

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Alignment of the CSEDW service units with Mental Health Parity requirements by updating all program service limits to soft limits.

Waiver capacity increase- 250 slot starting year 2 and adding every other year

Permanent allowance for telehealth as an allowable service modality for select services and defined percent of total service units

Expanded language around MCO requirements to help ensure an adequate and robust provider network

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The State of West Virginia requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (optional - this title will be used to locate this waiver in the finder):

Children with Serious Emotional Disorder

C. Type of Request: renewal

Requested Approval Period: (For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

3 years 5 years

Waiver Number: WV.1646.R01.00

Draft ID: WV.021.01.00

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)

02/01/23

Approved Effective Date: 02/01/23

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**Nursing Facility**

Select applicable level of care

Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

The CSEDW program operates concurrently with the specialized managed care waiver (1915(b)) for children and youth who are in foster care. All youth who are eligible for the CSEDW program will be placed into the specialized managed care for children and youth MCO regardless of whether or not they are in foster care as the CSEDW program does not limit eligibility to children in foster care. The 1915(b) specialized managed care for children and youth waiver application was approved by CMS concurrently with this 1915 (c) waiver.

Specify the §1915(b) authorities under which this program operates (check each that applies):

§1915(b)(1) (mandated enrollment to managed care)

§1915(b)(2) (central broker)

§1915(b)(3) (employ cost savings to furnish additional services)

§1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

West Virginia amended its section 1115 SUD Demonstration (Project Number II-W-0028516) in order to create a lock-in period requiring continuous enrollment into a single specialized managed care organization (MCO) for beneficiaries in 1915(c) Waiver, WV-1646.R00.01, "Children with Serious Emotional Disorders," (CSEDW). Continuous enrollment in the specialized MCO will enable delivery of specialized and coordinated care to CSEDW members in the most seamless and cost-effective way possible. The 1115 amendment provides the authority to automatically enroll CSEDW beneficiaries on a mandatory basis into the single specialized MCO, authorized pursuant 1915(b) Waiver WV-06, and does not provide a right to disenroll and still maintain CSEDW benefits. Further, children eligible through the CSEDW will not have the option to disenroll into FFS.

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Children with Serious Emotional Disorder Waiver (CSEDW) is a Medicaid HCBS Waiver program authorized under §1915(c) of the Social Security Act. The CSEDW provides services that are additions to Medicaid State Plan coverage for CSED who are enrolled in the CSEDW program, from age 3 up to the youth's 21st birthday. The CSEDW permits WV to provide an array of HCBS that enables children who would otherwise require institutionalization to remain in their homes and communities. In addition, it is anticipated that this waiver will reduce the number of children housed both in-state and out-of-state in Psychiatric Residential Treatment Facilities (PRTFs) and shorten the lengths of stay for children who require acute care.

WV defines the term "children with a serious emotional disorder" (CSED) as children with an SED who are age 3 to age 21 and who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM) (or International Classification of Disease (ICD) equivalent) that is current at the date of evaluation that results in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, and/or community activities.

The Bureau for Medical Services (BMS), within the WV Department of Health and Human Resources (DHHR), is the single state agency responsible for statewide administration of the Title XIX Medicaid Program. BMS operates the CSEDW in conjunction with the specialized managed care program for children and youth (1915(b) waiver). As appropriate, Medicaid members receiving services under the CSEDW may receive any of the Medicaid State Plan services and waiver services identified in Appendix C of this §1915(c) HCBS Waiver application. Members enrolled in the CSEDW may not be enrolled simultaneously in another WV §1915(c) waiver. Members are permitted to receive services on the CSEDW while on a waitlist for another 1915(c) waiver.

WV Medicaid authority under the direction of the WV DHHR will contract with an Administrative Service Organization (ASO) and psychological practice as the Medical Eligibility Contracted Agent (MECA) to address program eligibility and enrollment. Medicaid managed care entities will be responsible for utilization management. The WV Medicaid Management Information System (WVMMS) contractor will be responsible for enrollment of providers who then must contract with the Managed Care Organization (MCO) to be providers for the CSEDW.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

Yes. This waiver provides participant direction opportunities. Appendix E is required.

No. This waiver does not provide participant direction opportunities. Appendix E is not required.

- F. Participant Rights.** Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

Not Applicable

No

Yes

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (*select one*):

No

Yes

If yes, specify the waiver of statewideness that is requested (*check each that applies*):

Geographic Limitation. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make *participant-direction of services* as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state. *Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in Appendix C, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in Appendix C are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source,

including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

This application was placed out for 30-day public comment on August 22, 2022, and was available to the public through September 26, 2022, BMS announced the public comment period from August 23, 2022, to September 23, 2022, and the notice was placed on the DHHR Public Notice page and the WVDHHR Facebook page and Twitter feed. A flyer was sent to the MCO to be shared by the care coordinators with providers, members, and families. BMS also announced the public comment period at the August and September CSED Policy Clarification calls facilitated by Kepro, and the August and September WV Wraparound Provider Check-in call facilitated by Marshall University.

All comment received any BMS' responses are available for the public review:
<https://dhhr.wv.gov/bms/CMS/Pages/default.aspx>

- J. Notice to Tribal Governments.** The state assures that it has notified in writing all federally-recognized Tribal

Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Hill

First Name:

Randall

Title:

HCBS Director

Agency:

Bureau for Medical Services WVDHHR

Address:

350 Capitol Street, Room 251

Address 2:

City:

Charleston

State:

West Virginia

Zip:

25301

Phone:

(304) 558-1700

Ext:

TTY

Fax:

(304) 558-4398

E-mail:

randall.k.hill@wv.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

West Virginia

Zip:

Phone:

Ext:

TTY

Fax:

E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

	Bureau of Medical Service		
Address:	350 capital street		
Address 2:	suite 251		
City:	Charleston		
State:	West Virginia		
Zip:	25301		
Phone:	(304) 558-1700	Ext:	TTY
Fax:	(304) 558-4398		
E-mail:	cynthia.e.beane@wv.gov		
Attachments			

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

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Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCBS Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Section Main 8.b: Additional information for CMS Appendix A. Waiver Administration and Operation has been added to this section due to the limited character count availability in Appendix A under Responsibility.

In order to enhance its critical Incident Management System, has developed a CSED HCBS Waiver Incident reporting Guide (IRG); The CSED IRG outlines the activities that WV is undertaking to enhance reporting and monitoring of critical incidents. The IRG's information is referenced in this application and will be available as a separate document. In addition to the IRG, the MCO provides training about the incident reporting policy and process at the required HCBS provider onboarding training as well as monthly refresher trainings.

Additional information for Appendix F-3 has been added to this section due to the limited the character count available in that section.

Additional information for public input was added to this section due to the limited character count in the public comment section of this application.

Family Therapy can be provided for up to two 50-minute sessions per day; one for individual therapy and one for family therapy. Family Therapy consists of counseling and training services for the member and family provided by a licensed mental health professional (with a master's degree or a licensed individual under supervision). This service includes trauma-informed individual and family therapy in the family home and should assist the family to acquire the knowledge and skills necessary to understand and address the specific needs of the member in relation to their SED and treatment, such as developing and enhancing the family's problem-solving skills, coping mechanisms, and strategies for the member's symptom/behavior management.

The Waiver provides for In-Home Family Support for up to two hours per day, based on recommendations from the family therapist. In-Home Family Support services allow the member and family to practice and implement the coping strategies introduced by the in-home therapist. The family support worker works with the member and family on the practical application of the skills and interventions that will allow the member and family to function more effectively. The family support worker assists the family therapist by helping with parent/child communicate their concerns; providing feedback to the therapist about observable family dynamics; helping the family and youth implement changes discussed in the family therapy and/or parenting classes; providing education to the parent/legal representative regarding their child's mental illness; coaching, supporting, and encouraging new parenting techniques; helping parents/legal representatives learn new parenting skills specific to meet the needs of their child; participating in family activities and supports parents/legal representatives in applying specific and on-the-spot parenting methods in order to change family dynamics.

Mobile Response services are available 24 hours a day, 7 days a week to respond immediately to issues that threaten the stability of the member's placement and their ability to function in the community. This service is intended to be of very short duration and primarily to engage/link to other services and resources, e.g., intensive in-home support and services. This service may only be delivered in an individual, one-to-one session. Mobile response includes: de-escalation issue resolution support, and the development of a stabilization plan for any additional services that are needed to resolve the immediate situation. The Case Manager will remain the primary contact for the CSEDW, however the agency providing the Family Therapy will implement and oversee all Mobile Response activities; including primary point of contact for the service, on-call coverage, staff training and credentialing, referral, and data reporting. Family Therapy providers will implement and oversee all Mobile Response activities, including primary point of contact for the service, on-call coverage, staff training and credentialing, referral, and data reporting.

In addition to the information above, one of the public comments focused on workforce issues identified in WV in which WV wanted to provide clarification regarding what steps have been taken and are being taken in an attempt to bolster workforce. There is an existing network of treatment and support providers who are able to provide the waiver services immediately as this waiver functions a lot like the existing wraparound program where children and families with Serious Emotional Disorder are provided wraparound services in their homes and local communities. WV has attempted to mirror this wraparound program as much as possible with the development of this waiver and as such, this waiver will tap into the already existing network of providers to ensure service delivery. An evolution of the provider network is also expected to occur with the implementation and ongoing availability of the waiver; as this growth and development occurs as will efficiency for the overall waiver programming. The MCO is also obligated to uphold network adequacy standards regarding this waiver as a requirement in their contract.

To further provide information, there are currently 103 Licensed Behavioral Health Centers (LBHCs) enrolled as Medicaid Providers across WV. As a part of the MCO contract, the MCO is responsible for enrolling and credentialing the providers participating in the CSEDW program. As such, the MCO will establish standards for providers to participate in their network. It is important to note that the MCO standards must meet or exceed those for traditional Medicaid fee-for-service providers. BMS retains a vendor to oversee the MCO network adequacy by completing regular network adequacy assessments and monitoring

the contractual obligations of the MCO's performance. To ensure this is completed, the MCO must submit annual network materials to BMS for review and approval. These documents are compared against the State fiscal agent's (FA) records to determine if the provider has enrolled with them first, as required per the CMS managed care regulation. BMS also defines within its contract the specific number of providers that must be contracted within each specialty. Given that CSEDW services are new, the State will review access more rigorously for the first year of the program to make sure services are able to be accessed timely and can survey CSEDW enrollees to determine if their needs are being met. If not, the State will require additional resources be contracted with, assuming providers are available. Failure to maintain an adequate network, or allow members to see providers out of network, will result in sanctions.

As an additional attempt to bolster workforce related to this waiver, rates for both Family Therapy and In-Home Family Supports were raised specifically for this waiver. It is also important to note that direct care rate increases have been approved to take effect for this Waiver in July 2020. In an attempt to bolster workforce related to the Therapy service, our sister bureau, the Bureau for Behavioral Health (BBH) is assisting with addressing workforce development needs through Federal State Opioid Response (SOR) funding by providing scholarship opportunities for those entering the behavioral healthcare field along with an agreement that the individual will work in the area of Opioid Use Disorder/Medication Assisted Treatment for a certain length of time. The Bureau for Public Health (BPH) is providing a Parent and Family Network Specialist education and training curriculum to develop Peer Parent/Family Support Specialists for children with special healthcare needs, which will assist with the growth of available providers for the Peer Parent service provided in this waiver. The BSS is also in the process of renewing its Title IV-E waiver (referred to Safe at Home) which will continue to build and expand on the existing wraparound workforce discussed above.

In terms of network adequacy and the MCO, BMS continues to actively work with Bureau (BBH and BSS) partners to engage providers interested in becoming CSEDW providers as well as the MCO. The MCO will ensure network adequacy per their contract as indicated above and BMS will work with the MCO to improve areas with limited providers. BMS will require the MCO to perform outreach as part of ensuring network adequacy along with reporting data on the network. This is a collaborative process and is ongoing between BMS and the MCO. BMS will work with the MCO as necessary to enhance and expand the CSEDW provider network.

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

The waiver is operated by the state Medicaid agency.

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

The Medical Assistance Unit.

Specify the unit name:

Bureau for Medical Services

(Do not complete item A-2)

Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency

agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (*Complete item A-2-b*).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

MCO: Responsible for managing;

- Manage Medicaid MCO member enrollment, execution and maintenance of Medicaid CSEDW provider agreements,
- Management of the CSEDW provider network (including contracting, training, technical assistance, and maintenance of accurate provider list),
- Educating external entities about the CSEDW as a resource for children with SED and an alternative to institutionalization if selected by the member and family,
- managing prior authorization and service utilization for the CSEDW program,
- The MCO will manage prior authorizations and service utilization for the CSEDW program.
- The MCO will ensure related service authorizations are in accordance with the POC.
- Assist with utilization management by reviewing the POC to ensure that all assessed needs are met and that the POC complies with federal requirements
- The MCO Care Manager will contact the child/family periodically to monitor the implementation of the POC, Care Coordination (differs from the CSEDW Wraparound services) of enrolled CSEDW members
- Help ensure the development and execution of the CSEDW members' Plan of Care (POC) in alignment with state and federal Person-Centered Planning and HCBS requirements,
- Concurrent reviews of all enrolled members to help ensure the members developed POC addresses all identified goals and needs,
- Periodic review of the members claims history to ensure they are receiving all services outlined and can monitor and address barriers as they develop, with services being received and quality assurance and quality improvement activities, including incident management collection and reporting.

MECA: Responsible for;

- Determining eligibility for all applicants,
- Determining both initial and annual redetermination of waiver participant eligibility,
- The MECA is responsible for oversight and management of the Independent Evaluator Network (IEN),
- Assisting with recruiting and training new independent evaluators for the CSEDW,
- Monitoring the IEN to assess Statewide coverage and availability of independent evaluators,
- Monitor the assignment of requests for CSEDW evaluations to help ensure equitable distribution,
- Help ensure that members and families have an active role in the selection process of appointments for evaluation, including; date, time and modality.

ASO: Responsible for;

- Processing CSEDW applications to determine initial eligibility,
- Conducting and coordinating initial level-of-care evaluations and other requirements to complete or maintain CSEDW enrollment, and reapplication processes,
- Assisting members and families with application and maintenance of WV Medicaid,
- Conducting on-site HCBS and Wraparound Facilitator provider reviews (clinical service reviews of the member POC, staff credentialing and education reviews, program documentation reviews),
- Collecting and aggregating ad hoc reports,
- Compiling the CSEDW D&R report monthly and review program compliance with BMS,
- Compiling the monthly D&R into a quarterly report for review by the CSEDW Quality Improvement and Advisory (QIA) Council.

No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The WVDHHR BMS is responsible for assessing the performance of contracted entities with delegated Waiver operations and administrative functions. The BMS CSEDW Program Manager will manage contracts with the Managed Care Organization (MCO), Administrative Service Organization (ASO), and Medical Eligibility Contracted Agent (MECA).

The WVDHHR has an ongoing contract with the MCO. The MCO will provide assistance and services as stated in the current contract; this includes claims processing and reporting to WV's Fiscal Agent. Note: The Fiscal Agent will not act as WV's claims processing vendor for this waiver; it will serve as a repository for MCO claims data. The WVDHHR will be responsible for updating the MCO contract to align with CSEDW. The MCO is also responsible for development and distribution of the CSEDW Program Member Handbook and a reference guide to individuals accepted onto the program to assist the individual making a decision regarding which providers they want to receive services from. In addition to the information above, the MCO is responsible for the management and oversight of the Incident Management System.

The EQRO vendor for the State will conduct annual, on-site reviews of the MCO to determine if they are meeting performance requirements; these can be conducted more frequently if deemed necessary by BMS. State staff participate in these reviews and Corrective Action Plans (CAP) are put in place in the event an MCO is not meeting expectations around performance improvement. In the event the MCO fails to meet requirements of the CAP, financial penalties are issued against the MCO. The BMS Program Oversight vendor, Lewin, also conducts reviews of documentation submitted by the MCO to determine compliance with contractual requirements.

The EQRO vendor will serve as the ASO for the CSEDW program. The vendor's responsibilities will include some initial eligibility assessment, tracking eligibility, tracking participant waiting list (as applicable), and verifying and tracking provider training through initial and annual provider reviews. The vendor will also provide training and technical assistance to providers enrolled in the CSEDW program and will be responsible for completing the annual member revaluation. As a part of the program's quality assurance activities, the ASO will report on performance measures as identified in the approved application. Additionally, they will conduct health and safety follow-up with providers as necessary to ensure the continued health and safety of the individuals enrolled in the program. ASO will also facilitate the meetings of the quarterly Quality Improvement Advisory Council meetings with the Bureau for Medical Services.

The MECA will provide eligibility criteria assistance, provide assistance with training of the Independent Evaluator Network (IEN), recruit Evaluators for the IEN, develop standards and report to the EQRO vendor, review assessment reports for eligibility, monitor and track application timelines, make eligibility determinations/redeterminations, attend eligibility hearings, provide continued training to the IEN, and will remain actively involved in the evaluation process.

Appendix A: Waiver Administration and Operation

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

BMS conducts monthly contractual oversight meetings with the MCO, ASO, MECA, and WV DHHR's Office of Health Facility Licensure and Certification (OHFLAC). During these monthly meetings, performance for each contractor is reviewed and any issues/concerns are identified and addressed.

The quality management data collected through discovery methods are compiled using the Discovery and Remediation Report (D&R) template and reviewed at least monthly by BMS at its contract meetings. The D&R is also compiled and reviewed quarterly by the Quality Improvement Advisory (QIA) Council. A comprehensive report summarizing the findings of provider reviews is compiled at the end of each review cycle, reviewed and analyzed by Waiver staff and presented to the QIA Council for its review and analysis.

Reports:

BMS management staff will receive and review the following contract reports:

1. ASO's monthly D&R report on delegated functions, ad hoc reports, and audits as requested.
2. Claims Processing Vendor (MCO) monthly D&R report on delegated functions and routine reports on claims data and ad hoc reports as requested.
3. MECA Vendor Monthly Discovery and Remediation Report on delegated functions and ad hoc reports as requested.
4. Reports from OHFLAC on licensure reviews, investigations and monthly Discovery and Remediation report on delegated functions.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment		
Waiver enrollment managed against approved limits		
Waiver expenditures managed against approved levels		
Level of care evaluation		
Review of Participant service plans		
Prior authorization of waiver services		
Utilization management		
Qualified provider enrollment		
Execution of Medicaid provider agreements		
Establishment of a statewide rate methodology		
Rules, policies, procedures and information development governing the waiver program		
Quality assurance and quality improvement activities		

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

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.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

A-ai-2: Number of written grievances/complaints resolved by the MCO within established timelines. Numerator- Number of written grievances/complaints resolved by the MCO within established timelines. Denominator- Number of written grievances/complaints submitted to the MCO.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="MCO"/>	Annually	Stratified Describe Group: <input type="text"/>

	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; padding: 2px;">ASO</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

Performance Measure:

**A-ai-6: Number of authorizations granted. Numerator - Number of authorizations granted.
Denominator - Number of authorizations requested.**

Data Source (Select one):**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="MCO"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="MCO"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

Performance Measure:

A-ai-5: Number of service level appeals resolved following approved processes. Numerator - Number of service level appeals resolved. Denominator - Number of appeals resolved.

Data Source (Select one):**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="MCO, ASO"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>MCO, ASO</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

A-ai-1: Number of requests for prior authorizations that the MCO responded to within established timelines. Numerator- Number of requests for prior authorization responded to by the MCO within established timelines. **Denominator-** Number of requests for prior authorization.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div></div>
Other Specify: <div>MCO</div>	Annually	Stratified Describe Group: <div></div>

	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px;">MCO</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

A-ai-4: Number of required monthly reports provided by the contracted entities to BMS by the due date. Numerator- The number of required monthly reports provided to BMS by the due date. Denominator- The number of required monthly reports.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="ASO, MCO and MECA"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="ASO"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

Performance Measure:**A-ai-7 Number of authorizations denied. Numerator - Number of authorizations approved.****Denominator - Number of authorizations requested.****Data Source** (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="MCO"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

A-ai-3: Number of member satisfaction surveys pertaining to MCO functions rated 80% or higher. Numerator- Number of member satisfaction surveys pertaining to MCO functions rated 80% or higher. Denominator- Number of member satisfaction surveys submitted.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify:	Annually	Stratified Describe Group:

MCO		
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: ASO	Annually
	Continuously and Ongoing
	Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

--

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The ASO, MCO, OHFLAC and MECA are required to submit a number of regular reports to the BMS. BMS utilizes these reports to monitor delegated administrative functions. Any issues or concerns that are identified via these reports are addressed directly with individual contractors during monthly contract oversight meetings. Strategies to remedy specific identified issues are developed with the contractors and monitored through these meetings. Documentation is maintained with contract meeting minutes.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>ASO, MCO, MECA, OHFLAC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

- a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age		Maximum Age			
					Maximum Age Limit		No Maximum Age Limit	
Aged or Disabled, or Both - General								
		Aged						

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Disabled (Physical)			
		Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Intellectual Disability			
Mental Illness					
		Mental Illness	18	21	
		Serious Emotional Disturbance	3	17	

b. Additional Criteria. The state further specifies its target group(s) as follows:

In order to be eligible to receive CSEDW program services, an applicant must meet the following eligibility criteria:

The applicant must be a WV resident, between the ages of 3 up to age 21, meet medical eligibility, and meet financial eligibility. Applicants must choose HCBS over those provided in an institution.

Medical eligibility criteria is defined as having 1) an overall Child and Adolescent Functional Assessment Scale (CAFAS) / Preschool and Early Childhood Functional Assessment Scale (PECFAS) score of 90 or higher and 2) currently or at any time during the past year (12 months) having had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most current edition of the DSM. These disorders include any mental disorders listed in the DSM with the exception of "V" codes, substance use, and developmental disorders, which are excluded unless they co-occur with another diagnosable serious emotional disorder (SED). A potentially eligible diagnosis is confirmed by the Behavior Assessment System for Children (BASC) scores of 60 and above on at least two clinical scales.

Additionally, this Waiver prioritizes children/youth with SED who are in Psychiatric Residential Treatment Facilities (PRTFs) or other residential treatment providers out-of-state, and those who are in such facilities in-state. Then, Medicaid-eligible Children with SED who are at risk of institutionalization are the target group.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Youth enrolled in the CSEDW might have additional health needs in the future, this requires planning on the part of Child and Family Team (CFT). The waiver's purpose is to establish connections to community-based services and supports, to develop coping skills, and to improve mental health functioning across life domain areas, and to decrease the need for psychiatric or other mental health institutional placement in the future.

When youth are enrolled in the CSEDW, the Wraparound Facilitator assists the CFT with developing measurable outcomes that guide the member toward transition or graduation from CSEDW services. As stated above, this does not always mean that the individual no longer needs any type of mental health services; rather, the individual typically needs less- intensive services after receiving waiver services and graduating the program. The Wraparound Facilitator should also work with the child/youth to transition to other service programs if they better fit the member and family's long-term needs.

