronically within the UMC portal 501.12 Enrollment clarified language on agencies meeting with the member 501.15 PCSP Development added that all participants at the Service Plan meeting must sign the Service Plan, clarified that either a Service Plan Addendum or an update to the Service Plan can be made when a member has a change of needs 501.16 Assisted Living Residences, Group Residential Facilities, and Provider-Owned Settings removed language pertaining to provider owned/leased settings, added reference to Section 501.1 of this Chapter 501.17.3 Case Manager Initial and Annual Training Requirements updated case management certification course numbers 501.17.4 Case Management Responsibilities removed the West Virginia Personal Care Dual Services Request form from documents required to be uploaded 501.18 Personal Attendant Service added awake and alert provision for staff 501.18 Personal Attendant Services added clarity on the circumstances in which more than one personal attendant agency can be requested 501.18.1 Personal Attendant Qualifications added awake and alert provision for staff 501.18.1 Personal Attendant Qualifications removed parent of a minor child from the category of legally responsible persons	

	501.18.1 Personal Attendant Qualifications updated document requirements for personal attendant qualifications 501.18.2 Personal Attendant Initial and Annual Training Requirements specified those able to provide training and updated training requirements 501.18.3 Personal Attendant Responsibilities clarified community activity language 501.19.3 Registered Nurse Initial and Annual Training Requirements specified that the RN or the case manager can sign with Service Level Request Form 501.22 Environmental Accessibility Adaptations (Home and Vehicle) Services added that if additional funding is needed (above the $1,000 per member, per service year), the member will be responsible for determining an additional funding source and arrange payment for the balance 501.24 Pest Eradication updated qualifications and procedure for receiving pest eradication services 501.26 Added guidelines for rounding of units when billing for services. 501.28 Service Limitations and Service Exclusions added requirement that ADW members cannot be the documented unpaid caregivers for another program participant or family member during service plan time 501.31 Additional Sanctions updated the order of potential sanctions Glossary removed parent of a minor child from the category of legally responsible persons, defined common law employer, defined nurse, defined Person-Centered Service Planning	