As a youth approaches their 15th birthday, the CFT focuses on planning for this period of transition toward adulthood. Many things must be considered during this time. Some basic issues to address include housing, employment, vocational training or school status, emotional/behavioral health, physical health, and safety. During this time, it is common to focus on the life domain areas that will impact the youth's success as an adult. The Wraparound Facilitator will focus on identifying and improving necessary skills needed for adulthood using Medicaid State Plan and waiver services. The Wraparound Facilitator will also helping the youth and family identify and understand what services might be useful post-Waiver. If the youth's disability impacts their ability to earn income, the Wraparound Facilitator will work with the youth to apply for Supplemental Security Income (SSI) benefits at age 18. The Wraparound Facilitator will also work with the youth to identify other entitlements that would assist the youth post- Waiver. This is also the time during which the team will explore what mental health needs the youth may have after their 21st birthday and start that transition process with adult services. Whenever possible, the adult services staff are encouraged to become part of the CFT to assure a smooth transition to adult services.

When youth are enrolled in the Waiver, transition planning starts at referral and continues until the youth successfully transitions. Transitions are different for each individual, but the CFT assumes the responsibility for meeting the youth's needs post-Waiver.

The oversight process includes review of all plans, including transition plans. This process identifies individual and systems issues, including those related to transition planning. Transition planning for youth enrolled in the Waiver is part of the plan of service and is individualized for each youth. Some older youth may receive services from adult mental health services or they may receive services from other systems (vocational, housing, etc.) this is part of the transition planning that occurs. This planning will assist the youth/young adults in making a smooth transition to adult mental health or community-based services to maximize their success remaining in the community.

For individuals who transition out of the CSEDW program, they will have the ability to apply for evaluation for other Waivers offered by WV if they wish to pursue application and evaluation. The ASO that manages the application process for CSEDW is also responsible for the application process for all other BMS waiver programs. An applicant will not be evaluated for other waivers during the CSEDW eligibility process, however a referral for an alternate waiver program would be made if deemed more appropriate for the individual. Additionally, applicants who are not eligible or not interested in CSEDW enrollment will be issued information on alternative behavioral health services available to them.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is *(select one)*

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is *(select one)*:

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	<div>2000</div>
Year 2	<div>2250</div>
Year 3	<div>2250</div>
Year 4	<div>2500</div>

Waiver Year	Unduplicated Number of Participants
Year 5	2500

- b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: (*select one*) :

The state does not limit the number of participants that it serves at any point in time during a waiver year.

The state limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	2000
Year 2	2250
Year 3	2250
Year 4	2500
Year 5	2500

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

- c. Reserved Waiver Capacity.** The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Purpose(s) the state reserves capacity for:

Purposes	
Prioritizing Youth in PRTF or Other Residential Treatment Facilities	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (*provide a title or short description to use for lookup*):

Prioritizing Youth in PRTF or Other Residential Treatment Facilities

Purpose (*describe*):

This Waiver prioritizes children/youth with SED who are in Psychiatric Treatment Facilities or other residential treatment facilities out-of-state, and those who are in such facilities in-state.

Describe how the amount of reserved capacity was determined:

WV is currently serving up to 100 children/youth at in-state PRTFs. Another 350 children/youth are being served in settings out-of-state; this figure is an average and subject to change based on demand. By combining these figures, it has been determined that 250 waiver slots will be reserved to best serve these two priority populations.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	250
Year 2	250
Year 3	250
Year 4	250
Year 5	250

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

When the capacity for people served by the CSEDW program is reached, applicants for CSEDW services are placed on a Managed Enrollment List (MEL). Applicants for entry into the program will be processed on a first-come-first-serve basis based upon the date/time of the determination of medical eligibility and will come onto the program as capacity becomes available.

Appendix B: Participant Access and Eligibility**B-3: Number of Individuals Served - Attachment #1 (4 of 4)**

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility**B-4: Eligibility Groups Served in the Waiver**

- a. **1. State Classification.** The state is a (*select one*):

§1634 State

SSI Criteria State

209(b) State

- 2. Miller Trust State.**

Indicate whether the state is a Miller Trust State (*select one*):

No

Yes

- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

Low income families with children as provided in §1931 of the Act

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

Optional state supplement recipients

Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

100% of the Federal poverty level (FPL)

% of FPL, which is lower than 100% of FPL.

Specify percentage:

Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)

Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)

Medically needy in 209(b) States (42 CFR §435.330)

Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Parents and other caretaker relatives (42 CFR 435.110)
 Children under age 19 (42 CFR 435.118)
 Pregnant Women (42 CFR 435.116)
 Adult Group (42 CFR 435.119)
 Former WV Foster Care Children (42 CFR 435.150)
 Adoption Assistance, Foster Care, or Guardianship Care under IV-E (42 CFR 435.145)
 Non IV-E Adoption Assistance (42 CFR 435.227)

Special home and community-based waiver group under 42 CFR §435.217 Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.

Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

All individuals in the special home and community-based waiver group under 42 CFR §435.217

Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the state elects to (select one):

Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

- b. Regular Post-Eligibility Treatment of Income: SSI State.**

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

- i. Allowance for the needs of the waiver participant (select one):**

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

ii. Allowance for the spouse only (select one):

Not Applicable

The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (*select one*):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (*select one*):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

- ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

- iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

- e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.**

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

- f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.**

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility**B-6: Evaluation/Reevaluation of Level of Care**

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The state requires (select one):

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

- b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

The Medical Eligibility Contracted Agent (MECA). BMS will make the final determination as to whether or not a member is eligible in the waiver by utilizing all the information gathered by the ASO and MECA to determine a participant's waiver eligibility.

Other

Specify:

- c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the

educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Per BMS contract with the MECA, approved independent evaluators specifically trained to evaluate applicants with SED will conduct eligibility assessments to determine medical eligibility for this waiver. BMS will make the final determination as to whether or not a member is eligible for the waiver by utilizing all the information gathered by the ASO and MECA to determine a participant's waiver eligibility. MECA independent evaluators include licensed psychologists, licensed independent clinical social workers (LICSW), licensed professional counselors (LPC) and supervised psychologists who have completed training in completing the CAFAS/PECFAS and BASC-3 (for applicants who are residing at home and not currently in a PRTF).

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

An Independent Evaluation (IE) will be utilized by the MECA to determine initial eligibility for applicants seeking participation in the CSEDW. Psychometric instruments, to include the CAFAS/PECFAS (if there is not one completed in the last 90 days) and the Behavior Assessment System for Children-Third Edition (BASC-3), will be utilized and eligibility criteria will be identified within BMS' CSEDW policy. Other specific instruments may be required based on the needs and age of the applicant. All members will be administered a CAFAS/PECFAS prior to enrollment and at annual redetermination; if the member has had a CAFAS/PECFAS completed within 90 days of application, then it can be used as the initial assessment for CSEDW. The CANS instrument will also be administered at any identified "significant life event" (as determined by the CFT that may alter the member's existing level-of-care status, as well as in preparation for the annual Plan of Care (POC) development, the member's POC development every 30-45 days and during the annual redetermination. BMS will make the final determination as to whether a member is eligible in the waiver by utilizing all information gathered by the ASO and MECA to determine a participant's waiver eligibility. This includes: residency, Medicaid member, aged 3 through age 20, eligible diagnosis, a score of over 90 on the CAFAS/PECFAS overall, the completed IE and admission or imminent danger of admission to a PRTF within the last 6 months. Additionally, this Waiver prioritizes children/youth with SED who are in Psychiatric Rehabilitation Treatment Facilities (PRTFs) or other residential treatment providers Out-of-state, and those who are in such facilities in-state. Then, Medicaid-eligible Children with SED who are at risk of institutionalization are the target group. For medical eligibility for applicants residing in a PRTF, The ASO reviews the intake psychiatric evaluation that was completed to obtain an eligible diagnosis and admit the child to the PRTF as well as the most recent psychiatric evaluation. The ASO also reviews the current treatment plan from the PRTF in which the applicant is currently residing that details the child's progress from the past 90 days. A CAFAS assessment is then completed by the PRTF. (The BASC is not required for applicants currently residing in a PRTF.) The ASO forwards this documentation on to the MECA. Once these documents are reviewed by the MECA, if CSED medical eligibility is approved, the Wraparound facilitator can complete a CANS assessment and assemble a CFT meeting within the 30 days prior to discharge so services are ready to begin as soon as the child returns home.

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

An IE will be completed to determine initial eligibility for CSEDW level of care. Psychometric instruments, to include the CAFAS/PECFAS (if there is not one within the last 90 days), the BASC-3, and other instruments based on the needs and age of the applicant, will be identified within BMS' CSEDW policy and administered by trained representatives of the IEN ensuring reliable, valid, and fully comparable results. BMS will make the final determination as to whether a member is eligible in the waiver by utilizing all information gathered by the ASO and MECA to determine a participant's waiver eligibility. This includes: residency, Medicaid member, aged 3 up to age 21, eligible diagnosis with concurrent scores of 60 or above in at least two clinical scales on the BASC, a substantial impairment score on the PECFAS/CAFAS overall of higher than 90, the completed IE, admission or imminent danger of admission to a PRTF within the last 6 months. Additionally, this

Waiver prioritizes children/youth with SED who are in Psychiatric Rehabilitation Treatment Facilities (PRTFs) or other residential treatment providers Out-of-state, and those who are in such facilities in-state, then, Medicaid-eligible Children with SED who are at risk of institutionalization. For medical eligibility for applicants residing in a PRTF, The ASO reviews the intake psychiatric evaluation that was completed to obtain an eligible diagnosis and admit the child to the PRTF as well as the most recent psychiatric evaluation. The ASO also reviews the current treatment plan from the PRTF in which the applicant is currently residing that details the child's progress from the past 90 days. A CAFAS/PECFAS assessment is then completed by the PRTF. (The BASC is not required for applicants currently residing in a PRTF.) The ASO forwards this documentation on to the MECA. Once these documents are reviewed by the MECA, if CSED medical eligibility is approved, the Wraparound facilitator can complete a CANS assessment and assemble a CFT meeting as soon as the child returns home.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The ASO will contact the applicant within 1 business day and determine if the child is Medicaid eligible and if so, screen the child for medical eligibility for waiver services and, if the screening determines that the child appears to be eligible, the IE can complete the CAFAS if they do not already have one within the last 90 days. If the overall score is greater than 90 then the ASO will, at that time, with the family complete an application for the CSEDW, and a Freedom of Choice forms (FOCs) and make a referral/appointment with Independent Evaluator (IE) of the family's choice. The initial FOC offers the child/family the election between institutional and home and community-based services. If the child/family elects home and community-based services, the ASO asks the family to select a provider from the IEN and contacts the IE to schedule an evaluation. If the IE is unable to schedule and complete a report within 14 days, then the ASO will work with the family to choose another IE who can. Once the child/family has scheduled the IE, the ASO will obtain an FOC form for the selected IE provider. The ASO will discuss service options with the family and provide information about the CSEDW, offering the family the option to select a preferred Wraparound Facilitation Agency and complete an FOC for CSEDW services, so that services will be ready to begin as soon as the child is found eligible. The ASO will also inform the family that the ASO will refer the family to appropriate alternative behavioral health services even if the child is not eligible for CSEDW services. Within 14 days, the IE will send the completed report electronically to the ASO who will forward it on to the Medical Eligibility Contracted Agency (MECA) to determine if the applicant is eligible for the CSEDW. The completed report must include background information, mental status examination and measure of emotional functioning when appropriate and all scores. The MECA electronically notifies the ASO of determination of medical eligibility within seven (7) days of receiving the completed IE from the ASO. The ASO notifies the applicant and the MCO (as applicable) of the eligibility determination. If the applicant is found to not meet medical eligibility requirements, the ASO also provides the applicant with Medicaid Fair Hearing information, which includes the right to request a second medical evaluation by a different member of the IEN. BMS will make the final determination as to whether a member is eligible in the waiver by utilizing all information gathered by the ASO and MECA to determine a participant's waiver eligibility. This includes residency, Medicaid member, aged 3 up to age 21, eligible diagnosis, a substantial impairment score of at least 90 on the PECFAS/CAFA, the completed IE, admission or imminent danger of admission to a PRTF within the last 6 months, and the ability to respond to treatment. Additionally, this Waiver prioritizes children/youth with SED who are in Psychiatric Rehabilitation Treatment Facilities (PRTFs) or other residential treatment providers Out-of-state, and those who are in such facilities in-state. Then, Medicaid-eligible Children with SED who are at risk of institutionalization are the target group.

Since this waiver prioritizes children/youth with SED who are in Psychiatric Residential Treatment Facilities (PRTFs) or other residential treatment providers Out-of-State, and those who are in such facilities in-state, the inpatient facility will determine readiness for discharge from the facility. To apply for CSED Waiver while presently placed in an out of state PRTF, the guardian will submit an application and the ASO will gather treatment facility records that include but is not limited to a treatment plan, therapy records, psychiatric or psychological evaluation and a complete CAFAS/PECFAS. These records will be submitted to the MECA for review. If an individual is found eligible for CSEDW services and has received notification of a funded slot, but is not yet deemed eligible for discharge from the facility, the member will have up to 365 days, unless the member ages out of eligibility to access their funded slot in the community before being discharged for non-use of their waiver slot. The member will not be enrolled into CSED waiver until discharged from the PRTF.

For annual reevaluation, the ASO submits diagnoses and annual functional assessments within 45 days prior to the anchor "annual date" to the MECA. The MECA reviews the diagnoses and annual assessments and determines eligibility. Every person must have a re-determination of medical eligibility completed at least annually. Additionally, if at the member's POC review the CFT determines he/she has not benefited from waiver enrollment (i.e. no progress has been made on the member's treatment goals and objects), then the CFT will refer the member to the IEN to re-determine level-of-care placement. The anchor date of the person's annual re-determination is the first day of the month after the initial medical eligibility was established by the MECA. If the reevaluation results in waiver eligibility the final decision will be made by BMS by utilizing all the information gathered by the ASO and MECA to determine a participant's waiver enrollment.

The ASO employs assessors to conduct re-evaluations for program members and this process is consistent with WV's other waivers and the information gathered is reviewed by the MECA for eligibility determination. To ensure these evaluations meet standard, the MECA will perform a 100% quality assurance check on LOC renewals. In addition to the MECA completing the 100% sample review, the ASO will also conduct monthly interrater reliability activities. Interrater activities include training with the MECA and completion of monthly case studies requiring the assessor to score within a designated range. Failure to meet the scoring requirements will result in the assessor being retrained. The individual being retrained on the process will be given one week to come into compliance, and if they are still unable to meet the requirements after being retrained, they will no longer work within this capacity with the ASO. WV utilizes this same

interrater technique for all other waivers effectively. Qualifications for the ASO assessors include a bachelor's degree in a human service field and at least one-year experience with the target population. Staff go through a rigorous training protocol, which includes trainer-led instruction, shadowing experienced staff, and periodic evaluation of their work.

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

- For annual medical eligibility redeterminations, waiver members must have a Child and Adolescent Functional Assessment Scale (CAFAS) or Preschool and Early Childhood Functional Assessment Scale (PECFAS) score of 90 or greater to continue to meet medical eligibility for Psychiatric Residential Treatment Facility (PRTF) Level of Care (LOC). In addition, the Medical Eligibility Contracted Agent (MECA) will review the latest Child and Adolescent Needs and Strengths (CANS) assessment completed by the Wraparound Facilitator and any comments for assessment areas that are rated as a two or three to determine those are addressed in the CAFAS. If the waiver member no longer meets medical eligibility, the applicant has the option to request an additional Independent Evaluation (IE), and/or appeal the medical eligibility determination.
- For situations where a Children with Serious Emotional Disorder Waiver (CSEDW) member does appear to be improving with waiver services, the Managed Care Organization (MCO) tracks the incident reports by CSEDW member. If there is a single serious report or a number of incident reports made for the same member, the MCO Care Management team will confer with the Wraparound Facilitator and offer suggestions of additional services and supports available to help stabilize the member. The Wraparound Facilitator will convene the Child and Family Team (CFT) to review the child's progress and recommend services to address the needs. The MCO will review these and generally approve additional services for the waiver member, based on the CFT's recommendations.
- Since the population served under the waiver is at a PRTF LOC, at times stability would be considered an improvement for the waiver member. As long as the waiver member continues to meet medical eligibility and participates in treatment, waiver services continue. If waiver members are hospitalized due to a crisis that puts themselves or others at imminent risk of harm, the member's waiver slot is suspended during that time so that they can return home with waiver supports.
- If the waiver member's behaviors continue to escalate or put the member at risk of harm to themselves or others, or that the waiver member is not participating in services, a referral may be made for further evaluation and referral to services.

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.

Specify the qualifications:

Reevaluations will be conducted by the ASO with minimal qualifications of a bachelor's degree in a human service field and at least one-year experience, with rigorous training in CAFAS/PECFAS is required to administer the instrument identified by BMS policy.

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care (*specify*):

Working with the Wraparound Facilitator, the ASO schedules the annual assessment. The ASO is responsible for ensuring that annual redetermination functional assessments are completed within 45 days prior to the anchor "annual date." BMS will make the final determination as to whether or not a member continues to be enrolled in the waiver based upon review of the re-evaluation completed as compared to the eligibility criteria necessary to participate in the CSEDW program.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All initial assessments and reevaluations of medical eligibility determinations are maintained for a minimum of five years by the MECA and the ASO.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

- a. Sub-assurance:** *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

B.aia.1 Percent of applicants whose eligibility determination was performed within seven (7) days of receipt of a completed evaluation. Numerator = Number of applicants whose eligibility determination was performed within seven (7) days of receipt of a completed evaluation. Denominator = Number of eligibility determinations performed.

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="ASO"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="Medical Eligibility Contracted Agency (MECA)"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

- b. *Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

B.aib.a Percent of enrolled CSEDW members that were reevaluated within 1 year of their previous LOC review. Numerator - Number of enrolled CSEDW members that were reevaluated within 1year of their previous LOC review. Denominator - Number of enrolled CSEDW members that were reevaluated.

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
Other Specify:	Annually	Stratified Describe Group:

ASO		
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: MECA	Annually
	Continuously and Ongoing
	Other Specify:

- c. **Sub-assurance:** *The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The ASO, MCO and the MECA are required to submit a number of regular reports to the BMS. BMS utilizes these reports to monitor delegated administrative functions. Any issues or concerns identified via these reports are addressed directly with individual contractors during monthly contract oversight meetings. Strategies to remedy specific identified issues are developed with the contractors and monitored through these meetings. Documentation is maintained with contract meeting minutes.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>ASO, MCO, and MECA</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

As part of the CSEDW Application process, applicants and/or parent/legal representative (as applicable) are provided informational materials from the ASO that detail services available to eligible individuals through the CSEDW. The member and/or their parent/legal representative (as applicable) are provided with the Freedom of Choice Form at the time of the initial meeting with the ASO in order to indicate their selection between HCBS and institutional services. An additional form will also be transmitted that allows the applicant to choose from a designated Independent Evaluator to perform the medical eligibility assessment as well as choosing their Wraparound Facilitator agency and their agency to provide all other CSEDW services. The Wraparound Facilitator agency may not provide any services except Wraparound Facilitation unless a geographical or cultural waiver is granted by BMS. A third FOC form is provided to the family by the ASO at the time of referral to select a Wraparound Facilitation Agency, so that services can begin as soon as possible once the child is determined eligible. The ASO will provide referrals for other community-based behavioral health services if the child is not eligible.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The ASO maintains Freedom of Choice Forms electronically for a minimum of five years.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

BMS utilizes the latest census data, data from school systems and community organizations, and data from state and local governments to inform the proportion of Limited English Proficiency (LEP) persons within WV and the WV Medicaid program. In 2014, data from the Department of Justice Civil Rights Division indicated that 0.4% of WV residents were LEP persons. As of 2017, 97.5% of West Virginians spoke English as their primary language, with 2.5% of persons over five years of age speaking a language other than English in their household.

To accommodate individuals with LEP, BMS and the MCO address needs for alternative language requests on an ad hoc basis. Requests for printed materials in alternative languages are fulfilled within five business days, per CFR 438.10(c)-(d) at no charge to the enrollee. All materials are currently available in alternative formats for individuals who cannot access standard print material, including large print, audio, and braille. The MCO will notify enrollees that oral interpretation services are available for any language, that written information is available in prevalent languages, and how to access those services. Written materials include taglines in the prevalent non-English languages and large print (in a font size no smaller than 18 point) explaining the availability of written translation or oral interpretation and the toll-free and Teletypewriter (TTY)/Telecommunication Device for the Deaf (TDY) telephone number of the MCO. The MCO makes their written materials available in the prevalent non-English languages in their service areas.

BMS also makes available information regarding the waiver on the DHHR and BMS websites for electronic access and utilization. BMS and the MCO will provide oral interpretation services for all languages via a language interpretation line for verbal review of applicable Waiver materials, and BMS and all contract staff are available to read printed materials to enrollees upon request.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	In-Home Family Support		
Statutory Service	Independent Living/Skills Building		
Statutory Service	Job Development		
Statutory Service	Respite Care, In-Home		
Statutory Service	Supported Employment, Individual		
Statutory Service	Wraparound Facilitation		
Other Service	Assistive Equipment		
Other Service	Community Transition		
Other Service	Family Therapy		
Other Service	Mobile Response		
Other Service	Non-Medical Transportation		
Other Service	Peer Parent Support		
Other Service	Respite Care, Out-of-Home		
Other Service	Specialized Therapy		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Alternate Service Title (if any):**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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

The family support worker will use an evidence-based therapeutic approach to assist the member and their family with their goals and overall treatment. They will be supported by the family support worker in developing the skills and knowledge that is necessary to understand and address the specific needs of the member in relation to the child's SED and treatment. The evidence-based therapy sessions may focus on elements such as developing and enhancing the family's problem-solving skills, coping mechanisms, and strategies for the member's symptom/behavior management. While scheduling may allow the Family therapist and the In-Home Family support worker to be in the home concurrently, it is not required nor is it the intent. However, the Family therapist and the In-Home Family support worker will be in regular communication through many mechanisms: one-on-one case staffing; POC meetings; joint family therapy or support sessions, and review of service documentation. This expectation will be outlined in the provider policy for these services.

Due to the overwhelming response from HCBS providers, members and families during the COVID-19 Public Health Emergency, BMS is implementing telehealth as an allowable service modality for the CSED Waiver permanently. Telehealth is only allowable for indicated services and does not replace required face-to-face visits. Providers are mandated to report any critical incidents to the State, including any health and safety concerns. Telehealth delivery will not eliminate any face-to-face requirements the State has already implements that are designed to address the health and safety of the individual receiving the service. The health and safety of West Virginia's health care providers and our ability to provide and support the member and family remain the state's top priorities.

Services via telehealth increases opportunities for the member to integrate with the community and find systems of support, while decreasing isolation. Telehealth also increases access to available services for members while providing enrollees the flexibility to address their needs defined in their POC, reducing transportation barriers and scheduling conflicts. Leveraging telehealth flexibilities when appropriate to keep enrollees engaged in treatment in the community supports the overall Home and Community-based goal of meeting the enrollee where they are at. In collaboration with the child, the family and/or personal care attendee the CSED waiver staff will address any hands-on/physical assistance if they choose telehealth for service delivery. As part of the person-centered planning process, during POC meetings, the type of service and delivery method will be determined in the best interests of the member, with their active engagement when age appropriate, and agreed upon by the family, the child and the members of the child and family treatment team. If as part of this process a limitation to what is available to the family via telehealth is determined, the family can request to update their service modality (telehealth or in-person) at any time. CSEDW HCBS providers must act on behalf of the child and family and actively follow their choice. To utilize telehealth, providers must document that the service was rendered under that modality.

HCBS providers must work with the member and family to determine if telehealth will be utilized for a specified service occurrence. While some HCBS can be delivered effectively via telehealth, in certain instances, face-to-face contact may still be clinically indicated and may be a life safety issue. If the participant has an immediate need for services that must be delivered face-to-face, the HCBS provider should take appropriate measures to ensure service needs are met to safeguard the health, safety and welfare of the participant. Wraparound Facilitators and HCBS providers must document if telephonic methods were utilized to meet HCBS requirements. It is the ongoing responsibility of Wraparound Facilitators and HCBS providers to make all efforts to utilize telephonic and telehealth mechanisms to ensure regular contacts with their participants and the ongoing continuation of services to the best of their ability.

Discussions about this service and how it will support the member and family/guardian to meet their goals must be person-centered. The member and family/guardian's selection of services will be documented in the member POC and include the types of services selected and to be provided to the child and family by their chosen providers including service name, provider, frequency, and duration of the service and how this service will support the strengths and needs of the child. Service selection will support a specific goal/s in the member's Plan of Care (POC)

and will not duplicate any other services provided to the member and based on medical necessity. The services under the waiver are limited to additional services not otherwise covered under the Medicaid State plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Unit = 15 minutes; Up to 2 hours per day (8 units per day), approximately 14 hours per week (56 units/week). All services are person-centered and the established service limits may be exceeded when medical necessity is established.

The CSEDW provider must request authorization to deliver services beyond the “soft” unit limits (i.e., daily, weekly, monthly, annually, dollar amount) and must send documentation to the MCO justifying the child/youth’s need for services exceeding the “soft” limit. The MCO may approve the additional service units if determined to be medically necessary. The additional service units must be documented in the member’s POC and all documentation must be kept with the child/youth’s file and available for review upon request.

Telehealth is an allowable service modality for Independent In-Home Family Support. Telehealth may be utilized to deliver services for up to 50% of the total services the member receives per year of enrollment (one calendar year from the members anchor date). Providers will discuss with the member the allowable service modalities. Service selection, modality, scope, frequency, and duration are person-centered and represent the choice of the member and family. The member may utilize telehealth in alignment with the frequency and duration outlined in the member Plan of Care, if telehealth is selected by the member and family a telehealth backup plan must be discussed and added to the Plan of Care, the telehealth backup plan must include alternative service connections available to the member and family, for example switching to an in person face to face visit, emergency power supply or a mobile device that allows connection.

Delivery of services through telehealth will be conducted in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Telehealth services are available via web-based applications and/or smartphone applications (apps) as long as they meet the current HIPAA and 42 CFR Part 2 regulations of compliance and is accepted by the West Virginia HIPAA Compliance Officer.

Telehealth will not be authorized as a duplicate service. Providers will be trained on limitations and exclusions of the services, and they will be provided in writing. Providers must follow program billing procedures ensuring providers will not duplicate services and billing. The MCO will monitor service provision through POC and claims reviews. The originating site must bill with the appropriate telehealth originating site code and distant site providers must bill the appropriate Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT)/(HCPCS) code with the appropriate Place of Service code.

Privacy is paramount in any health care and telemedicine interaction. The use of video conference, video monitoring, or any type of surveillance is not at any time permitted in bedrooms and bathrooms.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: In-Home Family Support

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications

License (specify):

Agency must have a current WV Behavioral Health License issued by the WVDHHR Office of Health Facility Licensure and Certification (OHFLAC).

Certificate (specify):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.

Other Standard (specify):

Must have a minimum of a bachelor's degree in social work, psychology, sociology or other human services field plus one (1) year of experience working with this population. Must have a contract with the MCO.

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by OHFLAC and the BMS.

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the OHFLAC.
Agency staff is verified by the Licensed Behavioral Health Provider every other year and the ASO annually.
The ASO will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.
Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are updated every five (5) years and the OIG, which is checked monthly.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:**Service:****Alternate Service Title (if any):****HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Independent Living/Skills Building (CMS defined: Day habilitation) services focus on enabling the member to attain or maintain his or her maximum potential and will be coordinated with any needed therapies in the individual's person-centered service plan, such as physical, occupational, or speech therapy.

The provision of regularly scheduled activities in a non-residential setting, separate from the member's private residence or other residential living arrangement, will support the retention, or improvement in self-help, socialization and adaptive skills all which will help the member enhance their social development while developing skills of daily living.

Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, community inclusion, relationship building, self-advocacy and informed choice necessary to successfully function in the home and community. Services are furnished consistent with the member's POC. Meals provided as part of these services will not constitute a "full nutritional regimen" (3 meals per day).

Independent Living/Skills Building services will also utilize a Therapeutic Mentoring (TM) model to facilitate the member's achievement of their goals of community inclusion and remaining in/returning to their home. TM offers structured, one-to-one, strength-based support services between a therapeutic mentor and a youth for the purpose of addressing daily living, social, and communication needs. The mentor works with a clinical therapist to explore a youth's interests and abilities and creates activities that build various life skills and result in linkages to community activities. Utilizing this model services will include: coaching, supporting, and training the youth in age-appropriate behaviors, interpersonal communication, conflict resolution and problem solving, and are provided in community settings (such as libraries, stores, parks, city pools, etc.). Independent living/skills building can be related to activities of daily living, such as personal hygiene, household chores, volunteering, household management, money management/budgeting, and socialization, if these skills are affected by the Waiver member's SED.

Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy and informed choice necessary to successfully function in the home and community.

Due to the overwhelming response from HCBS providers, members and families during the COVID-19 Public Health Emergency, BMS is implementing telehealth as an allowable service modality for the CSED Waiver permanently. Telehealth is only allowable for indicated services and does not replace required face-to-face visits. The health and safety of West Virginia's health care providers and our ability to provide and support the member and family remain the state's top priorities.

HCBS providers must work with the member and family to determine if telehealth will be utilized for a specified service occurrence. While some HCBS can be delivered effectively via telehealth, in certain instances, face-to-face contact may still be clinically indicated and may be a life safety issue. If the participant has an immediate need for services that must be delivered face-to-face, the HCBS provider should take appropriate measures to ensure service needs are met to safeguard the health, safety and welfare of the participant. Wraparound Facilitators and HCBS providers must document if telephonic methods were utilized to meet HCBS requirements. It is the ongoing responsibility of Wraparound Facilitators and HCBS providers to make all efforts to utilize telephonic and telehealth mechanisms to ensure regular contacts with their participants and the ongoing continuation of services to the best of their ability.

Discussions about this service and how it will support the member and family/guardian to meet their goals must be person-centered. The member and family/guardian's selection of services will be documented in the member POC and include the types of services selected and to be provided to the child and family by their chosen providers including service name, provider, frequency, and duration of the service and how this service will support the strengths and needs of the child. Service selection will support a specific goal/s in the member's Plan of Care (POC) and will not duplicate any other services provided to the member and based on medical necessity. The services under the waiver are limited to additional services not otherwise covered under the Medicaid State plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

This service is provided in the general public community and is not to be provided in a facility-based center and are to be provided in a 1:1 ratio as this not a group service for this waiver. Transportation is not included with the rate of this service and can be billed concurrently with Non-Medical Transportation.

Electronic Visit Verification (EVV) System: The state will demonstrate compliance with the EVV System requirements for personal care services (PCS) by April 1, 2021, having received approval for a Good Faith Effort (GFE) exemption; and home health services by January 1, 2023 in accordance with section 12006 of the 21st Century Cures Act.

Electronic Visit Verification (EVV) System: The state will demonstrate compliance with the EVV System requirements for personal care services (PCS) by April 1, 2021, having received approval for a Good Faith Effort (GFE) exemption; and home health services by January 1, 2023 in accordance with section 12006 of the 21st Century Cures Act.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Unit = 15 minutes; Up to 40 hours per week (160 units/week), approximately 160 hours/month (640 units/month) in combination with Job Development and Supported Employment.

All services are person-centered and the established service limits may be exceeded when medical necessity is established.

The CSEDW provider must request authorization to deliver services beyond the “soft” unit limits (i.e., daily, weekly, monthly, annually, dollar amount) and must send documentation to the MCO justifying the child/youth’s need for services exceeding the “soft” limit. The MCO may approve the additional service units if determined to be medically necessary. The additional service units must be documented in the member’s POC and all documentation must be kept with the child/youth’s file and available for review upon request.

Telehealth is an allowable service modality for Independent Living/ Skills Building. Telehealth may be utilized to deliver services for up to 25% of the total services the member receives per year of enrollment (one calendar year from the members anchor date). Providers will discuss with the member the allowable service modalities. Service selection, modality, scope, frequency, and duration are person-centered and represent the choice of the member and family. The member may utilize telehealth in alignment with the frequency and duration outlined in the member Plan of Care, if telehealth is selected by the member and family a telehealth backup plan must be discussed and added to the Plan of Care, the telehealth backup plan must include alternative service connections available to the member and family, for example switching to an in person face to face visit, emergency power supply or a mobile device that allows connection. Delivery of services through telehealth will be conducted in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Telehealth services are available via web-based applications and/or smartphone applications (apps) as long as they meet the current HIPAA and 42 CFR Part 2 regulations of compliance and is accepted by the West Virginia HIPAA Compliance Officer.

Telehealth will not be authorized as a duplicate service. Providers will be trained in limitations and exclusions of the services, and they will be provided in writing. Providers must follow program billing procedures ensuring providers will not duplicate services and billing. The MCO will monitor service provision through POC and claims reviews. The originating site must bill with the appropriate telehealth originating site code and distant site providers must bill the appropriate Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT)/(HCPCS) code with the appropriate Place of Service code.

Privacy is paramount in any health care and telemedicine interaction. The use of video conference, video monitoring, or any type of surveillance is not permitted at any time in bedrooms and bathrooms.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Independent Living/Skills Building****Provider Category:**

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications**License (specify):**

Agency must have a current WV Behavioral Health License issued by the WVDHHR Office of Health Facility Licensure and Certification (OHFLAC).

Certificate (specify):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.

Other Standard (specify):

Bachelor's or Associates degree in a human service field and a minimum of one (1) year of experience working with children/adolescents OR High school diploma or GED and a minimum of two (2) years of experience working with this age group. Must have a contract with the MCO.

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by OHFLAC and the BMS.

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Agency is verified by the OHFLAC.
Agency staff are verified by the Licensed Behavioral Health Provider and the ASO.
The ASO will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.
Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are verified every five (5) years and the OIG, which is checked monthly.

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:**Service:****Alternate Service Title (if any):****HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Job Development (CMS defined: Prevocational Services) provides learning and work experiences, including volunteer work and personal care activities, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time that does not exceed one (1) year and have specific outcomes to be achieved, as determined by the member and his/her Child and Family Team (CFT) through an ongoing Plan of Care (POC) process. Members receiving Job Development must have employment-related goals in their POC; the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which a member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by members without disabilities is considered to be the successful outcome of Job Development.

Job Development should enable each member to attain the highest level of work in the most integrated setting and with the job matched to the member's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills that lead to competitive and integrated employment including, but not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training.

Participation in Job Development is not a required pre-requisite for supported employment services provided under the waiver. Many members, particularly those transitioning from school to adult activities, are likely to choose to go directly into supported employment. Similarly, the evidence-based Individual Placement and Support (IPS) model of supported employment for members with behavioral health conditions emphasizes rapid job placement in lieu of Job Development.

Discussions about this service and how it will support the member and family/guardian to meet their goals must be person-centered. The member and family/guardian's selection of services will be documented in the member POC and include the types of services selected and to be provided to the child and family by their chosen providers including service name, provider, frequency, and duration of the service and how this service will support the strengths and needs of the child. Service selection will support a specific goal/s in the member's Plan of Care (POC) and will not duplicate any other services provided to the member and based on medical necessity. The services under the waiver are limited to additional services not otherwise covered under the Medicaid State plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Documentation is maintained in the file of each member receiving this service that a referral has been made to a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Members may utilize the CSEDW Non-Medical Transportation service for travel to and from the member's residence and his/her supported employment or job development sites. Services provided in this category will be in response to a specific goal/s in the member's POC and will not duplicate any other services provided to the member.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Unit = 15 minutes; up to 40 hours per week (160 units/week), approximately 160 hours/month (640 units/month) in combination with Independent Living/Skills Building and Supported Employment.

All services are person-centered and the established service limits may be exceeded when medical necessity is established.

The CSEDW provider must request authorization to deliver services beyond the "soft" unit limits (i.e., daily, weekly, monthly, annually, dollar amount) and must send documentation to the MCO justifying the child/youth's need for services exceeding the "soft" limit. The MCO may approve the additional service units if determined to be medically necessary. The additional service units must be documented in the member's POC and all documentation must be kept with the child/youth's file and available for review upon request.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Job Development

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications

License (*specify*):

Agency must have a current WV Behavioral Health License issued by the WVDHHR Office of Health Facility Licensure and Certification (OHFLAC).

Certificate (*specify*):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.

Other Standard (*specify*):

Supervised by bachelor's-level In-Home Support staff person. Must have a High School diploma or GED. Must have a contract with the MCO.

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by OHFLAC and the BMS.

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the OHFLAC.

Agency staff is verified by the Licensed Behavioral Health Provider and the ASO.

The ASO will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.
Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are updated every five (5) years and the OIG, which is checked monthly.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Care, In-Home

HCBS Taxonomy:**Category 1:**

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Respite Care services provide temporary relief to the member's regular caregiver and include all the necessary care that the usual caregiver would provide during that period. In-Home Respite must be provided in the member's home that may include biological homes, kinship homes, and adoptive homes. Member's residing in a foster care, facility or independent living setting do not qualify for the service. Foster parents/homes are excluded from this service under the Waiver, as the Title IV-E payment to foster care families should include respite. Foster parents access respite as part of their foster care benefits and do not need to utilize CSEDW respite services. Otherwise, the limit is a total of 24 days per year for both in- and Out-of-home respite.

Respite may be provided in the local public community if delivery begins and ends in the member's home. Service can be used to support the member in engaging in age-appropriate community activities, such as shopping, volunteering, attending concerts, etc.

Discussions about this service and how it will support the member and family/guardian to meet their goals must be person-centered. The member and family/guardian's selection of services will be documented in the member POC and include the types of services selected and to be provided to the child and family by their chosen providers including service name, provider, frequency, and duration of the service and how this service will support the strengths and needs of the child. Service selection will support a specific goal/s in the member's Plan of Care (POC) and will not duplicate any other services provided to the member and based on medical necessity. The services under the waiver are limited to additional services not otherwise covered under the Medicaid State plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Service cannot be provided while the member is asleep.

Electronic Visit Verification System (EVV): The state will demonstrate compliance with the EVV System requirements for personal care services (PCS) by April 1, 2021, having received approval for a Good Faith Effort (GFE) exemption; and home health services by January 1, 2023 in accordance with section 12006 of the 21st Century Cures Act.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Unit = 15 minutes; Up to 24 days per year in combination with Out-of-Home Respite Care.
All services are person-centered and the established service limits may be exceeded when medical necessity is established.

The CSEDW provider must request authorization to deliver services beyond the "soft" unit limits (i.e., daily, weekly, monthly, annually, dollar amount) and must send documentation to the MCO justifying the child/youth's need for services exceeding the "soft" limit. The MCO may approve the additional service units if determined to be medically necessary. The additional service units must be documented in the member's POC and all documentation must be kept with the child/youth's file and available for review upon request.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite Care, In-Home

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications

License (*specify*):

Agency must have a current WV Behavioral Health License issued by the WVDHHR Office of Health Facility

Licensure and Certification (OHFLAC).

Certificate (*specify*):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.

Other Standard (*specify*):

Must have a High School diploma or GED. Must have a contract with the MCO.

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by OHFLAC and the BMS.

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the OHFLAC.

Agency staff is verified by the Licensed Behavioral Health Provider and the ASO.

The ASO will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are updated every five (5) years and the OIG, which is checked monthly.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:**Service:****Alternate Service Title (if any):****HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Supported Employment - Individual Employment Support services are the ongoing supports to adult members who, because of their disabilities need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above WV's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by members without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported employment - individual employment supports may also include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits and work-incentives planning and management, transportation, asset development and career advancement services. Other workplace support services including services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting such as personal care activities. Personal care services in the form of direct, on-the-job support are included within this service.

Discussions about this service and how it will support the member and family/guardian to meet their goals must be person-centered. The member and family/guardian's selection of services will be documented in the member POC and include the types of services selected and to be provided to the child and family by their chosen providers including service name, provider, frequency, and duration of the service and how this service will support the strengths and needs of the child. Service selection will support a specific goal/s in the member's Plan of Care (POC) and will not duplicate any other services provided to the member and based on medical necessity. The services under the waiver are limited to additional services not otherwise covered under the Medicaid State plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Documentation is maintained in the file of each member receiving this service that a referral has been made to a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of supported employment services.

Members may utilize the CSEDW Non-Medical Transportation service for travel to and from the member's residence and his/her supported employment or job development sites. Services provided in this category will be in response to a specific goal/s in the member's Plan of Care (POC) and will not duplicate any other services provided to the member. The services under the waiver are limited to additional services not otherwise covered under the Medicaid State plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

The Supported Employment worker may attend and bill for participating in the POC meetings.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Unit = 15 minutes; up to 40 hours per week (160 units/week), approximately 160 hours/month (640 units/month) in combination with Independent Living/Skills Building and Job Development.

All services are person-centered and the established service limits may be exceeded when medical necessity is established.

The CSEDW provider must request authorization to deliver services beyond the "soft" unit limits (i.e., daily, weekly, monthly, annually, dollar amount) and must send documentation to the MCO justifying the child/youth's need for services exceeding the "soft" limit. The MCO may approve the additional service units if determined to be medically necessary. The additional service units must be documented in the member's POC and all documentation must be kept with the child/youth's file and available for review upon request.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person**Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Supported Employment, Individual****Provider Category:**

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications**License (specify):**

Agency must have a current WV Behavioral Health License issued by the WVDHHR Office of Health Facility Licensure and Certification (OHFLAC).

Certificate (specify):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.

Other Standard (specify):

Supervised by bachelor's-level In-Home Support staff person. Must have a High School diploma or GED. Must have a contract with the MCO.

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by OHFLAC and the BMS.

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Agency is verified by the OHFLAC.
Agency staff is verified by the Licensed Behavioral Health Provider and the ASO.
The ASO will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.
 Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are updated every five (5) years and the OIG, which is checked monthly.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Wraparound Facilitation

HCBS Taxonomy:

Category 1:

01 Case Management

Sub-Category 1:

01010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

The Wraparound Facilitator is responsible for engaging the member and family in a partnership of shared decision-making regarding the Plan of Care (POC) development and implementation throughout their enrollment in the CSEDW. The Wraparound Facilitator ensures and coordinates a comprehensive set of supports, resources and strategies for each member and family. S/he works closely with service providers to assure that CSEDW services and clinical treatment modalities augment each other for optimal outcomes for members and parents/legal representatives/foster parents (when applicable).

The Wraparound Facilitator will lead the Child and Family Team (CFT) through engagement and team preparation, initial plan development, plan implementation, and transition, and provide intensive case management. This includes the development and implementation of a transition plan for participants who will reach the Waiver's maximum age limit.

The Wraparound Facilitator:

- Engages the Child and Family Team once the WF Agency is selected by the child/family/legal representative/foster parents (as applicable) and enrolled in the CSEDW;
- Assembles the CFT, including the member and their parent/legal representative/foster parents (if applicable);
- Helps to identify strengths and needs of the member and parent/legal representative/foster parents (as applicable) as a precursor to POC development;
- Leads POC meetings;
- Develops and updates POC in partnership with the member and parent/legal representative/foster parents (as applicable) that is reflective of the member's and parent/legal representative/foster parents' priorities, individualized, strengths-based, related to all life domains, coordinated with any psychiatric treatment received through other providers, focused on developmental tasks, resiliency and wellness, inclusive of safety issues, targeted to address assessment indicators (e.g., CANS), and oriented towards discharge readiness;
- Administers the CANS to the member at any identified 'significant life event(s),' in preparation for the annual POC development, as well as for the member's POC meeting;
- Works with the MCO Care Manager to identify service providers, natural supports, and other community resources to meet member and parent/legal representative/foster parents' needs and make necessary referrals to include behavioral health, health, and dental care providers.
 - o Facilitates connections with identified resources and providers; advocacy which includes the process of helping to empower members and parents/legal representatives/foster parents to initiate and sustain interactions that support their overall wellness, interceding on their behalf when necessary to gain access to needed services and supports;
- Documents and maintains all documentation regarding the POC and all revisions to the POC;
- Monitors the implementation of POC, making sure the member and parent/legal representative/foster parents are receiving the services identified in POC; on-going assessment and documentation of the member and parent/legal representative/foster parents' strengths and needs, progress towards achieving goals, and efficacy of delivered services;
- Maintains communication among all team members;
- Discuss with the member and family available waiver services, how they may support the members needs and goals, the allowable service modalities for delivery per the CSEDW;
- Consults with the family and other team members to make sure the services the member and parents/legal representatives/foster parents are receiving continue to meet their needs, and assembles the team to make necessary adjustments and revisions;
- Initiates and coordinates discharge and after-care planning; linkage and referral to services and supports as specified in the POC; this encompasses identifying local resources and services for use during both enrollment and discharge planning, sharing information with the member and parent/legal representative on relevant resources and

service providers, including local family support programs, advisors and advocates; engaging the member and parent/legal representative/foster parents in making informed choices;

- Meets at least weekly with the member and their parent/legal representative or foster parents. The purpose of these visits is to determine the progress of the person receiving services and resources, assess achievement of training objectives, to identifying unmet needs and provide for the appropriate support as necessary;

Acts as the primary CSEDW contact for the member, parent/legal representative/foster parents, or other CFT members;

Manages and warehouses all information related to member, parent/legal representative/foster parents, or other CFT member issues, questions, critical incidents, etc. and will work to ensure all such items are addressed; and

Facilitates the development and implementation of an individualized transition plan for members who will reach the Waiver's maximum age limit.

Assure that children are only placed in Therapeutic Foster Care (TFC) homes through BSS that comply with the CMS Integrated Settings Rule (42 CFR 44.301c-4-i.vi/441.71-a-1/441.530a-1) by completing the Integrated Settings Rule Checklist monthly during one of their weekly home visits. Any negative answer must be discussed at all CFT meetings and resolved as soon as the barrier can be removed. If the CFT is not able to remove the barrier within 30 days, then the Wraparound Facilitator will report the issue to the MCO Care Coordinator for help with resolving the issue. Inability to resolve the issue within 30 more days will result in the issue being escalated to BMS during a monthly contract meeting and BMS will work with the MCO and Therapeutic Foster Care (TFC) provider to resolve the issue.

The Wraparound Facilitator, and the agency that employs them, cannot provide any other Waiver or State plan services for the member, unless a geographical or cultural waiver is approved by BMS. The agency providing Wraparound Facilitation must provide freedom of choice for all other Waiver and State plan services providers.

Due to the overwhelming response from HCBS providers, members and families during the COVID-19 Public Health Emergency, BMS is implementing telehealth as an allowable service modality for the CSED Waiver. Telehealth is only allowable for indicated services and does not replace required face-to-face visits. Providers are mandated to report any critical incidents to the State, including any health and safety concerns. Telehealth delivery will not eliminate any face-to-face requirements the State already implements that are designed to address the health and safety of the individual receiving the service.

HCBS providers must work with the member and family to determine if telehealth will be utilized for a specified service occurrence. While some HCBS can be delivered effectively via telehealth, in certain instances, face-to-face contact may still be clinically indicated and may be a life safety issue. If the participant has an immediate need for services that must be delivered face-to-face, the HCBS provider should take appropriate measures to ensure service needs are met to safeguard the health, safety and welfare of the participant. Wraparound Facilitators and HCBS providers must document if telephonic methods were utilized to meet HCBS requirements. It is the ongoing responsibility of Wraparound Facilitators and HCBS providers to make all efforts to utilize telephonic and telehealth mechanisms to ensure regular contacts with their participants and the ongoing continuation of services to the best of their ability.

Discussions about this service and how it will support the member and family/guardian to meet their goals must be person-centered. The member and family/guardian's selection of services will be documented in the member POC and include the types of services selected and to be provided to the child and family by their chosen providers including service name, provider, frequency, and duration of the service and how this service will support the strengths and needs of the child. Service selection will support a specific goal/s in the member's Plan of Care (POC) and will not duplicate any other services provided to the member and based on medical necessity. The services under the waiver are limited to additional services not otherwise covered under the Medicaid State plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Unit = 15 minutes; up to 874 units per service plan year; caseloads are continuously monitored and determined by program capacity. capped at 15 members per case manager.

All services are person-centered and the established service limits may be exceeded when medical necessity is established.

The CSEDW provider must request authorization to deliver services beyond the “soft” unit limits (i.e., daily, weekly, monthly, annually, dollar amount) and must send documentation to the MCO justifying the child/youth’s need for services exceeding the “soft” limit. The MCO may approve the additional service units if determined to be medically necessary. The additional service units must be documented in the member’s POC and all documentation must be kept with the child/youth’s file and available for review upon request.

Telehealth is an allowable service modality for Wraparound Facilitator. Telehealth may be utilized to deliver services for up to 50% of the total services the member receives per year of enrollment (one calendar year from the members anchor date). Providers will discuss with the member the allowable service modalities. Service selection, modality, scope, frequency, and duration are person-centered and represent the choice of the member and family. The member may utilize telehealth in alignment with the frequency and duration outlined in the members Plan of Care, if telehealth is selected by the member and family a telehealth backup plan must be discussed and added to the Plan of Care, the telehealth backup plan must include alternative service connections available to the member and family, for example switching to in person face to face visits, emergency power supply or a mobile device that allows connection. Delivery of services through telehealth will be conducted in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Telehealth services are available via web-based applications and/or smartphone applications (apps) as long as they meet the current HIPAA and 42 CFR Part 2 regulations of compliance and is accepted by the West Virginia HIPAA Compliance Officer.

Telehealth will not be authorized as a duplicate service. Providers will be trained in limitations and exclusions of the services, and they will be provided in writing. Providers must follow program billing procedures ensuring providers will not duplicate services and billing. The MCO will monitor service provision through POC and claims reviews. The originating site must bill with the appropriate telehealth originating site code and distant site providers must bill the appropriate Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT)/(HCPCS) code with the appropriate Place of Service code.

Privacy is paramount in any health care and telemedicine interaction. The use of video conference, video monitoring, or any type of surveillance is not permitted at any time in bedrooms and bathrooms.

Service Delivery Method *(check each that applies):*

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies):*

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center
Agency	Certified Wraparound Facilitation Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Wraparound Facilitation**Provider Category:**

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications**License** (*specify*):

Licensed Behavioral Health Center (LBHC).

Certificate (*specify*):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.

Other Standard (*specify*):

Wraparound Facilitation services must be provided by an individual fully licensed (this does not include provisional or temporary license) in West Virginia as a social worker, professional counselor or registered nurse OR may be an individual with a four year degree (BA or BS) in a human service field with two (2) years post college, work experience in this field and certification in the on-line case management training developed by BMS. Must be fully certified in the Children and Adolescent Needs and Strengths (CANS) assessment at all times. Must have a contract with the MCO.

Agency staff must also have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by OHFLAC and the BMS. The agency will be certified by the ASO as meeting standards for high-fidelity wraparound.

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Agency is verified by the OHFLAC.

Agency staff is verified by the Licensed Behavioral Health Provider every other year and the ASO annually.

The ASO will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are updated every five (5) years and the OIG, which is checked monthly.

The ASO will review fidelity standards of the Agency at the time of application and annually.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service**

Service Name: Wraparound Facilitation**Provider Category:**

Agency

Provider Type:

Certified Wraparound Facilitation Agency

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):

Must be an approved CSEDW provider and enrolled as a WV Medicaid provider.
Agency is certified by the ASO.

Other Standard (*specify*):

Wraparound Facilitation services must be provided by an individual fully licensed (this does not include provisional or temporary license) in West Virginia as a social worker, professional counselor or registered nurse OR may be an individual with a four year degree (BA or BS) in a human service field with two (2) years post college, work experience in this field and certification in the on-line case management training developed by BMS. Must have a contract with the MCO.

Staff of the certified Wraparound Facilitation Agency must also have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by the BMS. The Agency will be certified by the ASO as meeting standards for high-fidelity wraparound. Must be fully certified in the Children and Adolescent Needs and Strengths (CANS) assessment at all times.

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications**Entity Responsible for Verification:**

ASO verifies initially and annually via on-site review.

Frequency of Verification:

Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are updated every five (5) years and the OIG, which is checked monthly. The ASO verifies fidelity standards initially and annually.

Appendix C: Participant Services**C-1/C-3: Service Specification**

the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Equipment

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:

14 Equipment, Technology, and Modifications

Sub-Category 2:

14032 supplies

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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

Discussions about this service and how it will support the member and family/guardian to meet their goals must be person-centered. The member and family/guardian's selection of services will be documented in the member POC and include the types of services selected and to be provided to the child and family by their chosen providers including service name, provider, frequency, and duration of the service and how this service will support the strengths and needs of the child. Service selection will support a specific goal/s in the member's Plan of Care (POC) and will not duplicate any other services provided to the member and based on medical necessity. The services under the waiver are limited to additional services not otherwise covered under the Medicaid State plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Unit is \$1. Up to \$1000 per service plan year in combination with Specialized Therapy. If this service is not covered by the state plan or private insurance, then members can access this service through the waiver using up to 500 units (\$500) per Person-Centered Service Plan year; Specialized Therapy and Assistive Equipment share this source of funding.

All services are person-centered and the established service limits may be exceeded when medical necessity is established.

The CSEDW provider must request authorization to deliver services beyond the “soft” unit limits (i.e., daily, weekly, monthly, annually, dollar amount) and must send documentation to the MCO justifying the child/youth’s need for services exceeding the “soft” limit. The MCO may approve the additional service units if determined to be medically necessary. The additional service units must be documented in the member’s POC and all documentation must be kept with the child/youth’s file and available for review upon request.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center, CSEDW Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Assistive Equipment

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center, CSEDW Provider

Provider Qualifications

License (*specify*):

Business license and/or relevant skills for work to be performed.

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

The MCO is responsible for ensuring that providers of Assistive Equipment meet qualification standards prior to processing invoices. The MCO is responsible to review for prior authorization to assure items/services are indicated on the POC as a need. The ASO will perform certification validation during on-site reviews.

Frequency of Verification:

The ASO will monitor compliance during annual on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Transition

HCBS Taxonomy:**Category 1:**

16 Community Transition Services

Sub-Category 1:

16010 community transition services

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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

- (a) security deposits that are required to obtain a lease on an apartment or home;
- (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
- (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;
- (e) moving expenses;
- (f) necessary home accessibility adaptations; and,
- (g) activities to assess need, arrange for and procure needed resources.

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. 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.

Discussions about this service and how it will support the member and family/guardian to meet their goals must be person-centered. The member and family/guardian's selection of services will be documented in the member POC and include the types of services selected and to be provided to the child and family by their chosen providers including service name, provider, frequency, and duration of the service and how this service will support the strengths and needs of the child. Service selection will support a specific goal/s in the member's Plan of Care (POC) and will not duplicate any other services provided to the member and based on medical necessity. The services under the waiver are limited to additional services not otherwise covered under the Medicaid State plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Unit = \$1; Up to \$3,000 for a one time transition. A transition period can last up to six (6) months.
All services are person-centered and the established service limits may be exceeded when medical necessity is established.

The CSEDW provider must request authorization to deliver services beyond the “soft” unit limits (i.e., daily, weekly, monthly, annually, dollar amount) and must send documentation to the MCO justifying the child/youth’s need for services exceeding the “soft” limit. The MCO may approve the additional service units if determined to be medically necessary. The additional service units must be documented in the member’s POC and all documentation must be kept with the child/youth’s file and available for review upon request.

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.), or;
- Discretionary cash
- Assistive Technology

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

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center, CSEDW Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Transition

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center, CSEDW Provider

Provider Qualifications

License (specify):

Business license and/or relevant skills for work to be performed.

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The MCO is responsible for ensuring that providers of Community Transition meet qualification standards prior to processing invoices. The ASO is responsible to review for prior authorization to assure items/services are indicated on the POC as a need. The ASO will perform certification validation during on-site reviews.

Frequency of Verification:

The ASO will monitor compliance during on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Therapy

HCBS Taxonomy:

Category 1:**Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Family Therapy consists of counseling and training services for the member and family provided by a licensed mental health professional (with a master's degree or a licensed individual under supervision). This service includes trauma-informed individual and family therapy in the family home and should assist the family to acquire the knowledge and skills necessary to understand and address the specific needs of the member in relation to their SED and treatment, such as developing and enhancing the family's problem-solving skills, coping mechanisms, and strategies for the member's symptom/behavior management.

Per West Virginia code, the term "family" relates to, but is not limited to, custodians, legal guardians, and family, except in those instances where a different meaning is provided or the context in which the word is used clearly indicates that a different meaning is intended.

"Caregiver" means any person who is at least eighteen years of age and:

- a. Is related by blood, marriage, or adoption to the minor, but who is not the legal custodian or guardian of the minor; or
- b. Has resided with the minor continuously during the immediately preceding period of six months or more.

"Custodian" means a person who has or shares actual physical possession or care and custody of a child, regardless of whether that person has been granted custody of the child by any contract or agreement

Family Therapy providers will use an evidence-based therapeutic approach to assist the member and their family in developing the knowledge and skills necessary to understand and address the specific needs of the member in relation to the child's SED and treatment. The evidence-based therapy sessions may focus on but not limited to elements such as developing and enhancing the family's problem-solving skills, coping mechanisms, and strategies for the member's symptom/behavior management. Family Therapy providers will implement and oversee all Mobile Response activities; including primary point of contact for the service, on-call coverage, staff training and credentialing, referral, and data reporting.

Written policy and procedures, as defined by BMS, specific to Mobile Response must be developed and maintained by any agency providing the service. Additionally, the Family therapist supervises the In-Home Family support worker. The In-Home Family support worker will coordinate with the Family therapist to help the member and family practice and implement the coping strategies introduced by the Family therapist. The In-Home Family support worker works with the member and family on the practical application of the skills and interventions that will allow the member and family to function more effectively.

The In-Home Family support worker assists the family therapist by:

- a) Helping the parent/child communicate their concerns;
- b) Providing feedback to the therapist about observable family dynamics;
- c) Helping the family and youth implement changes discussed in family therapy and/or parenting classes;
- d) Providing education to the parent/legal representative/foster parents regarding their child's mental illness;
- e) Coaching, supporting, and encouraging new parenting techniques;
- f) Helping parents/legal representatives/foster parents learn new parenting skills specific to meet the needs of their child;
- g) Supporting parents/legal representatives/foster parents in applying specific and on-the-spot parenting methods to change family dynamics.

While scheduling may allow the Family therapist and the In-Home Family support worker to be in the home concurrently, it is not required nor is it the intent. However, the Family therapist and the In-Home will be in regular communication through many mechanisms: one-on-one case staffing; Plan of Care (POC) meetings; joint family therapy or support sessions and review of service documentation. This expectation will be outlined in the provider

policy for these services.

Due to the overwhelming response from HCBS providers, members and families during the COVID-19 Public Health Emergency, BMS is implementing telehealth as an allowable service modality for the CSED Waiver permanently. Telehealth is only allowable for indicated services and does not replace required face-to-face visits. Providers are mandated to report any critical incidents to the State, including any health and safety concerns. Telehealth delivery will not eliminate any face-to-face requirements the State already implements that are designed to address the health and safety of the individual receiving the service. The health and safety of West Virginia's health care providers and our ability to provide and support the member and family remain the state's top priorities.

HCBS providers must work with the member and family to determine if telehealth will be utilized for a specified service occurrence. While some HCBS can be delivered effectively via telehealth, in certain instances, face-to-face contact may still be clinically indicated and may be a life safety issue. If the participant has an immediate need for services that must be delivered face-to-face, the HCBS provider should take appropriate measures to ensure service needs are met to safeguard the health, safety and welfare of the participant. Wraparound Facilitators and HCBS providers must document if telephonic methods were utilized to meet HCBS requirements. It is the ongoing responsibility of Wraparound Facilitators and HCBS providers to make all efforts to utilize telephonic and telehealth mechanisms to ensure regular contacts with their participants and the ongoing continuation of services to the best of their ability.

Discussions about this service and how it will support the member and family/guardian to meet their goals must be person-centered. The member and family/guardian's selection of services will be documented in the member POC and include the types of services selected and to be provided to the child and family by their chosen providers including service name, provider, frequency, and duration of the service and how this service will support the strengths and needs of the child. Service selection will support a specific goal/s in the member's Plan of Care (POC) and will not duplicate any other services provided to the member and based on medical necessity. The services under the waiver are limited to additional services not otherwise covered under the Medicaid State plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Unit = 15 minutes; Up to 2 hours per day (8 units per day), approximately 14 hours per week (56 units/week). All services are person-centered and the established service limits may be exceeded when medical necessity is established.

The CSEDW provider must request authorization to deliver services beyond the “soft” unit limits (i.e., daily, weekly, monthly, annually, dollar amount) and must send documentation to the MCO justifying the child/youth’s need for services exceeding the “soft” limit. The MCO may approve the additional service units if determined to be medically necessary. The additional service units must be documented in the member’s POC and all documentation must be kept with the child/youth’s file and available for review upon request.

Telehealth is an allowable service modality for Family Therapy. Telehealth may be utilized to deliver services for up to 50% of the total services the member receives per year of enrollment (one calendar year from the members anchor date). Providers will discuss with the member and family the allowable service modalities. Service selection, modality, scope, frequency, and duration are person-centered and represent the choice of the member and family. The member may utilize telehealth in alignment with the frequency and duration outlined in the members Plan of Care, if telehealth is selected by the member and family a telehealth backup plan must be discussed and added to the Plan of Care. The telehealth backup plan must include alternative service connections available to the member and family, for example switching to in person face to face visits, emergency power supply or a mobile device that allows connection. Delivery of services through telehealth will be conducted in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Telehealth services are available via web-based applications and/or smartphone applications (apps) as long as they meet the current HIPAA and 42 CFR Part 2 regulations of compliance and is accepted by the West Virginia HIPAA Compliance Officer.

Telehealth will not be authorized as a duplicate service. Providers will be trained on limitations and exclusions of the services, and they will be provided in writing. Providers must follow program billing procedures ensuring providers will not duplicate services and billing. The MCO will monitor service provision through POC and claims reviews. The originating site must bill with the appropriate telehealth originating site code and distant site providers must bill the appropriate Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT)/(HCPCS) code with the appropriate Place of Service code.

Privacy is paramount in any health care and telemedicine interaction. The use of video conference, video monitoring, or any type of surveillance is not permitted at any time in bedrooms and bathrooms.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Family Therapy

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications**License** (*specify*):

Agency must have a current WV Behavioral Health License issued by the WVDHHR Office of Health Facility Licensure and Certification (OHFLAC).

Certificate (*specify*):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.

Other Standard (*specify*):

Must be performed by a minimum of a master's level therapist who is licensed or under master's level licensure supervision, including Board Certified Behavior Analyst (BCBA), who is experienced in trauma-informed care and is using generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work. Must have a contract with the MCO.

Staff qualified for this service are as follows: Doctor of Medicine (MD); Doctor of Osteopathic Medicine (DO); Advanced Practice Registered Nurse (APRN); Licensed Psychologist (LP); Supervised Psychologist (SP); Licensed Professional Counselor (LPC); Licensed Independent Social Worker (LICSW); Licensed Clinical Social Worker (LCSW); Licensed Social Worker (LSW); Advanced Alcohol and Drug Counselor (AADC) and an Addictions Counselor (ADC).

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by OHFLAC and the BMS.

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Agency is verified by the OHFLAC.
Agency staff is verified by the Licensed Behavioral Health Provider and the ASO.
The ASO will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.
Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are updated every five (5) years and the OIG, which is checked monthly.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Mobile Response services are 24-hour services designed to respond immediately to issues that threaten the stability of the member's placement and his/her ability to function in the community. This service is intended to be of very short duration and primarily to engage/link to other services and resources, e.g., intensive in-home supports and services. This service may only be delivered in an individual, one-to-one session. The service includes: de-escalation, issue resolution support, and the development of a stabilization plan for any additional services that are needed to resolve the immediate situation.

The Wraparound Facilitator will remain the primary contact for CSEDW, however the agency providing the Family Therapy will implement and oversee all Mobile Response activities; including primary point of contact for the service, on-call coverage, staff training and credentialing, referral, and data reporting. Written policy and procedures, as defined by BMS, specific to Mobile Response must be developed and maintained by any agency providing the service. The Case Management agency will be notified of any Mobile Response activities.

Must have a minimum of a bachelor's degree in social work, psychology, sociology or other human services field plus one (1) year of experience working with a mental health population. Must have a contract with the MCO. Services provided in this category will be in response to a specific goal/s in the member's Plan of Care (POC) and will not duplicate any other services provided to the member. The services under the waiver are limited to additional services not otherwise covered under the Medicaid State plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Unit = 15 minutes; up to 14 hours per week.

All services are person-centered and the established service limits may be exceeded when medical necessity is established.

The CSEDW provider must request authorization to deliver services beyond the "soft" unit limits (i.e., daily, weekly, monthly, annually, dollar amount) and must send documentation to the MCO justifying the child/youth's need for services exceeding the "soft" limit. The MCO may approve the additional service units if determined to be medically necessary. The additional service units must be documented in the member's POC and all documentation must be kept with the child/youth's file and available for review upon request.

BPH's Office of Maternal, Child and Family Health (OMCFH) is responsible for providing and overseeing the Children with Special Healthcare Needs (CSHCN) services. Any services are intended to be non-clinical, 'gap filling' wraparound and care management; CSHCN can help CSEDW members/families find and access similar services offered by the Waiver. CSHCN is available statewide via regionally-located teams of registered nurses and licensed social workers. The Team for each child is served regardless of foster care involvement. The MCO will provide any participants in jeopardy of maxing out services a referral to CSHCN.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Mobile Response

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications

License (*specify*):

Agency must have a current WV Behavioral Health License issued by the WVDHHR Office of Health Facility Licensure and Certification (OHFLAC).

Certificate (*specify*):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.

Other Standard (*specify*):

Must have a minimum of a bachelor's degree in social work, psychology, sociology or other human services field plus one (1) year of experience working with this population. Must have a contract with the MCO.

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by OHFLAC and the BMS.

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the OHFLAC.

Agency staff is verified by the Licensed Behavioral Health Provider every other year and the ASO annually.

The ASO will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are verified every five (5) years and the OIG, which is checked monthly.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Service offered in order to enable waiver members to be transported to and from local, public community locations for services specified in the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the state plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Foster parents/homes are excluded from this service under the Waiver, as the Title IV-E payment to foster care families should include transportation.

Discussions about this service and how it will support the member and family/guardian to meet their goals must be person-centered. The member and family/guardian's selection of services will be documented in the member POC and include the types of services selected and to be provided to the child and family by their chosen providers including service name, provider, frequency, and duration of the service and how this service will support the strengths and needs of the child. Service selection will support a specific goal/s in the member's Plan of Care (POC) and will not duplicate any other services provided to the member and based on medical necessity. The services under the waiver are limited to additional services not otherwise covered under the Medicaid State plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Unit = 1 mile; up to 800 miles per month.

All services are person-centered and the established service limits may be exceeded when medical necessity is established.

The CSEDW provider must request authorization to deliver services beyond the “soft” unit limits (i.e., daily, weekly, monthly, annually, dollar amount) and must send documentation to the MCO justifying the child/youth’s need for services exceeding the “soft” limit. The MCO may approve the additional service units if determined to be medically necessary. The additional service units must be documented in the member’s POC and all documentation must be kept with the child/youth’s file and available for review upon request.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications

License (*specify*):

Agency must have a current WV Behavioral Health License issued by the WVDHHR Office of Health Facility Licensure and Certification (OHFLAC).

Certificate (*specify*):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.

Other Standard (*specify*):

Must have a current and valid drivers license. The vehicle must also be insured and have a current WV Motor Vehicle Inspection. Must have a contract with the MCO.

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by OHFLAC and the BMS.

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the OHFLAC.

Agency staff is verified by the Licensed Behavioral Health Provider and the ASO.

The ASO will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.

Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are verified every five (5) years and the OIG, which is checked monthly.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Peer Parent Support

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09020 caregiver counseling and/or training

Category 2:

Sub-Category 2:

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Service Definition (Scope):

Peer Parent Support services are designed to offer support to the parent/legal representative/foster parents of the member with SED. The services are geared toward promoting parent/legal representative/foster parent empowerment, enhancing community living skills, and developing natural supports. This service connects the parent/legal representative/foster parent with a parent(s) who is raising or have raised a child with mental health issues and are personally familiar with the associated challenges.

Peer Parent Support providers are mentors who have shared experiences with the member, family, or both member and family and who provide support and guidance to the member and his or her family members. Peer Parent Support providers explain community services, programs and strategies they have used to achieve the waiver member's goals. It fosters connections and relationships which builds the resilience of the member and his or her family. This service, limited in nature, is aimed at providing support and advice based on the lived experience of a family member or self-advocate. Peer Parent Support providers cannot mentor their own family members.

Peer Parent Support services encourage members and their family members to share their successful strategies and experiences in navigating a broad range of community resources beyond those offered through the waiver with other waiver members and their families. Includes facilitation of parent or family member "matches" and follow-up support to assure the matched relationship meets peer expectations. Peer Parent Support providers will not supplant, replace, or duplicate activities that are required to be provided by the Wraparound Facilitator.

This service is different than the In-Home Family support worker as the support worker is focused on supporting and reinforcing knowledge, skills and behaviors stemming from Family Therapy. The key difference is the provider relationship is not clinical; peer providers will have lived experience similar to the youth and families being served. These services will not have the same clinical emphasis the In-Home Support worker will have wherein the therapist and the support worker are working in tandem to address specific therapeutic treatment goals. Peer Parent Support will address separate, non-clinical goals that focus on community and other natural engagement that can help support, increase awareness and benefit the family.

Services provided by the Peer Parent can include: Provides training and supports necessary to support and ensure engagement and active participation of the family in the treatment process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. The peer parent will attend meetings with the family and assist in helping family members to effectively contribute to planning and accessing services including assistance with removing barriers. Also assist in describing the program model and providing information as needed to assist the family. This service is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child/youth (e.g., parenting children with various behavior challenges). This involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the Medicaid eligible child in relation to their mental illness and treatment; development and enhancement of the symptom/behavior management; assisting the family in understanding various requirements of the waiver process, such as the crisis/safety plan and plan of care process; training on understanding the child's diagnoses; understanding service options offered by service providers; and assisting with understanding policies, procedures and regulations that impact the child with mental illness/addictive disorder concerns while living in the community (e.g., training on system navigation and Medicaid intervention with other child serving systems.). The peer parent may also conduct follow-up with families regarding services provided and continuing needs.

BMS acknowledges that family participation plays an essential role in its programs. Studies demonstrate that engaging families as equal partners in their child's health care decision-making reduces unmet health needs, problems with specialty referrals, Out-of-pocket expenses, and improves patient physical and behavioral function. The goal of Peer Parent Support will be to empower other parents to take on leadership roles within their communities; to decrease isolation and to deliver parents' perspectives to service providers. The waiver will use Peer Parent Support to promote family support through linking families to family organizations and other family-oriented services and supports; these are not clinical in nature but will contribute to the overall health of the family. Such services can include: mutual support networking/groups/activities, health/wellness activities, healthcare system navigation, community engagement and outreach opportunities, etc. To determine if families are utilizing and benefiting from this service, this information will be reported through monthly quality measures via claims data, along with ongoing quality improvement initiatives.

Due to the overwhelming response from HCBS providers, members and families during the COVID-19 Public

Health Emergency, BMS is implementing telehealth as an allowable service modality for the CSED Waiver permanently. Telehealth is only allowable for indicated services and does not replace required face-to-face visits. Providers are mandated to report any critical incidents to the State, including any health and safety concerns. Telehealth delivery will not eliminate any face-to-face requirements the State already implements that are designed to address the health and safety of the individual receiving the service. The health and safety of West Virginia's health care providers and our ability to provide and support the member and family remain the state's top priorities.

HCBS providers must work with the member and family to determine if telehealth will be utilized for a specified service occurrence. While some HCBS can be delivered effectively via telehealth, in certain instances, face-to-face contact may still be clinically indicated and may be a life safety issue. If the participant has an immediate need for services that must be delivered face-to-face, the HCBS provider should take appropriate measures to ensure service needs are met to safeguard the health, safety and welfare of the participant. Wraparound Facilitators and HCBS providers must document if telephonic methods were utilized to meet HCBS requirements. It is the ongoing responsibility of Wraparound Facilitators and HCBS providers to make all efforts to utilize telephonic and telehealth mechanisms to ensure regular contacts with their participants and the ongoing continuation of services to the best of their ability.

Discussions about this service and how it will support the member and family/guardian to meet their goals must be person-centered. The member and family/guardian's selection of services will be documented in the member POC and include the types of services selected and to be provided to the child and family by their chosen providers including service name, provider, frequency, and duration of the service and how this service will support the strengths and needs of the child. Service selection will support a specific goal/s in the member's Plan of Care (POC) and will not duplicate any other services provided to the member and based on medical necessity. The services under the waiver are limited to additional services not otherwise covered under the Medicaid State plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Unit = 15 minutes; Up to 2 hours/week (8 units/week), approximately 8 hours/month (32 units/month).

All services are person-centered and the established service limits may be exceeded when medical necessity is established.

The CSEDW provider must request authorization to deliver services beyond the “soft” unit limits (i.e., daily, weekly, monthly, annually, dollar amount) and must send documentation to the MCO justifying the child/youth’s need for services exceeding the “soft” limit. The MCO may approve the additional service units if determined to be medically necessary. The additional service units must be documented in the member’s POC and all documentation must be kept with the child/youth’s file and available for review upon request.

Telehealth is an allowable service modality for Peer Parent Support. Telehealth may be utilized to deliver services for up to 50% of the total services the member receives per year of enrollment (one calendar year from the members anchor date). Providers will discuss with the member and family the allowable service modalities. Service selection, modality, scope, frequency, and duration are person-centered and represent the choice of the member and family. The member may utilize telehealth in alignment with the frequency and duration outlined in the members Plan of Care, if telehealth is selected by the member and family a telehealth backup plan must be discussed and added to the Plan of Care, the telehealth backup plan must include alternative service connections available to the member and family, for example switching to in person face to face, emergency power supply or a mobile device that allows connection. Delivery of services through telehealth will be conducted in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Telehealth services are available via web-based applications and/or smartphone applications (apps) as long as they meet the current HIPAA and 42 CFR Part 2 regulations of compliance and is accepted by the West Virginia HIPAA Compliance Officer.

Telehealth will not be authorized as a duplicate service. Providers will be trained on limitations and exclusions of the services, and they will be provided in writing. Providers must follow program billing procedures ensuring providers will not duplicate services and billing. The MCO will monitor service provision through POC and claims reviews. The originating site must bill with the appropriate telehealth originating site code and distant site providers must bill the appropriate Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT)/(HCPCS) code with the appropriate Place of Service code.

Privacy is paramount in any health care and telemedicine interaction. The use of video conference, video monitoring, or any type of surveillance is not permitted at any time in bedrooms and bathrooms.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Peer Parent Support

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications

License (*specify*):

Agency must have a current WV Behavioral Health License issued by the WVDHHR Office of Health Facility Licensure and Certification (OHFLAC).

Certificate (*specify*):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.

Other Standard (*specify*):

Must have a contract with the MCO.

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by OHFLAC and the BMS.

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the OHFLAC.
Agency staff is verified by the Licensed Behavioral Health Provider every other year and the ASO annually.
The ASO will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.
Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are verified every five (5) years and the OIG, which is checked monthly.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Respite Care, Out-of-Home

HCBS Taxonomy:**Category 1:**

09 Caregiver Support

Sub-Category 1:

09011 respite, out-of-home

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Respite Care services provide temporary relief to the member's regular caregiver and include all the necessary care that the usual caregiver would provide during that period. Out-of-Home Respite must be provided by a certified therapeutic foster parent(s) in a certified therapeutic foster care home, but only for children that are living in natural family home or adoptive family homes. Children living in Therapeutic Foster homes are excluded from receiving this service under the Waiver, as the Title IV-E payment to foster care families should include respite. Please note waiver services may be furnished to children in foster care living arrangements but only to the extent that waiver services supplement maintenance and supervision services furnished in such living arrangements and waiver services are necessary to meet the identified needs of the children. Waiver funds are not available to pay for room and board and supervision of children who are under the state's custody, regardless of whether the child is eligible for funding under Title IV-E of the Act. The costs are associated with maintenance and supervision of these children are considered a state obligation. Foster parents/homes are excluded from this service under the Waiver, as the Title IV-E payment to foster care families should include respite. Foster parents access respite as part of their foster care benefits and do not need to utilize CSEDW respite services. Otherwise, the limit is a total of 24 days per year for both In- and Out-of-home respite.

Respite may be provided in the local public community if delivery begins and ends in the member's certified therapeutic foster care home. Service can be used to support the member in engaging in age-appropriate community activities, such as shopping, volunteering, attending concerts, etc.

Discussions about this service and how it will support the member and family/guardian to meet their goals must be person-centered. The member and family/guardian's selection of services will be documented in the member POC and include the types of services selected and to be provided to the child and family by their chosen providers including service name, provider, frequency, and duration of the service and how this service will support the strengths and needs of the child. Service selection will support a specific goal/s in the member's Plan of Care (POC) and will not duplicate any other services provided to the member and based on medical necessity. The services under the waiver are limited to additional services not otherwise covered under the Medicaid State plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Service cannot be provided while the member is asleep.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Unit = 15 minutes; Up to 24 days per year in combination with In-Home Respite Care.
All services are person-centered and the established service limits may be exceeded when medical necessity is established.

The CSEDW provider must request authorization to deliver services beyond the "soft" unit limits (i.e., daily, weekly, monthly, annually, dollar amount) and must send documentation to the MCO justifying the child/youth's need for services exceeding the "soft" limit. The MCO may approve the additional service units if determined to be medically necessary. The additional service units must be documented in the member's POC and all documentation must be kept with the child/youth's file and available for review upon request.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Respite Care, Out-of-Home

Provider Category:

Agency

Provider Type:

Licensed Behavioral Health Center

Provider Qualifications

License (*specify*):

Agency must have a current WV Behavioral Health License issued by the WVDHHR Office of Health Facility Licensure and Certification (OHFLAC).

Certificate (*specify*):

Must be an approved CSEDW provider, enrolled as a WV Medicaid provider.
Must have a current Therapeutic Foster Care Home Certification.

Other Standard (*specify*):

Must have a High School Diploma or GED. Must have a contract with the MCO.

Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by OHFLAC and the BMS.

Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs; Trauma-Informed Care and Practice; and Cultural Competency.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency is verified by the OHFLAC.
Agency staff is verified by the Licensed Behavioral Health Provider every other year and the ASO annually.
The ASO will perform certification validation during on-site reviews.

Frequency of Verification:

Agency behavioral health license is verified biennially.
Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks, which are updated every five (5) years and the OIG, which is checked monthly.
Renewal for Therapeutic Foster Care Home is completed every three (3) years.

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Specialized Therapy refers to activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of a member's needs that arise as a result of his/her SED. The service is intended to assist the member in acquiring the knowledge and skills necessary to understand and address these treatment needs, e.g., developing and enhancing problem-solving skills, coping mechanisms, strategies for the member's symptom/behavior management.

Specialized Therapy are professional services that should promote full membership in the community and/or increase safety in the home environment and local public community and/or assist the individual in self-directing his or her services. Specialized Therapy services must be directed and provided by professionals who are trained, qualified, and/or certified to provide activity therapies. Providers of Specialized Therapy cannot treat their own family members. A member receiving the service does not have the funds to purchase it directly or the service is not available through another source; cannot be accessed as a means of reimbursement for services that have already been obtained and not been pre-approved by the MCO.

Discussions about this service and how it will support the member and family/guardian to meet their goals must be person-centered. The member and family/guardian's selection of services will be documented in the members POC and include the types of services selected and to be provided to the child and family by their chosen providers including service name, provider, frequency, and duration of the service and how this service will support the strengths and needs of the child. Service selection will support a specific goal/s in the member's Plan of Care (POC) and will not duplicate any other services provided to the member and based on medical necessity. The services under the waiver are limited to additional services not otherwise covered under the Medicaid State plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Unit is \$1. Up to \$1000 per service plan year in combination with Assistive Equipment. If this service is not provided by the state plan or private insurance, then members can access these services through this waiver using up to 1000 units (\$1000) per Plan of Care service year; Specialized Therapy and Assistive Equipment share this source of funding.

All services are person-centered and the established service limits may be exceeded when medical necessity is established.

The CSEDW provider must request authorization to deliver services beyond the "soft" unit limits (i.e., daily, weekly, monthly, annually, dollar amount) and must send documentation to the MCO justifying the child/youth's need for services exceeding the "soft" limit. The MCO may approve the additional service units if determined to be medically necessary. The additional service units must be documented in the member's POC and all documentation must be kept with the child/youth's file and available for review upon request.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Behavioral Health Center, CSEDW Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Therapy

Provider Category:

Provider Type:

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications**Entity Responsible for Verification:**

Frequency of Verification:

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf

of waiver participants:

--

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

WV was one of 25 states awarded grant funds from the Centers for Medicare and Medicaid Services (CMS) to create a comprehensive background check program for employees who have direct access to patients. Title VI, Subtitle B, Part III, Subtitle C, Section 6201 of the Patient Protection and Affordable Care Act of 2010 (PL 111-148) established the framework for a nationwide program for states to conduct background checks, review the results and provide employers with a fitness determination for potential employees. The program's purpose is to protect members from neglect, abuse, and financial exploitation.

Per WV Code §16-49-1 et. seq, covered providers licensed by the WV DHHR to perform services that include any direct access services are required to conduct employee background checks. These providers include:

- Nursing homes
- Skilled nursing facilities
- Home health agencies
- Hospice care
- Long-term care hospitals
- Long-term residential care
- Personal care services
- Adult daycare services
- Intermediate care facilities
- Substance Use Disorder Waiver providers
- Other facilities and providers required to participate by DHHR

Policy:

WV Clearance for Access: Registry & Employment Screening (WV CARES) is administered by the DHHR in consultation with the WV State Police Criminal Investigation Bureau (CIB), CMS, the Department of Justice (DOJ), and the Federal Bureau of Investigation (FBI).

The web-based system provides an efficient and effective means for an employer to prescreen an applicant prior to paying the cost of fingerprints. Through fingerprinting, this program provides a comprehensive criminal history records search of national and state criminal history records that was not available under the previous reliance on name-based records searches.

In addition to the initial fingerprint-based criminal history background check, WV CARES is able to monitor applicants and employees through RapBack for potential changes in criminal history and employment status. RapBack allows applicants/employees to move between providers covered by WV CARES without waiting for additional fingerprints.

A facility must receive documentation that fingerprints have been taken before hiring an individual. An applicant may be provisionally employed for up to 60 days while the WV CARES fitness determination is pending. Provisional employees must be directly supervised by an employee who has cleared both the criminal background and the required registry checks, completed at the time of their hire.

The WV State Police contracts with a private agency to securely capture and transmit fingerprints to be processed through the WV State Police and the FBI.

Any covered provider that knowingly hires or retains a person who has been convicted of a disqualifying offense will be in violation of WV Code §16-49-3 and WV Code of State Rules (CSR) §69-10-2.10.

Pre-Screening:

All direct access personnel will be prescreened for negative findings by way of an internet search of registries and licensure databases through WV CARES application process.

Direct access personnel includes individuals who have direct access by virtue of ownership, employment, engagement, or agreement with a covered provider or covered contractor. Direct access personnel do not include volunteers or students performing irregular or supervised functions, or contractors performing repairs, deliveries, installations, or similar services for the covered provider.

Any applicant with a negative finding on any required registry or licensure database is not eligible to be employed.

Fingerprinting Requirements:

If the applicant does not have a negative finding in the prescreening process, and the entity or independent health contractor, if applicable, is considering the applicant for employment, the applicant must submit to fingerprinting for a state and federal criminal history record check. An applicant may be employed as a provisional employee once fingerprints have been collected and documentation submitted to the provider. Provisional hire is not to exceed 60 days subject to the provisions of this policy.

Applicants considered for hire must be notified by the hiring entity that their fingerprints will be retained by the CIB and the FBI to allow for updates of criminal history record information according to applicable standards, rules, regulations, or laws.

Note: WV CARES may request a name-based search when two federal or two state rejections have been received. Once the name-based search results are received they will enter a fitness determination.

Employment Fitness Determination:

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

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

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

Negative findings that would disqualify an applicant in the WV CARES Rule:

1. State or federal health and social services program-related crimes;
2. Patient abuse or neglect;
3. Health care fraud;
4. Felony drug crimes;
5. Crimes against care-dependent or vulnerable individuals;
6. Felony crimes against the person;
7. Felony crimes against property;
8. Sexual Offenses;
9. Crimes against chastity, morality and decency;
10. Crimes against public justice;
11. Felony driving offenses;
12. Felony crimes against the peace; and
13. Falsification of the self-disclosure and consent form.

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

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

Responsibility of the Covered Provider or Contractor:

The covered provider or covered contractor is required to review monthly registry rechecks for any disqualifying offenses. The covered provider and covered contractor are to retain documentation in relation to background checks for all direct access personnel.

Monthly Registry Rechecks:

The WV CARES system will provide monthly rechecks of all current employees against the required registries. The covered provider or covered contractor will receive notification of any potential negative findings. The covered provider or covered contractor is required to research each finding to determine if the potential match is a negative finding for the employee. The covered provider or covered contractor must maintain documentation establishing no

negative findings for current employees.

NOTE: This includes the Office of Inspector General List of Excluded Individuals and Entities (OIG LEIE) check.

Record Retention:

Documents related to the background checks for all direct access personnel must be maintained by the covered provider or covered contractor for the duration of their employment. These documents include:

1. Documents establishing that an applicant has no negative findings on registries and licensure databases.
2. The employee's eligible employment fitness determination;
3. Any variance granted by the Secretary or designee, if applicable; and
4. For provisional employees, the covered provider or covered contractor shall maintain documentation that establishes that the individual meets the qualifications for provisional employment.

Failure of a covered provider or covered contractor to ensure proper completion of the background check process for each individual employed as a direct access personnel may result in the imposition of civil money penalties of \$2,500 per occurrence. Engaging individuals knowing that they are ineligible to work may subject the employer to civil money penalties of \$2,500 per occurrence. Each civil money penalty will be levied by the Secretary or his designee.

All providers who have direct access to children/youth on the CSEDW program are required to have background checks.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Per WV Code Chapter 15, Article 13, WV Police are responsible for maintaining WV's abuse and neglect registry. The WV CARES system utilized by BMS is linked with this registry. The following outlines the WV CARES system and procedures:

WV was one of 25 states awarded grant funds from the Centers for Medicare and Medicaid Services (CMS) to create a comprehensive background check program for employees who have direct access to patients. Title VI, Subtitle B, Part III, Subtitle C, Section 6201 of the Patient Protection and Affordable Care Act of 2010 (PL 111-148) established the framework for a nationwide program for states to conduct background checks, review the results and provide employers with a fitness determination for potential employees. The program's purpose is to protect members from neglect, abuse, and financial exploitation.

Per WV Code §16-49-1 et. seq, covered providers licensed by the WV DHHR to perform services that include any direct access services are required to conduct employee background checks. These providers include:

- Nursing homes
- Skilled nursing facilities
- Home health agencies
- Hospice care
- Long-term care hospitals
- Long-term residential care
- Personal care services
- Adult daycare services
- Intermediate care facilities
- Substance Use Disorder Waiver providers
- Other facilities and providers required to participate by DHHR

Policy:

WV Clearance for Access: Registry & Employment Screening (WV CARES) is administered by the DHHR in consultation with the WV State Police Criminal Investigation Bureau (CIB), CMS, the Department of Justice (DOJ), and the Federal Bureau of Investigation (FBI).

The web-based system provides an efficient and effective means for an employer to prescreen an applicant prior to paying the cost of fingerprints. Through fingerprinting, this program provides a comprehensive criminal history records search of national and state criminal history records that was not available under the previous reliance on name-based records searches.

In addition to the initial fingerprint based criminal history background check, WV CARES is able to monitor applicants and employees through RapBack for potential changes in criminal history and employment status. RapBack allows applicants/employees to move between providers covered by WV CARES without waiting for additional fingerprints.

A facility must receive documentation that fingerprints have been taken before hiring an individual. An applicant may be provisionally employed for up to 60 days while the WV CARES fitness determination is pending. Provisional employees must be directly supervised by an employee who has cleared both the criminal background and the required registry checks, completed at the time of their hire.

The WV State Police contracts with a private agency to securely capture and transmit fingerprints to be processed through the WV State Police and the FBI.

Any covered provider that knowingly hires or retains a person who has been convicted of a disqualifying offense will be in violation of WV Code §16-49-3 and WV CSR§69-10-2.10.

Pre-Screening:

All direct access personnel will be prescreened for negative findings by way of an internet search of registries and licensure databases through WV CARES application process.

Direct access personnel include individuals who have direct access by virtue of ownership, employment, engagement, or agreement with a covered provider or covered contractor. Direct access personnel do not include

volunteers or students performing irregular or supervised functions, or contractors performing repairs, deliveries, installations, or similar services for the covered provider.

Any applicant with a negative finding on any required registry or licensure database is not eligible to be employed.

Fingerprinting Requirements:

If the applicant does not have a negative finding in the prescreening process, and the entity or independent health contractor, if applicable, is considering the applicant for employment, the applicant must submit to fingerprinting for a state and federal criminal history record check. An applicant may be employed as a provisional employee once fingerprints have been collected and documentation submitted to the provider. Provisional hire is not to exceed 60 days subject to the provisions of this policy.

Applicants considered for hire must be notified by the hiring entity that their fingerprints will be retained by the CIB and the FBI to allow for updates of criminal history record information according to applicable standards, rules, regulations, or laws.

Note: WV CARES may request a name-based search when two federal or two state rejections have been received. Once the name-based search results are received, they will enter a fitness determination.

Employment Fitness Determination:

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

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

If the review of the criminal history record information reveals a conviction of a disqualifying offense, the applicant will receive a fitness determination of "not eligible" and may not be employed, unless a variance has been requested or granted. A variance may be granted if mitigating circumstances surrounding the disqualifying offense are provided, and it is determined that the individual will not pose a danger or threat to residents or their property.

Mitigating circumstances may include: 1. The passage of time; 2. Extenuating circumstances such as the applicant's age at the time of conviction, substance abuse, or mental health issues; 3. A demonstration of rehabilitation such as character references, employment history, education, and training; and 4. The relevancy of the particular disqualifying information.

Negative findings that would disqualify an applicant in the WV CARES Rule:

1. State or federal health and social services program-related crimes;
2. Patient abuse or neglect;
3. Health care fraud;
4. Felony drug crimes;
5. Crimes against care-dependent or vulnerable individuals;
6. Felony crimes against the person;
7. Felony crimes against property;
8. Sexual Offenses;
9. Crimes against chastity, morality and decency;
10. Crimes against public justice;
11. Felony driving offenses;
12. Felony crimes against the peace; and
13. Falsification of the self-disclosure and consent form.

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

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

Responsibility of the Covered Provider or Contractor:

The covered provider or covered contractor is required to review monthly registry rechecks for any disqualifying offenses. The covered provider and covered contractor are to retain documentation in relation to background checks for all direct access personnel.

Monthly Registry Rechecks:

The WV CARES system will provide monthly rechecks of all current employees against the required registries. The covered provider or covered contractor will receive notification of any potential negative findings. The covered provider or covered contractor is required to research each finding to determine if the potential match is a negative finding for the employee. The covered provider or covered contractor must maintain documentation establishing no negative findings for current employees.

NOTE: This includes the Office of Inspector General List of Excluded Individuals and Entities (OIG LEIE) check.

Record Retention:

Documents related to the background checks for all direct access personnel must be maintained by the covered provider or covered contractor for the duration of their employment. These documents include:

1. Documents establishing that an applicant has no negative findings on registries and licensure databases.
2. The employee's eligible employment fitness determination;
3. Any variance granted by the Secretary or designee, if applicable; and
4. For provisional employees, the covered provider or covered contractor shall maintain documentation that establishes that the individual meets the qualifications for provisional employment.

Failure of a covered provider or covered contractor to ensure proper completion of the background check process for each individual employed as a direct access personnel may result in the imposition of civil money penalties of \$2,500 per occurrence. Engaging individuals knowing that they are ineligible to work may subject the employer to civil money penalties of \$2,500 per occurrence. Each civil money penalty will be levied by the Secretary or his designee.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Self-directed

Agency-operated

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

To become a CSEDW Agency, an agency must apply for a Certificate of Need (CON) through an expedited Summary Review process and be approved by the WV Health Care Authority. Then, the agency must obtain a Behavioral Health License through OHFLAC. Licensure of a new agency involves an initial onsite OHFLAC review followed by a six month comprehensive on-site review (as necessary) to ensure all certification standards are substantially met.

Medicaid Enrollment:

The Affordable Care Act (ACA) and related regulations at 42 CFR 455, imposed new requirements on SMAs, and Children's Health Insurance Programs (CHIP) to enhance their provider enrollment and screening practices. The SMA and providers must comply with these federal regulations and the Centers for Medicare and Medicaid Services (CMS) Medicaid Provider Enrollment Compendium (MPEC). In addition, Medicaid-enrolled providers must comply with all additional requirements established by WV and the WV BMS. Providers may enroll as inpatient or outpatient facilities, agencies, pharmacies, suppliers, individual practitioners, or groups. All group practices must comply with WV law applicable to group and corporate practice. All rendering practitioners (i.e. providers who are providing services and directly bill WV Medicaid) and ordering, referring, and prescribing (ORP) practitioners or other professional practitioners (i.e. providers who are providing services, writing prescriptions and/or referring members, but are not permitted to directly bill WV Medicaid) must be enrolled as participating providers to be eligible for reimbursement of services. Not all applicable requirements are specified in 42 CFR 455.

The BMS fiscal agent's (FA) Provider Enrollment Unit is responsible for screening and enrolling providers into the WV Medicaid Program. Some provider types also require BMS' approval for enrollment.

Enrolled providers, in accordance with their license and scope of practice, may be eligible to participate and receive reimbursement for services provided to Medicaid members when they:

- Meet all applicable licensing as required by WV in which services will be performed and maintain a valid copy on file with the BMS FA;
- Have a valid signed provider enrollment application/agreement on file with the BMS FA;
- Meet and remain in compliance with BMS' provider enrollment requirements; and
- Meet all Federal Requirements pertaining to provider screening and enrollment

The required screening measures vary according to the provider's categorical risk level of "limited," "moderate" or "high" in accordance with 42 CFR 455 and 42 CFR 424.518. All screening includes mandatory disclosures related to ownership and controlling interests and information about disclosing entities, fiscal agents, or managed care entities. Screening for providers in the moderate and high-risk categories includes site visits. Screening for high risk also includes fingerprint-based background checks. All providers are screened against state and federal databases to assure no provider is enrolled who is not deemed eligible based on federal and state criteria. A provider will not be enrolled, re-enrolled, re-activated, or revalidated until all screening activities applicable to that provider are completed.

Section 1902(a)(27) of the Social Security Act provides general authority for the Department of Health and Human Services (DHHS) Secretary to require provider agreements under WV Medicaid Plans with every person or institution providing services under the State plan. Under these agreements, the Secretary may require information regarding any payments claimed by such person or institution for providing services under the State plan. In addition, Section 2107(e) of the Act, provides that certain Title XIX and Title XI provisions apply to States under Title XXI, including 1902(a)(4)(C) of the Act, related to conflict of interest standards, and 1902(a)(77) and (kk) related to screening, oversight, and reporting requirements.

Renewals of license and/or certification must be current, and the documentation must be submitted to the BMS FA's Provider Enrollment Unit for inclusion in the provider record. A provider's participation in the WV Medicaid Program may be terminated if the BMS FA does not receive a copy of the provider's license/certification.

As a part of the federally required revalidation process, providers must verify their enrollment information and update the required disclosures at predetermined intervals. If a provider has been screened by Medicare or another State's Medicaid or CHIP program within the previous five years, information pertaining to federal requirements from that screening may be accepted by WV Medicaid. Additional state requirements may apply. Off cycle revalidations may be carried out by WV Medicaid, when warranted by situations such as random checks indicating health care fraud, complaints, national initiatives, etc.

WV will comply with the national system for reporting criminal and civil convictions, sanctions, negative licensure

actions, and other adverse actions.

Managed Care Enrollment:

The MCO must enroll as a provider and are responsible for contracting and credentialing their participating providers. The MCO establishes standards for providers that participate in their networks. MCO standards must meet or exceed those for traditional Medicaid fee-for-service providers. If a provider wants to become a participating provider with the MCO, he/she must contact the MCO directly.

Under Section 5005(b)(2) of the 21st Century Cures Act, by January 1, 2018, WV Medicaid must require that a provider in a managed care network is enrolled with WV Medicaid consistent with section 1902(kk) of this Title. Enrollment of the managed care provider must include provision of the provider's identifying information, including the name, specialty, date of birth, Social Security Number, National Provider Identifier (NPI) Number, Federal Tax ID Number, and WV license or certification number of the provider. Each provider must execute a provider agreement with WV Medicaid and all applicable screening must be performed.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: 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.

i. Sub-Assurances:

- a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

C-aia-1: Number of CSEDW agency staff that meet all licensing and certification requirements. Numerator- Number of CSEDW agency staff that meet all licensing and certification requirements. Denominator- Total number of CSEDW agency staff fields reviewed.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
---	--	--

State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95</div>
Other Specify: <div>ASO,MCO</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>ASO</div>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

C-aib-1: Number of non-licensed and non-certified CSEDW agency staff that meet waiver program requirements. Numerator- Total number of non-licensed and non-certified CSEDW staff who meet agency program requirements. Denominator- Total number of CSEDW agency staff files reviewed.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; display: inline-block; padding: 2px 10px;">95</div>
Other Specify:	Annually	Stratified Describe Group:

ASO		
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: ASO	Annually
	Continuously and Ongoing
	Other Specify:

- c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:**C-aic-1: Number of CSEDW agency staff that meet all training requirements.****Numerator-** Number of CSEDW agency staff that meet all training requirements.**Denominator-** Total number of CSEDW agency staff fields reviewed.**Data Source** (Select one):**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>ASO and MCO.</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: 150px;">ASO</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

All data surrounding this sub-assurance will be collected through the ASO Quality and Utilization Review process. As individual problems are identified by the ASO during the review process, any agency staff who do not meet the required training components will not be permitted to provide any Waiver service and the provider will repay BMS for any disallowances for services provided by unqualified staff. The provider agency must submit proof of required training prior to reinstating the staff. The provider agency must also submit a Corrective Action Plan, which identifies the means by which they will monitor and track required staff training.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
ASO	
	Continuously and Ongoing
	Other Specify: <div></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, [HCB Settings Waiver Transition Plan](#) for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The members of the CSEDW may reside with their natural or adoptive families in private homes located in residential communities. These members receive their CSEDW services in their homes or communities the same as people without disabilities do. These settings are presumed to meet the requirements of the CMS Integrated Settings Rule found at 42 CFR 441.301(c)(4)).

Some children, who are in the custody of the WVDHHR Bureau for Children and Families, who also have a mental health diagnosis of Serious Emotional Disorder, may also reside in Therapeutic Foster Care (TFC) Homes which are also private homes located in residential communities, but these homes are licensed/certified by WVDHHR's sister bureau, the Bureau for Children and Families. These members receive their CSEDW services in their homes or communities the same as people without disabilities do. These homes are visited at least twice a month by the licensing agency and certified on an annual basis. These settings have been assessed and verified to meet the requirements found at 42 CFR 441.301(c)(4). BMS has partnered with BCF to assure that the settings checklist is added to the home study when initially licensing therapeutic foster homes.

For current CSEDW members, who reside in TFC homes, the checklist has already been completed. These TFC homes met settings requirements.

For all children receiving CSEDW services, the wraparound facilitator will use the checklist to review any potential new home or placement prior to the move to assure that it meets settings requirements. If there are any concerns identified, the wraparound facilitator will assist the member/family in locating other housing options prior to the move.

In addition, the wraparound facilitator will review each placement setting prior to the annual recertification process.

Due to the global pandemic, on-site reviews by BMS was not possible, however, a thorough review of the certification standards were conducted. The standards included Title 78 Legislative Rule Series 2 Child Placing Agencies License (<https://casetext.com/regulation/west-virginia-administrative-code/agency-78-human-services/title-78-legislative-rule-department-of-health-and-human-resources/series-78-02-child-placing-agencies-licensure>, WVDHHR Bureau for Children and Families Foster Family Care (FFC) Provider Agreement and the WVDHHR BCF Office of Children and Adults Homefinding Policy (<https://dhhr.wv.gov/bcf/policy/Documents/Homefinding%20Policy%20January%202021.pdf>). The BCF TFC homes are required to meet all of these standards prior to certification and continuing thereafter. This is verified by the Child Placing Agency Certification Specialist.

These TFC foster families sign an annual contract with WVDHHR Bureau for Children and Families to attest these settings meet the settings requirements along with BCF's licensing requirements.

For ongoing monitoring of these settings, the Wraparound Facilitator will use the settings checklist based on the Integrated Settings Rule (42 CFR 441.301(c)(4)) and complete monthly during one of their weekly home visits. If modifications are identified either prior to or (after the child is placed in a TFC Home, then the modification must be in response to a specific addressed need and must be identified during a Child and Family Team Meeting and justified in the member's Plan of Care.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Plan of Care (POC)

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)**b. Service Plan Development Safeguards. *Select one:***

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant.

1. The ASO notifies members and/or their parents/legal guardians are informed of their choice of system of care; institutionalization or community-based waiver program, as well as the choice of available waiver services and waiver service providers.
2. The member completes a Freedom of Choice form to identify their preferred provider, which will be forwarded to the provider of choice. 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. When BMS has determined that the only willing and qualified entity responsible for the development of the member's plan of care, within a 15- mile radius of the member's home OR if there are no willing and qualified Wraparound Facilitation providers who have a common language or cultural background with the member, then the State can approve to allow a Licensed Behavioral Health Agency to provide Wraparound Facilitation services as well as other waiver services for the same member.
3. In situations when the Licensed Behavioral Health Agency is providing Wraparound Facilitation services and other CSEDW services, the MCO will review the member's individualized, person-centered Plan of Care (POC) and ensure that the individual providers of wraparound facilitation and direct care services in the Agency are distinct units separate from the wraparound facilitation unit within the Agency, supervised by separate Managers. The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the member when a Licensed Behavioral Health Agency is authorized to deliver wraparound facilitation services and direct waiver services to the same member.
 - (1) The LBHA must have separate files for Wraparound Facilitation and for other CSEDW services. It is the responsibility of the LBHA to ensure separate file maintenance.
 - (2) The Wraparound Facilitation offices are in a separate location from the Direct Care Services (may be in same building, but physically separated).
 - (3) There shall be no sharing of supervisory staff between the Wraparound Facilitation Agency and the Direct Care Services Agency.
 - (4) The Wraparound Facilitator may not provide any direct care services and other CSEDW services may not provide Wraparound Facilitation.
 - (5) The Wraparound Facilitator must have evidence of a written 15-mile radius, language or cultural background authorization issued by the MCO on behalf of BMS agency present in the member's file.
 - (6) WV will monitor the conflict free wraparound facilitation process via retro-reviews conducted by the ASO and may periodically request additional reports from the MCO.
 - (7) For LBH agencies authorized to deliver wraparound facilitation services and direct care services, BMS has ensured conflict of interest protections, certifying that wraparound facilitators employed by that LBH agency remain neutral during the development of the Plan of Care and including the requirement that the LBH agency separate direct care services and Wraparound Facilitation into distinct functions, with separate oversight.

Wraparound Facilitation agencies must have a policy to ensure, at a minimum:

- (8) Explains how members are given choice of Wraparound Facilitators within the LBH agency.
 - a. The LBH agency will obtain the member's signature on an option letter that documents the member's selection from at least 2 Wraparound Facilitators, who have capacity on their caseload if the agency has more than one Wraparound Facilitators.
 - b. Explains how the LBH agency ensures that the Wraparound Facilitator is free from influence of direct service providers regarding member Plans of Care.
- (9) Any Wraparound Facilitator working for a Wraparound Facilitation agency that will also be providing other CSEDW services will sign a Wraparound Facilitator Conflict of Interest Assurance form and the completed form must be placed in the member file at the Wraparound Facilitation Agency. Failure to have the form in the file when reviewed will result in sanctions.
- (10) Evidence of administrative separation on organizational chart that includes position titles and names of staff must be available to BMS or their designee during all retro-reviews or upon request.
- (11) The LBH agency owner/administrator must also sign an Attestation/Conflict of Interest Application for Home and Community Based Waiver Services that includes, at a minimum, the following:
 - a. The agency has administrative separation of supervision of Wraparound Facilitation and HCB services.
 - b. Members are offered choice for HCB services between and among available service providers.
 - c. Members are not limited to HCB services provided only by this agency.
 - d. Members are given choice of at least two Wraparound Facilitators who have capacity on their caseload within the agency if the agency has more than one Wraparound Facilitator.

- e. Members are free to choose or deny HCB services without influence from the internal agency Wraparound Facilitation and HCB service staff.
- f. Members choose how, when, and where to receive their approved HCB services in accordance with the person-centered service planning process and plan.
- g. Members are free to communicate grievance(s) regarding Wraparound Facilitation and/or HCB services delivered by the agency.
- h. The grievance/complaint procedure is available (?), clear and understood by members and legal representatives.
- i. Grievances/complaints are resolved in a timely manner by giving the member the opportunity to file a grievance/complaint with the Agency. If the grievance/complaint is not resolved, then the member is given the opportunity to present their case to the OA/UMC for resolution.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

At the time of the initial medical eligibility assessment, applicants (or legal representative/foster parent) are provided information regarding their rights to be actively engaged in the Plan of Care development process. General information regarding hi-fidelity wraparound is also provided.

Plan of Care planning is the process by which the Wraparound Facilitator (WF) works in collaboration with the member (and legal representative) to develop the POC. The initial POC is scheduled and developed in collaboration with informal supports as requested by the member/legal representative/foster parent). Subsequent monthly, annual, and bi-annual revisions to the POC are conducted in collaboration with service providers and informal supports or as needed and requested by the member (and legal representative/family/foster parent).

The POC is developed utilizing the medical eligibility assessment and all available assessments. It incorporates the preferences and needs identified by the member. By participating in the assessment process and having access to the support of the WF and other professionals and informal supports, the member has the opportunity and tools to be actively engaged in the POC development process.

Each member will be enrolled with an MCO and provided a member handbook. In the member handbook, the member's rights and responsibilities are identified. Before the member receives a CSEDW slot, the MCO provides the member and parent/legal representative/foster parent with the list of all approved-CSEDW providers within 25 miles of where the member resides. The member must choose to receive Wraparound Facilitation from a separate agency from all other CSEDW services unless:

When BMS has determined there are no willing and qualified Wraparound Facilitation providers who provide Wraparound Facilitation services for the same member within a 25- mile radius of the member's home OR if there are no Wraparound Facilitation providers who have a common language or cultural background with the member, then BMS can approve to allow for a Licensed Behavioral Health Agency to provide Wraparound Facilitation services as well as other waiver services for the same member.

. CSEDW providers will be categorized by type of services offered (i.e. Wraparound Facilitation) and members may choose their individual providers for each category. Members may change CSEDW providers at any time with the transfer becoming effective the first day of the month following the request. The member and their parent/legal representative will complete a Freedom of Choice form, choosing their Wraparound Facilitation agency.

A Wraparound Facilitator with the chosen Wraparound Facilitation agency will contact the member and parent/legal representative/foster parent to begin engagement in the POC development process prior to the seven (7) day meeting taking place. During this contact, the Wraparound Facilitator assures the delivery of the CSEDW enrollment information describing the waiver services, free choice of providers, and how to report abuse and neglect. A mutually agreed upon date will be set for the initial POC meeting within seven (7) days of the CSEDW referral; the Wraparound Facilitator will also schedule and administer the CANS instrument for use in development of the annual POC. The member may have a CANS already begun or completed within the previous 30 days. The team may review this CANS to determine if a new one needs completed. Although the Wraparound Facilitator should begin administration of the CANS instrument at the seven (7) day meeting, the expectation is that the CANS will be completed within thirty (30) days of intake to assist with POC development. The POC shall be developed within seven (7) days and completed within thirty (30) days of intake.

The Wraparound Facilitator is responsible for scheduling and coordinating POC meetings, monitoring the implementation of the POC, and for initiating POC meetings as the needs of the member dictate. POC meetings must be scheduled at times and places that facilitate the inclusion of the member and parent/legal representative/foster parent of the member. It is important to remember that, although coordination of the POC process is the responsibility of the Wraparound Facilitator, development of the POC is the responsibility of the Child and Family Team (CFT). Participation of the CFT is expected to ensure the process is person-centered. WV utilizes the strengths model, which views the member and parent/legal representative/foster parent of the member as the expert on the strengths and needs of the member. These strengths and needs are then used to guide POC development in combination with the information gathered during the application process. The CFT captures the strengths, needs, preferences, and desired outcomes of the member and decides frequency and duration of services and supports.

During the initial POC meeting, the Wraparound Facilitator in conjunction with the CFT informs the member and the parents/legal representative/foster parents of the member of the available resources that may be included in the POC. CSEDW services will emphasize the importance of combining natural supports from the community with professionals to create an POC that supports the successful treatment of the member and the parents/legal representative/foster parents of the member. The CFT consists of the member and/or parent/legal representative/foster parent of the member, the member's Wraparound Facilitator, representatives of each professional discipline, provider and/or program providing services to that member (inter- and intra-agency), and MCO care coordinator (if requested). The Wraparound Facilitator is ultimately responsible for facilitating the development of and subsequent updates to the POC document.

The POC must be updated every 30-45 days or sooner in the case of critical treatment junctures; the member's progress or barriers related to his/her identified treatment plan goals and objectives will be reviewed and updated during these

meetings. Additionally, significant treatment successes, setbacks and incidents that have occurred during the is time will be revisited to inform the development process. The CANS instrument will be administered by the Wraparound Facilitator at any identified "significant life event" (as determined by the CFT) that may alter the member's existing level-of-care status, as well as in preparation of for the member's six (6) month CFT meeting, however, the CANS instrument cannot be administered more than once a month. The Wraparound Facilitator is responsible for scheduling and coordinating CFT meetings, monitoring the implementation of the POC, for initiating CFT meetings as the needs of the member dictate. The member and parent-legal representative of the member have the ability to request a meeting of their CFT at any time should needs or circumstances change. The member and parents/legal representatives of the member ultimately determine participation in the POC development, the identification of POC goals, and the designation of POC services and supports.

If at the member's six (6) month POC review the CFT determines he/she has not benefited from waiver enrollment (i.e. no progress has been made on the member's treatment goals and objects), then the CFT will refer the member to the IEN to re-determine level-of-care placement. Likewise, the CFT may determine the member has benefited from waiver enrollment and no longer requires services delivered by this program, at which time discharge planning will commence. Every person must have a re-determination of medical eligibility completed at least annually. The anchor date of the member's annual re-determination is the first day of the month after the initial medical eligibility was established by the MECA. If the reevaluation results in waiver eligibility the final decision will be made by BMS.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

- a) With the facilitation of a Wraparound Facilitator, the member and their parent/legal representative/foster parent lead the CFT Meeting to develop his/her POC. The member and his/her parent/legal representative/foster parent, together with other CFT members, will develop the POC based on a person-centered philosophy. The CFT is comprised of the member and their parent/legal representative and their natural support system from the community as well as professionals; team members may include any person the member wants to invite. At minimum, the CFT must consist of the member and his/her parent/legal representative/foster parent, the member's Wraparound Facilitator, and any CSEDW agencies providing paid support to the individual. The POC shall be developed within seven (7) days and completed within thirty (30) days of referral. An initial POC is developed based on initial application information within seven (7) days of referral. An annual POC is developed within 30 days of intake and must be updated monthly. It must be updated more frequently, at critical treatment junctures, if necessitated by the member's or parent/legal representative/foster parents' needs.
- b) The POC is the critical document that combines all information from the evaluations to guide the service delivery process as well as information from people who know the member outside the service delivery system. Evaluations include any significant medical, physical therapy, occupational therapy, speech therapy, nutritional, nursing evaluations, and behavior support evaluations in addition to an initial functional assessment administered by the MECA and annual reevaluation by the ASO.
- c) The MCO at the time of enrollment provides the member and his/her parent/legal representative/foster parent education and materials about the available services under the Waiver program and available provider agencies in their geographic area, which would include completion of the Freedom of Choice form if one is not already completed. A handbook is also made available to each member that contains the services offered under the Waiver program.
- d) The POC must be based upon person-centered philosophy. The development of the POC by the CFT must be guided by the member's needs and goals as well as address the needs that are identified in assessments and evaluations. The composition of the team must include the member and their parent/legal representative/foster parent, the Wraparound Facilitator and other CSEDW agencies that provide paid supports to the member. People the member wants to include who are not paid to provide services may also be invited. The Wraparound Facilitator has the responsibility for ensuring that the member's goals, needs and preferences as well as the needs that are addressed in the assessment and evaluations are addressed. Another safeguard is that the MCO will monitor health and safety as it relates to request for service authorizations and assure that service needs are addressed through individual service requests.
- e) The POC specifies services requested by the member and the party responsible for securing and/or offering the service designated on the POC. The signed POC is distributed to all members of the CFT within fourteen (14) calendar days. The Wraparound Facilitator is responsible for ensuring that service providers implement the content of the POC.
- f) The POC format specifically addresses the service, frequency of the service, and the responsible party for delivering the services. The Wraparound Facilitator is required to have a face-to-face contact with the member at least weekly in his/her residence to verify that services are being delivered in a safe environment and in accordance with the POC. Visits with the member and his/her parent/legal representative/foster parent will be used by the Wraparound Facilitator to update progress towards obtaining services and resources and discuss progress towards achieving objectives contained in the POC. The Wraparound Facilitator will also elicit information from the member and his/her parent/legal representative on their assessment of services, achievements, and/or unmet needs.
- g) In collaboration with the child's family and/or personal care attendee the CSED waiver staff will address any hands-on/physical assistance if they choose telehealth for service delivery. As part of the person-centered planning process, during POC meetings, the type of service and delivery method will be determined in the best interests of the member, with their active engagement when age appropriate, and agreed upon by the family and members child and family treatment team. If as part of this process a limitation to what is available to the family via telehealth is determined, the family can request to update their service modality (telehealth or in-person) for allowable services at any time. The POC must include what services will be delivered via telehealth, when allowable. CSEDW HCBS providers must act on behalf of the family and actively follow their choice. To utilize telehealth, providers must document that the service was rendered under that modality.
- h) The POC shall be developed within seven (7) days and completed within thirty (30) days of referral. The POC includes the development of the initial POC, annual POC and subsequent reviews or revisions of the POC to include monthly reviews and critical treatment junctures (as warranted). The POC is developed on an annual basis. An Initial POC is developed based on application information within seven (7) days of referral. An annual POC is developed within 30 days of referral and must be updated at least every 30 days; the member's progress or barriers related to his/her identified treatment plan goals and objectives will be reviewed and updated during these meetings. Additionally, significant treatment successes, setbacks and incidents that have occurred during this time period will be revisited to inform the process. The Wraparound Facilitator will also schedule and administer the CANS instrument for use in development of the annual POC, the six (6) month POC review and at any identified "significant life event" (as determined by the CFT).

It must be updated more frequently, at critical treatment junctures, if necessitated by the member or parent/legal representative/foster parent of the member's needs.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Strategies to mitigate risk should be designed to respect the needs and preferences of the Waiver Member and may include Waiver respite services (short-term respite), Mobile Response, and/or crisis intervention/stabilization services (Medicaid State Plan).

Each Plan of Care is required to contain a crisis plan. Crisis plans are developed in conjunction with the CFT during the POC meeting based upon the individualized preferences of the member and parent/legal representative/foster parent of member. As with the POC itself, the member and parent/legal representative/foster parent of member may choose to revise the crisis plan at any time they feel it is necessary. Each crisis plan is individualized to the member; crisis plan to include clinical and non-clinical events. A potential crisis (risk) and appropriate interventions (strategies to mitigate risk) are specific to the member and identified by the CFT. Training provided to the Wraparound Facilitator highlights the need to identify different levels of intervention on a crisis plan, the different stages of crisis, and how a crisis may be defined differently by each family.

The crisis plan includes action steps as a backup plan if the crisis cannot be averted. The action steps are developed by the CFT and incorporated in the crisis plan. The action steps may involve contacting natural supports, calling a crisis phone line, or contacting the Wraparound Facilitator. The CSEDW in-home services provider is required to provide 24 hours a day/365 days a year crisis response that is readily accessible to members and parent/legal representative/foster parent of member. A required component of the crisis plan is the contact information for those involved at all levels of intervention during the crisis. Families are provided a copy of the crisis plan as an attachment to their POC in order to have access to the identified information should a crisis occur. Should a crisis occur, or support worker not arrive for a scheduled appointment, the individual contact information in the crisis plan should be reviewed.

In the event that a crisis occurs which results in a critical incident being substantiated, then a prevention plan will be created by the member and the CFT to support the crisis plan and ensure similar incidents will not occur in the future. Short-term respite services which may be included in an POC if the CFT deems that the member and parent/legal representative need those services to give relief to the caregiver (short-term respite). Because each member is unique, the CFT designs a member-specific POC including a crisis plan and a back-up plan. The backup plan must be an individualized backup plan and include action steps for the individual to follow in the event of an emergency, including the failure of a support worker to appear when scheduled. Should a crisis occur or support worker not arrive for a scheduled appointment, individual contact information is included on the crisis plan. The Wraparound Facilitator and CFT must ensure that an effective back-up plan is crafted to meet the unique needs and circumstances of each youth. The crisis plan and backup plan must include the identification of potential risks to the enrolled youth and the development of strategies to mitigate such risks. Critical risks must be addressed by incorporating strategies into the plan to mitigate whatever risks may be present. Strategies to mitigate risk should be designed to respect the needs and preferences of the Waiver member and may include Waiver respite services (short-term respite) or crisis intervention/stabilization services (Medicaid State plan).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Members will have free choice of providers within the MCO structure and may change providers as often as desired with the effective date being the first day of the month following the date requested.. When a member becomes eligible for the CSEDW and is already established with a therapist who is not a member of the network, the MCO is required to make every effort to arrange for the member to continue with the same provider if the member so desires. The provider will be required to meet the same qualifications as other CSEDW providers in the network. In addition, if a member needs a specialized service that is not available through the network, the assigned MCO will arrange for the service to be provided outside the network if a qualified provider is available. Finally, except in certain situations, members will be given the choice between at least two providers. Exceptions involve highly specialized services, which are usually available through only one agency in the geographic area. This information is provided in the MCO member handbooks, which are given to members upon enrollment in the waiver. Member handbooks are also available on the MCOs website. CSEDW providers are permitted to offer all CSEDW services, however CSEDW providers are not permitted to deliver the full continuum of services to any single member (i.e., wraparound facilitation). The MCO will ensure each member maintains the described interdependent network of CSEDW providers; this network will also be mandatory members of the CFT.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The initial POC is developed within the first seven (7) days of waiver enrollment; the annual POC must be developed within the first thirty (30) days of waiver enrollment. The Wraparound Facilitator together with the CFT will develop the POC. The MCO will review all annual POCs for approval as the BMS' contracted oversight entity. It is the responsibility of the Wraparound Facilitator to send the POC to the MCO prior to requesting service authorization and service delivery. The MCO will review the POC to determine that requested services are listed on the POC prior to authorizing payment.

Any CSEDW service that is identified as needing prior authorizations will be sent to the MCO Utilization Manager (UM) for approval. The UM will request supporting documentation for the prior authorizations if needed. The MCO does not need to see the POC to authorize payment. The UM makes the final decision if a service will be authorized. If a prior authorization is denied, the agency that received the denial for service can send in an appeal for reconsideration and can also request a Medicaid Fair Hearing.

Additionally, as a part of the Quality Improvement system, staff of the ASO will review a representative sample of POCs with the ASO monthly to review audits conducted and to finalize a Final Disallowance Report which is sent to the MCO along with instructions related to payment options to re-pay for disallowed services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

Monthly or more frequently if needed.

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that*

applies):

Medicaid agency

Operating agency

Case manager

Other

Specify:

Wraparound Facilitator and MCO.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

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

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

In addition, the MCO Care Manager tracks and reviews all POCs and amendments ensuring that POC updates reflect the members choice and needs while also aligning with the identified POC goals. The MCO Care Manager is responsible for helping ensure that when telehealth services are selected that they are provided for only allowable services and when appropriate for the member and their needs. If as part of this process a limitation to what is available to the family via telehealth is determined, the family can request to update their service modality (telehealth or in-person) at any time. CSEDW HCBS providers must act on behalf of the family and actively follow their choice. To utilize telehealth, providers must document that the service was rendered under that modality. The MCO Care Manager also reviews all critical and non-critical incidents to ensure that the POC and Crisis Plan are adequate to meet the needs of CSEDW participants. The MCO Care Manager will document these reviews and any discussions with the Wraparound Facilitator in the CSEDW member's record. Issues with the POC that are not resolved during the CFT meeting will be considered a complaint or grievance to the MCO and responded to according to that process.

For any situations where the Wraparound Facilitator and the CSEDW services are delivered by the same LBHC, the MCO Care Manager will review claims for Wraparound Facilitation services and other CSEDW services on a monthly basis to ensure that the claims indicate that the frequency of services are in alignment with the POC. If there is any deviation from the expected service usage based on the CSEDW member's POC, the MCO Care Manager will contact the CSEDW Wraparound Facilitator to inquire whether there is a change in the POC. Whenever additional CSEDW providers (including Wraparound Facilitation providers) become available or current providers gain openings that would allow a CSEDW member to have a Wraparound Facilitator who does not work for the same LBHC as a CSEDW service provider, the MCO Care Manager will contact the CSEDW waiver member and family to offer a choice of service providers.

The MCO Care Manager will connect with the Wraparound Facilitator at least quarterly to discuss the CSEDW member's progress with the goals in the POC, if there are no incidents within that quarter. This contact will be documented in the member's record.

The MCO meets a minimum of monthly with BMS to discuss any concerns, including concerns stemming from CSEDW waiver needs and any issues that arise with CSEDW waiver providers.

In addition to the MCO's oversight, the ASO is responsible for monitoring the implementation of the POC and member's health and welfare. This monitoring will be conducted annually and consist of both a claims and clinical documentation review. Providers who are found in non-compliance with waiver standards will receive immediate feedback on formulating a Corrective Action Plan for the member. The MCO will also conduct POC monitoring as it relates to their Quality Assurance processes; typically, these reviews are conducted annually.

b. Monitoring Safeguards. Select one:

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The state has established the following safeguards to ensure that service plan monitoring is conducted in the best interests of the participant. Specify:

WV will monitor the conflict free wraparound facilitation process via retro-reviews conducted by the state ASO and may periodically request additional reports from the MCO.

BMS meets monthly with the ASO, MCO and MECA to discuss any concerns. The meetings include a discussion of any specific CSEDW member issues. The ASO also reports monthly on all CSEDW performance measures, which include findings from retroactive reviews of CSEDW provider records. This review includes the requirement for revision of the CSEDW POCs at least every 90 days. The ASO and MCO also report monthly on tracking of FOC forms indicating member choice of institutional versus home and community-based services and CSEDW member choice forms for CSEDW providers.

The ASO has a review tool that is used to ensure that documentation shows that services are provided in accord with the POC. For the sample reviewed, the ASO obtains claims data in advance of the review for comparison with the clinical documentation.

BMS directs the ASO, MECA and MCO to address any concerns raised during monthly oversight meetings.

Once a single LBHC Agency is approved to provide both WF and CSEDW services, the MCO will outreach to the CSEDW member and family to educate them regarding the option to have an independent WF or a choice of CSEDW service providers when one becomes available. This will give the CSEDW member/family the option to have a separate WF from CSEDW service providers whenever possible. The MCO Care Coordinator will contact each CSEDW legal guardian or family/CSEDW member quarterly to verify the frequency of services and offer additional providers if they are available. In addition to the separation of CSEDW services and Wraparound Facilitation services required above, the MCO conducts additional review of POCs to verify that the services in the plan are provided through claims data match for situations where a single LBHC is providing both WF and CSEDW services. Further, the ASO will review LBHC provider documentation during their annual quality reviews to verify that documentation aligns with separate and distinct services.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D-aia-1: Number of CSEDW members whose POC address needs (including health and safety risk factors) and personal goal, by provider of waiver services or through other means N# of CSEDW participants with a POC addressing needs (including health and safety risk factors) and personal goal, by the provider of waiver services

or through other means D# of CSEDW members POC reviewed

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95</div>
Other Specify: <div>ASO,MCO</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="ASO,MCO"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- b. Sub-assurance:** *The State monitors service plan development in accordance with its policies and procedures.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D-aib-1: Number and percent of CSEDW members with a POC that was updated/reviewed at least annually. N# of CSEDW participants whose POC was updated/reviewed within 365 days of the last POC evaluation D# of CSEDW members with a POC that were due to be updated/reviewed

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative

		Sample Confidence Interval = <div>95</div>
Other Specify: <div>ASO, MCO</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>ASO,MCO</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

- c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D-aic-2: Number of CSEDW members whose Plan of Care (POC) is comprehensive and includes access to non-waiver services. N: # of CSEDW members whose POC is comprehensive and includes access to non-waiver services D: # of CSEDW members with a documented change in need.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Management Agencies

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div></div>
Other Specify: <div>Wraparound facilitation Agencies MCO</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/> ASO	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

D-aic-1: Number of CSEDW members with a documented change in need whose service plan was revised. Numerator- Number of CSEDW participants with a documented change in need whose service plan was revised. Denominator- Number of CSEDW members with a documented change in need.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid	Weekly	100% Review

Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify: <div>ASO,MCO</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>ASO,MCO</div>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D-aid-1: Number of service plan issues/problems that are responded to and remediated promptly. Numerator: Service plan issues/problems responded to and remediated within timeframes set forth in the Member Handbook. Denominator: All service plan issues/problems reported in accordance with Member Handbook process and timeframes.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
Other Specify:	Annually	Stratified Describe Group:

<input type="text" value="MCO"/>		<input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="ASO"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

D-aid-2: Number of CSEDW members whose services were delivered in accordance with their Plan of Care (POC). Numerator: The number of CSEDW members who received the type, scope, amount, duration and frequency of services detailed in their POC. Denominator: The total number of POC reviewed.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="MCO,ASO"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
ASO	
	Continuously and Ongoing
	Other Specify:

e. *Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D-aie-1: Number of CSEDW members whose file contains documentation indicating a choice of waiver service providers (does not include Wraparound Facilitation Agency). Numerator- Number of CSEDW members whose file contains documentation indicating a choice of waiver service providers (does not include Wraparound Facilitation Agency). **Denominator-** Number of CSEDW files reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		95%
Other Specify: <input type="text" value="MCO"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="ASO"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

All information related to this assurance is collected by the ASO through the review of CSEDW recipients' charts. Individual issues/concerns related to this assurance identified during the chart review process are addressed immediately by the ASO with providers during an exit interview. Providers are then required to submit a Corrective Action Plan with evidence of completion addressing identified issues. All Plans of Correction must be approved by the ASO and BMS. Services provided that are not documented on the PCSP or are provided by unqualified staff are disallowed and payment is recouped from the Provider agency.

ii. Remediation Data Aggregation**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Applicability (from Application Section 3, Components of the Waiver Request):

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The member applying for or receiving CSEDW services and/or their parent/legal representative, as applicable, are notified in writing of Medicaid State Fair Hearing rights when:

1. The member's request for entry into the CSEDW program has been denied due to medical eligibility; or
2. The member's request for CSEDW services has been denied, reduced, suspended or terminated and they have exhausted all appeal rights.

Medicaid members who are determined to not meet medical eligibility standards for the CSEDW receive notification via a denial letter from the ASO. The letter advises the member and his/her parent/legal representative regarding the reason for the denial, listing the areas in which deficiencies were found against predetermined medical eligibility standards. The denial letter also provides the reason for the adverse decision, including appropriate policy manual references, a notice of free legal services, and a Request for Hearing Form to be completed if the member wishes to contest the decision.

Upon enrollment in the CSEDW program and with the MCO, members receive information from the MCO regarding the Appeals Process, Adverse Determinations, and the Medicaid State Fair Hearing Process through multiple avenues. If the member is contesting a program eligibility-related decision, fair hearing can be requested through the ASO. Members receive a Member Handbook from their MCO upon enrollment that is included in their welcome packet that provides detailed information regarding Appeals and the Medicaid State Fair Hearing Process, including exhaustion of the internal appeals process with the MCO (for service denials) or ASO (for eligibility denials), applicable timeframes for filing and MCO or ASO response times, instructions on how to file, and who to contact if assistance is needed. In addition, every Notice of Action and Adverse Benefit Determination letter includes detailed information regarding the Medicaid State Fair Hearing Process. At any time, a member can call his/her Wraparound Facilitator, the ASO or MCO to get additional information and/or assistance with the Medicaid State Fair Hearing Process. The MCO and the ASO maintain all records related to service requests and denials.

In the case of an Adverse Benefit Determination, members will receive a Notice of Action letter from their MCO, detailing the denial, limitation, reduction, suspension, or termination of the applicable service; the denial, in whole or part, of payment for a service; or the failure of the MCO to act within established time requirements for service accessibility. Notice of Action letters contain information on how to file an appeal, guidelines for verbal and written appeal requests, guidance on filing appeals within 30 days of receipt of the Notice of Action, and information on resolution timeframes.

https://wms-mmdl.cms.gov/WMS/faces/protected/35/apdxF1_1.jsp#

After exhausting the ASO's and/or MCO's internal Appeals process, members are provided written notification regarding the Medicaid State Fair Hearing Process that includes information that services will continue throughout the Medicaid State Fair Hearing Process if applicable policy is followed when making the request. Members are provided a Medicaid State Fair Hearing Request Form as an enclosure to the final Adverse Determination communication from their MCO. Information on available advocacy support is also provided, and the member is provided the opportunity for a Pre-Hearing Conference after they have filed a Medicaid State Fair Hearing Request with BMS. If the member has retained legal counsel, then the ASO or MCO will not conduct a Pre-Hearing Conference, and BMS legal counsel and the member's legal counsel may communicate as necessary prior to the occurrence of the Medicaid State Fair Hearing.

If at any time the CSEDW program cannot adequately ensure a member's health and safety through service utilization per their Plan of Care and utilization of additional community resources per referrals from their Wraparound Facilitator, the member will be referred for institutional services in a PRTF due to the severity of acute psychiatric symptoms contraindicating treatment at a lower level of care, indicators of severe functional impairment in three or more major life domains due to the related psychiatric diagnosis, and failure or lack of progress in a less restrictive level of care despite participation in treatment through the CSEDW. Should a referral be made for institutional services in a PRTF, the member would receive Medicaid State Fair Hearing rights per protocols associated with CSEDW case closure, as described previously.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a)

the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The MCO is responsible for receiving, reporting, and responding to grievances received for all enrolled members. BMS, in turn oversees this process through the quarterly MCO Grievances and Appeals Report. Complaints are tracked and responded to by the Office of Managed Care. The External Quality Review Organization (Qlarant) conducts an on-site review of grievances and appeals per the Code of Federal Regulations and National Committee for Quality Assurance (NCQA) every three years.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Per the MCO contract, a complaint or grievance is defined as an expression of dissatisfaction made about an MCO decision or services received from the MCO when an informal grievance is filed; some complaints may be subject to appeal. Complaints are handled through the MCO Provider Services Department.

Grievances and appeals are handled by the MCO in accordance with 42 CFR Part 438.400 through Part 438.424. Grievances or appeals can be made by a member either in writing (formal) or orally (informal), regarding any aspect of service delivery provided or paid for the MCO. Adverse benefit determinations are considered formal grievances and are always considered appeals. Informal and formal MCO grievances and appeals are separate from state fair hearings process. A member can request a Fair hearing for an adverse benefit determination upheld by the MCO and BMS and the MCO will abide by the decision of the Fair hearing official, regardless of the result of the grievance process.

Presenting a grievance:

Informal: A member always has the option to contact the MCO Provider Services Department or their Wraparound Facilitator (for SED waiver participants) or the MCO Care Coordinator by phone or in writing with a concern regarding services provided through the MCO, this would be the first recommended step.

Assistance will be provided for the member for translation or any auxiliary aids including TTY/TTD by each Medicaid provider serving the family. The MCO will send an acknowledgement of receipt of the grievance or complaint in writing within 5 business days of receipt, unless the member or provider requests an expedited review of the grievance.

Formal: Members may choose to file a formal grievance without going through the informal grievance process. The formal grievance must be filed within sixty (60) calendar days from the date on the notice of action from the MCO to the member. If they are filing the formal grievance due to a denial of any part of the member's request for services, it is considered an appeal. Formal grievances must be made in writing and include: The member's name; the service provider's name; the date of service; the member's mailing address; the basis for, or reason why, the MCO should change its decision; and a copy of any information that could support the appeal, such as written comments, additional documents, records or information related to the appeal.

MCO internal process for addressing grievances:

The MCO will provide written notification to members of their right to formally file a grievance for any change in their benefits or any denial of benefits at least 10 days in advance of any change in their services. This notification will explain how to file a formal grievance for an adverse benefit determination. Members may request to continue current services until the appeal can be heard if they file a grievance prior to the date that the change in benefits or services will be effective in the letter. Members will be given copies of any medical records requested without charge and will be given the opportunity to testify regarding their medical condition and present clinical evidence to support their request for services related to the grievance. With the written consent of the member, an authorized representative or provider can file a formal grievance and testify on their behalf with regard to their health concerns and reasons that they are requesting services continue to be provided.

Grievances and adverse benefit determinations will be reviewed by clinically appropriate individuals not involved in the original determination. Expedited grievances will be resolved with consideration of the member's health condition requires and within 72 hours. The member will be notified initially in person or by phone for expedited grievances, all other formal grievances of adverse benefit determinations will be resolved within 30 days.

The member will be notified of the MCO's determination in writing within 30 days of the request for appeal of an adverse benefit determination. The same requirements regarding translation and auxiliary aids, records, testimony and consideration for expedited review apply to formal grievances and informal grievances for adverse benefit determinations.

If the MCO upholds a grievance that is an adverse benefit determination, the member will be provided notice regarding the state's Fair Hearing process in the letter. Formal or informal grievances that are complaints, not constituting an adverse benefit determination, will be resolved within 90 days. Members will receive a written acknowledgement and disposition for all formal and informal grievances. To clarify, the MCO will send the member a letter acknowledging receipt of the grievance or complaint and a separate letter will be sent notifying the member of the outcome of the grievance or complaint. Letters addressing complaints and their resolution will offer the member the option to contact the Secretary's office (DHHR) if they are not satisfied with the MCO's resolution of their complaint. For informal grievances that are complaints, not constituting an adverse benefit determination requiring a quick resolution, the MCO will provide

a resolution within 72 hours after receiving the informal grievance.

Options for members who are unhappy with the MCO's resolution of their grievance:

Members or their Wraparound Facilitator can make a formal complaint to the BMS MCO Contract Manager to request BMS review the grievance. BMS can overturn any MCO resolution that is detrimental to the member's health, inconsistent with the member's treatment plan, not in alignment with provider policy or does not meet the member's specific needs. If a resolution is overturned, the MCO will be required to issue an updated resolution to the affected parties (e.g. member and family, provider agency, etc.).

A child/family who is not happy with the grievance coordinator's resolution and the grievance is not appealable to the Medicaid Fair Hearing have the following additional options to address their concerns:

1. Bring the grievance to their provider - Under OHFLAC, each LBHC (CSEDW provider) is required to have policy and procedures for handling, reporting, investigating and resolving all complaints and grievances received. Providers are required to report to the MCO on the type and number of complaints and grievances received on a monthly basis with their analysis of the concerns and progress on any plan of correction. The MCO rolls this information up to share with BMS during their monthly meetings, which includes the MCO's analysis and plans for addressing any patterns of concerns regarding effective provision of services with the provider.
2. If the concern is about their provider - provider complaints can also be made directly to the Secretary's office (DHHR) and OHFLAC outlines the process for this process within the behavioral health regulations in Section 4.7 'Complaint Investigations.'
3. Participation in the CSEDW is voluntary; members/families who are not satisfied with a grievance resolution may seek alternate providers or programming, including requesting institutional services instead of waiver services. The member can request their Wraparound Facilitator convene the Child and Family Team(CFT)to discuss concerns regarding current services. The MCO, ASO and BMS will help facilitate requests for alternative providers or services that at recommended by the CFT. BMS will make the final decision on the authorization of services, in conjunction with the MCO, based on clinical evidence and the CFT recommendations. If possible the MCO Care Coordinator will be present at the CFT meeting and if the team overturns the MCO's decision, the MCO Care Coordinator will take that information back so that the change can be made without delay. However, BMS will follow-up with the MCO during the monthly meetings regarding any grievances overturned by the CFT to discuss the reasons.
4. Additionally, the member/family will be given information on legal aid and advocacy that is also available for participants free of charge through WV Legal Aid. The information regarding legal aid and advocacy will be provided in the decision notice from the MCO for all grievances.

BMS oversight of MCO grievance resolutions:

BMS and the MCO will meet monthly and review data on the grievances reported by the MCO. The MCO will present a dashboard showing adverse determination and grievance data including:

1. Data on the number of complaints/grievances and reason for complaints by enrolled provider. This data will be analyzed to show the reasons for all informal and formal grievances and trended quarterly for BMS review.
2. Service denials for reason and names of members for cross-reference with any requested Fair hearings.
3. Any formal grievances and adverse benefit determinations where the independent clinical evaluator at the MCO overturned the first decision, reason and mitigation to prevent future inappropriate denials.
4. The MCO will report on any corrective actions taken with enrolled providers and members and the plan for reviewing progress on those actions.
5. BMS will review the MCO's success in addressing any concerns with enrolled providers and make a determination whether the MCO's plans to address any issues and progress in doing so are acceptable, meaning they assure access to quality services and protect the rights of members.
6. BMS will assist the MCO in monitoring member satisfaction by sharing the number and types of concerns raised from any provider complaints received by the DHHR Secretary's office following the MCO's handling of informal grievances. If there are any concerning patterns noted, the MCO will develop a corrective action plan.

BMS will review the timeliness of resolution of grievances and appeals during monthly meetings with the MCO. Further, BMS will look at any situations where the Fair hearing result differed from the determination of the MCO and discuss those in monthly meetings with the MCO. If there are patterns indicating concerns with the MCO's handling of the grievance process, BMS will elevate concerns to the Commissioner level with recommendations for resolution.

Appendix G: Participant Safeguards

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All CSEDW providers and the MCO have policies and procedures for the review, investigation and tracking of critical incidents involving the risk or potential risk to the health and safety of CSEDW members. CSEDW providers are required to report and track incidents using the web-based MCO Incident Management System (MCO IMS). MCOs track critical incidents through their internal MCO IMS and report identified incidents to BMS after investigation.

All incidents are classified as follows:

- “Critical incident” means the alleged, suspected, or actual occurrence of any of the following: abuse; neglect; death due to any cause; attempted suicide; behavior that will likely lead to serious injury or significant property damage; fire resulting in injury, relocation or an interruption of services; any major involvement with law enforcement authorities; injury that requires hospitalization or results in permanent physical damage; life-threatening reaction because of a drug or food; a serious consequence resulting from an apparent error in medication or dietary administration; extended and unauthorized absence of a consumer that exceeds his or her treatment plan for community access; or removal of a member from either residential or program services without the consent of the member or his or her legal representative. (WV Code 64-11-3.12)
- Allegation of abuse, neglect or exploitation:
 - o “Abused child” means a child whose health or welfare is harmed or threatened by: (a) A parent, guardian or custodian who knowingly or intentionally inflicts, attempts to inflict, or knowingly allows another person to inflict, physical injury or mental or emotional injury, upon the child or another child in the home; (b) Sexual abuse or sexual exploitation; (c) the sale or attempted sale of a child by a parent, guardian or custodian in violation of section 16, article 4, chapter 48 of this code; or (d) Domestic violence as defined in section 202, article 27, chapter 48 of this code. In addition to its broader meaning, physical injury may include an injury to the child as a result of excessive corporal punishment. (WV Code 49-1-3(1))
 - o “Neglected child” means a child: (i) Whose physical or mental health is harmed or threatened by a present refusal, failure or inability of the child’s parent, guardian or custodian to supply the child with necessary food, clothing, shelter, supervision, medical care or education, when such refusal, failure or inability is not due primarily to a lack of financial means on the part of the parent, guardian or custodian; or (ii) Who is presently without necessary food, clothing, shelter medical care, education or supervision because of the disappearance or absence of the child’s parent or custodian. (WV Code 49-1-3(11(A)))
 - o Financial Exploitation/Misappropriation of Funds: 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. (WV BMS Provider Manual, Ch 501, 512)

All critical incidents must be reported by CSEDW Providers and the MCO to Adult Protective Services (APS) for enrollees over the age of 18 per WV Code 9-6-1, or Child Protective Services (CPS) for enrollees under the age of 18 per WV Code 49-6A-2. The WV Code 49-2-803 details persons mandated to report suspected abuse and neglect. Persons required to report suspected abuse or neglect to DHHR immediately but not more than 48 hours after suspecting the abuse or neglect include, but are not limited to: any medical, dental or mental health professional, school teachers or other school personnel, social service workers, child care or foster care workers, emergency medical services personnel, peace officers or law enforcement officials, and circuit court or family court judges. If needed, involvement with emergency services, hospitals, and/or the police must follow the provider’s policies and procedures for handling medical and psychiatric emergencies per WV Code 64-11-7.8a. OHFLAC is responsible for the administration and oversight of the LBHC requirements (including incident reporting and follow-up) for WV; BMS works closely with OHFLAC to provide additional oversight support and compliance monitoring for all members however OHFLAC has presiding authority over these credentials, providers and subsequent regulations.

Any critical incident involving a CSEDW member utilizing CSEDW services must be reported to the MCO who will enter the incident into the MCO IMS within 24 hours of learning of the incident. The MCO will immediately review each Incident Report and determine whether a thorough investigation is warranted. Investigations must be initiated within 24 hours of learning of the incident. A completed Incident Report will be entered into the MCO IMS within fourteen (14) calendar days of the incident. At any time during the course of an investigation should an allegation of abuse or neglect arise, the CSEDW provider shall notify APS or CPS as mandated by State Code. CSEDW providers are responsible to investigate all incidents, including those reported to APS or CPS. The CSEDW provider will inform the person and/or their parent/legal representative in writing of the results of the internal investigation within 5 business days. In the event that a crisis occurs which results in a critical incident being substantiated, then a prevention plan will be created by the member and the CFT to support the crisis plan and outline strategies that will ensure similar incidents do not occur in the future.

CSEDW Providers and the MCO are required to regularly review and analyze incident reports to identify trends regarding health and safety of enrollees. Identified health and safety concerns and remediation strategies must be incorporated into the CSEDW Providers' and MCOs' Quality Management Plans.

The following will occur if a CSEDW provider is found to be out of compliance with program requirements: Following the first identified episode for the provider, the ASO will complete technical assistance with the provider in an attempt to bring them back to compliance. If the provider continues to remain out of compliance after the ASO completes technical assistance, the provider will be placed on a Corrective Action Plan. The provider will have thirty (30) days to provide the ASO with its detailed Corrective Action Plan outlining the steps they intend to take to remediate the deficiencies. In addition, the ASO will conduct a follow-up review within six (6) months of the deficiencies identified to ensure the Corrective Action Plan has been implemented and followed accordingly. If the provider continues to remain non-compliant after technical assistance and a Corrective Action Plan, then further action will be taken up to and including payment withholding and disenrollment as a CSEDW provider until they are determined compliant. The ASO reports this type of information to BMS as part of the monthly Quality Meetings for CSEDW; additional meetings can be scheduled if an issue needs to be addressed prior to the monthly meeting.

The critical incident management system, includes the following information: demographic information for the child, date and time of incident, date the incident was discovered, date the incident was received, date reported to BMS, date reported to CPS/APS, date reported to Law Enforcement, incident description and name of the person who reported the incident.

As soon as the report is received, it is logged on a spreadsheet, which is forwarded to BMS for oversight of timelines associated with the process. In addition to the spreadsheet, the incident is logged into the system which allows for the ability to pull reports as well as a copy of the incident report.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The MCO provides information and resources to all members regarding identification, prevention, and reporting any instances of potential abuse, neglect, or exploitation. Information on these subjects is provided by the MCO in the Member Handbook and is available for review at any time on the MCO member website. Information provided by the MCO is consistent with WV's abuse, neglect and exploitation incident and reporting management process.

The ASO also provides information to members and/or their parent/legal representative (as applicable) as part of mailed materials sent after the initial medical eligibility determination, as well as during their annual medical eligibility re-evaluation that defines abuse, neglect and exploitation and how to notify the appropriate authorities. The member and/or their parent/legal representative is required to sign-off indicating receipt and understanding of this information.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

For allegations of abuse, neglect or exploitation, or critical incidents, CSEDW Provider designated staff and the MCO must immediately review each Incident Report and determine whether the incident warrants a full investigation. Providers are required to enter all Incident Reports into the MCO IMS and issue a report to BMS. At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the CSEDW Provider or MCO shall immediately notify APS or CPS as mandated by State Code. The member and/or their parent/legal representative may request to review APS or CPS investigation findings at any time, however, those mandated investigative agencies must follow State Code regarding who can be informed of their investigative results. CSEDW providers and the MCO are required to investigate all incidents, including those reports to APS or CPS. Should APS or CPS substantiate the allegation, APS or CPS will inform the member and/or parent/legal representative of the outcome.

Per policy, when there has been an allegation of abuse, neglect or exploitation, CSEDW providers must:

1. Take immediate action and any necessary steps to ensure the health and safety of the member while investigating the incident,
2. Revise the member's POC, in collaboration with the Child and Family Team, if necessary, to implement additional supports, and
3. Implement necessary systems changes, including additional training that might be helpful in preventing future incidents.

CSEDW Providers and the MCO are required to report within 24 hours of learning of the incident. They are required to immediately initiate an investigation of critical incidents and complete their investigation within 14 calendar days. The provider or MCO is responsible for taking appropriate action on both an individual and systemic basis in order to identify potential harms, or to prevent further harm, to the health and safety of all members served. The MCO IMS does not supersede the reporting of incidents to APS or CPS. At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the provider or MCO shall immediately notify APS or CPS. CSEDW provider agencies or the MCO are responsible to investigate all incidents, including those reported to APS or CPS. If requested by APS or CPS, a provider or the MCO shall delay its own investigation and document such request in the web-based MCO IMS.

In any case where the mandated reporter believes that the child suffered serious physical abuse or sexual abuse or sexual assault, the reporter must also immediately report, or cause a report to be made to law enforcement. The report must be made to the State Police and to any law enforcement agency having jurisdiction to investigate the report, which would either be municipal police or the county sheriff's department. This report is in addition to the report made to CPS. (WV CPS Policy, 1.8.

CSEDW Providers are required to review their incident data and identify and address systemic issues and concerns on a quarterly basis, per WV policy. BMS works closely with OHFLAC to provide additional oversight support and compliance monitoring, however OHFLAC has presiding authority over credentials, providers and subsequent regulations. The MCO is responsible for regular review of the number and types of incidents across settings, providers, and provider types, identifying potential trends and patterns, opportunities for improvement, and the development and implementation of strategies to reduce the occurrence of incidents. The ASO will monitor compliance with this policy during annual on-site provider reviews.

Additionally, the OHFLAC has created Guidelines for Incidents. From these guidelines, OHFLAC states that, "The investigation must begin within 24 hours of the report of the allegation unless otherwise instructed by APS. If the committee is instructed to hold its investigation by APS, the date, time and individuals involved in the instruction shall be documented. A preliminary report must be received within five (5) days by the administrator or designee (may be verbal but must be documented) and a full written report must be completed no later than fourteen (14) days after the incident was identified." From 64 CSR 11 8.2.d, if the administrator's findings and actions on behalf of a consumer regarding a violation of the consumer's rights in unfavorable, insufficient or not forthcoming within a reasonable time, the consumer, or his or her parent/legal representative, may appeal to the governing body of the Center, WV licensure body, the WV advocate or other appropriate resources.

The critical incident management system, includes the following information: demographic information for the child, date and time of incident, date the incident was discovered, date the incident was received, date reported to BMS, date reported to CPS/APS, date reported to Law Enforcement, incident description and name of the person who reported the

incident.

As soon as the report is received, it is logged on a spreadsheet, which is forwarded to BMS for oversight of timelines associated with the process. In addition to the spreadsheet, the incident is logged into the system which allows for the ability to pull reports as well as a copy of the incident report.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The MCO is responsible for the monitoring and oversight of the MCO IMS and performs follow-ups as necessary regarding critical incident investigations. Incidents are entered into the MCO IMS by CSEDW providers. Incidents submitted into the MCO IMS are tracked, aggregated, and summarized by the MCO, which also performs real time monitoring of critical incident investigations. BMS receives a monthly incident report summary from the MCO to identify and address issues or concerns. Quarterly quality incident summary reports are also reviewed by the BMS QIA Council. As part of the Quality Improvement System (QIS), the ASO reviews a representative sample of files annually, including (as applicable) compliance with Incident Management policies. This data is also reviewed and analyzed by BMS, the MCO, the ASO, and the QIA Council. CSEDW Providers and the MCO are also required to analyze incident reports to identify health and safety trends and incorporate their findings into their Quality Management Plans. Identified health and safety concerns and remediation strategies are incorporated into the agency Quality Management Plan to address and remediate any potential concerns related to the population and/or CSEDW recipients.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The use of physical restraint as a de-escalation technique and emergency behavioral intervention is allowed only after all less restrictive interventions have been exhausted; the use of chemical and/or mechanical restraints and seclusion are not authorized under this waiver. The types of physical restraints that may be used for de-escalation are timeouts and holds. As noted in this application, there are detailed and stringent regulations and requirements around the use of such restraints, and as such are used only as a last resort. Regulation governing the use of physical restraint for the CSEDW are found in WV Code of State Rules: §§27-9-1; 27-17-3; 27-1A-4(g); 27-1. The Code defines restraint as a temporary behavior control intervention for reducing or eliminating inappropriate behavior. More specifically, physical or mechanical restraint is defined as any manual method or mechanical device for behavior control that restricts free movement. Examples of manual methods include therapeutic or basket holds prone or spine containment. Per the Code, use of physical restraint as a de-escalation technique and emergency behavioral intervention is allowed only after all less restrictive interventions have been exhausted; the use of chemical and/or mechanical restraints and seclusion are not authorized under this waiver. Restraint may only be performed by employees of licensed behavioral health centers (LBHCs). The OHFLAC requires all LBHCs to have written policy outlining training, documentation and reporting for the use of physical restraint on a member.

Per the LBHC regulation 12.20.6.e., restraint may only be used when less intrusive interventions have been exercised and determined, through documentation pursuant to this rule, to be ineffective to protect the member or others from harm. No restraint may be utilized more than a half hour without review of the member's condition by a licensed clinician to evaluate the member's immediate situation; the member's reaction to the intervention; and the member's medical and behavioral condition.

Restraint is permitted as an immediate response only in emergency safety situations when there is a danger to themselves or others. At all times, the least restrictive, effective intervention must be used. Documentation indicates that the more restrictive techniques, while relieving stress for the adults in charge, usually increase stress for the youths with whom they are applied. The potential therapeutic effects (prevention of self- and other-injury and reinforcement of behavioral boundaries) must be weighed against the counter-therapeutic effects, which include loss of dignity, increased feelings of impotence/helplessness, increased resentment/rage towards authority figures, and, for member's in recovery from physical/sexual abuse, the subjective experience of re-enacting their victimization.

For members who may require restraint, its use must be supported by a specific assessed need and justified in the Plan of Care:

1. Identify a specific and individualized assessed need.
2. Document the positive interventions and supports used prior to any modifications to the Plan of Care.
3. Document less intrusive methods of meeting the need that have been tried but did not work.
4. Include a clear description of the condition that is directly proportionate to the specific assessed need.
5. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
7. Include the informed consent of the individual.
8. Include an assurance that interventions and supports will cause no harm to the individual.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The WV DHHR's OHFLAC is the state agency responsible for overseeing the use of restraints and ensuring that WV's safeguards are followed. Each CSEDW agency must be a Licensed Behavioral Health Center (LBHC). In Behavioral Health Centers Licensure, 64 CSR 11, OHFLAC requires each provider agency to establish a Human Rights Committee (HRC). This committee's primary function is to assist the provider agency in the promotion and protection of a person's rights, and to review, approve and monitor individual programs designed to manage inappropriate behaviors and other programs that are intrusive or involve risks to the person's protection and rights. All staff involved with the delivery of CSEDW services are mandatory reports and required to report unauthorized use of restraint to the proper authorities (Child Protective Services or Adult Protective Services) immediately; CSEDW providers will also report all unauthorized use of restraint to the Wraparound Facilitator following the report to CPS/APS. During the site reviews and interviews conducted by the Wraparound Facilitator following the report to CPS/APS. During the site reviews and interviews conducted by the Wraparound Facilitator, MCO care manager, ASO and OHFLAC, any noted documentation or observation of unauthorized use of restraints will be reported to the proper authorities (Child Protective Services or Adult Protective Services). OHFLAC attends monthly Waiver Contract meetings with BMS and communicates their information and findings. Additional meetings are called if necessary. Incident reports must be sent to OHFLAC by the CSEDW provider agency if restraint is used. Unauthorized use of restraints may be detected during annual retroactive reviews by the ASO and every other year by OHFLAC in addition to reviews of incidences reported through the MCO Incident Management System and Adult and Child Protective Service reports.

The following will occur if a CSEDW provider is found to be out of compliance with program requirements: During the first identified episode for the provider, the ASO will complete technical assistance with the provider in an attempt to bring them back to compliance. If the provider continues to remain out of compliance after the ASO completes technical assistance, the provider will be placed on a Corrective Action Plan. The provider will have thirty (30) days to provide the ASO with its detailed Corrective Action Plan outlining the steps they intend to take to remediate the deficiencies. In addition, the ASO will conduct a follow-up review within six (6) months of the deficiencies being identified to ensure the Corrective Action Plan has been implemented and followed accordingly. If the provider continues to remain non-compliant after technical assistance and a Corrective Action Plan, then further action will be taken up to and including holding of payments and disenrollment as a waiver provider until they are determined compliant. The ASO reports this type of information to BMS as part of the monthly Quality Meetings for CSEDW; additional meetings can be scheduled if an issue needs addressed prior to the monthly meeting.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):*

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The WV DHHR's OHFLAC is the state agency responsible for overseeing the use of restrictive interventions and ensuring that WV's safeguards are followed by its provider network. Each CSEDW agency must be a Licensed Behavioral Health Center (LBHC) and is overseen by OHFLAC. All staff involved with the delivery of CSEDW services are mandatory reporters and required to report the use of restrictive interventions to the proper authorities (Child Protective Services or Adult Protective Services) immediately; CSEDW providers will also report the use of restrictive interventions to the Wraparound Facilitator following the report to CPS/APS.

All staff involved with the delivery of CSEDW services are mandatory reporters and required to report unauthorized use of restraint to the proper authorities (Child Protective Services or Adult Protective Services) immediately; CSEDW providers will also report all unauthorized use of restraint to the Wraparound Facilitator following the report to CPS/APS. OHFLAC is responsible for all CPS/APS investigations. During the site reviews and interviews conducted by the Wraparound Facilitator, MCO Care Manager, ASO and OHFLAC, any noted documentation or observation of unauthorized use of restraints will be reported to the proper authorities (Child Protective Services and Adult Protective Services). OHFLAC attends monthly Waiver Contract meetings with BMS and communicates their information and findings. Additional meetings are called if necessary. Incident reports must be sent to OHFLAC by the CSEDW provider agency if restraint is used. Unauthorized use of restraints may be detected during annual retroactive reviews by the ASO and every other year by OHFLAC in addition to reviews of incidents reported through the MCO Incident Management System and Adult and Child Protective Service reports.

Oversight is conducted during site reviews and interviews conducted by the Wraparound Facilitator, MCO care manager, ASO and OHFLAC; any noted documentation or observation of unauthorized use of restrictive interventions will be reported to the proper authorities (Child Protective Services or Adult Protective Services). OHFLAC attends monthly Waiver Contract meetings with BMS and communicates their information and findings. Additional meetings are called if necessary. Incident reports must also be sent to OHFLAC by the CSEDW provider agency if restrictive interventions are used. Unauthorized use of restrictive interventions may be detected during retroactive reviews by the ASO and OHFLAC in addition to reviews of incidences reported through the MCO Incident Management System and Adult and Child Protective Service reports. Lastly, Behavioral Health Centers Licensure, 64 CSR 11, OHFLAC requires each provider agency to establish a Human Rights Committee. This committee's primary function is to assist the provider agency in the promotion and protection of a person's rights, and to review, approve and monitor individual programs designed to manage inappropriate behaviors and other programs that are intrusive or involve risks to the person's protection and rights.

The following will occur if a CSEDW provider is found to be out of compliance with program requirements: During the first identified episode for the provider, the ASO will complete technical assistance with the provider in an attempt to bring them back to compliance. If the provider continues to remain out of compliance after the ASO completes technical assistance, the provider will be placed on a Corrective Action Plan. The provider will have thirty (30) days to provide the ASO with its detailed Corrective Action Plan outlining the steps they intend to take to remediate the deficiencies. In addition, the ASO will conduct a follow-up review within six (6) months of the deficiencies being identified to ensure the Corrective Action Plan has been implemented and followed accordingly. If the provider continues to remain non-compliant after technical assistance and a Corrective Action Plan, then further action will be taken up to and including holding of payments and disenrollment as a waiver provider until they are determined compliant. The ASO reports this type of information to BMS as part of the monthly Quality Meetings for CSEDW; additional meetings can be scheduled if an issue needs addressed prior to the monthly meeting.

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The WV DHHR's OHFLAC is the state agency responsible for overseeing the use of seclusion and ensuring that WV's safeguards are followed by its provider network. Each CSEDW agency must be a Licensed Behavioral Health Center (LBHC) and is overseen by OHFLAC. All staff involved with the delivery of CSEDW services are mandatory reports and required to report the use of seclusion to the proper authorities (Child Protective Services or Adult Protective Services) immediately; CSEDW providers will also report the use of seclusion to the Wraparound Facilitator following the report to CPS/APS.

Oversight is conducted during site reviews and interviews conducted by the Wraparound Facilitator, MCO care manager, ASO and OHFLAC; any noted documentation or observation of unauthorized use of seclusion will be reported to the proper authorities (Child Protective Services or Adult Protective Services). OHFLAC attends monthly Waiver Contract meetings with BMS and communicates their information and findings. Additional meetings are called if necessary. Incident reports must also be sent to OHFLAC by the CSEDW provider agency if seclusion is used. Unauthorized use of seclusion may be detected during retroactive reviews by the ASO and OHFLAC in addition to reviews of incidences reported through the MCO Incident Management System and Adult and Child Protective Service reports. Lastly, Behavioral Health Centers Licensure, 64 CSR 11, OHFLAC requires each provider agency to establish a Human Rights Committee. This committee's primary function is to assist the provider agency in the promotion and protection of a person's rights, and to review, approve and monitor individual programs designed to manage inappropriate behaviors and other programs that are intrusive or involve risks to the person's protection and rights.

The following will occur if a CSEDW provider is found to be out of compliance with program requirements: During the first identified episode for the provider, the ASO will complete technical assistance with the provider in an attempt to bring them back to compliance. If the provider continues to remain out of compliance after the ASO completes technical assistance, the provider will be placed on a Plan of Correction. The provider will have thirty (30) days to provide the ASO with its detailed Plan of Correction outlining the steps they intend to take to remediate the deficiencies. In addition, the ASO will conduct a follow-up review within six (6) months of the deficiencies being identified to ensure the Plan of Correction has been implemented and followed accordingly. If the provider continues to remain non-compliant after technical assistance and a Plan of Correction, then further action will be taken up to and including holding of payments and disenrollment as a waiver provider until they are determined compliant. The ASO reports this type of information to BMS as part of the monthly Quality Meetings for CSEDW; additional meetings can be scheduled if an issue needs addressed prior to the monthly meeting.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established

concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. Applicability.** Select one:

No. This Appendix is not applicable *(do not complete the remaining items)*

Yes. This Appendix applies *(complete the remaining items)*

- b. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

- c. Medication Administration by Waiver Providers**

Answers provided in G-3-a indicate you do not need to complete this section

- i. Provider Administration of Medications.** *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

- ii. State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- iii. Medication Error Reporting.** *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

- (a) Specify state agency (or agencies) to which errors are reported:

- (b) Specify the types of medication errors that providers are required to *record*:

- (c) Specify the types of medication errors that providers must *report* to the state:

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

- iv. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

a. Sub-assurance: *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

G-a-2: Number and percent of deaths with a determined need for investigation that were reported to the proper authorities (Law Enforcement and OHFLAC) for investigation. N: Number of deaths with a determined need for investigation that were reported to the proper authorities (Law Enforcement and OHFLAC) investigated. D: Total number of deaths with a determined need for investigation.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>

Other Specify: <div>MCO</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>ASO, OHFLAC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

G-a-3: Number and percent of deaths with a determined need for investigation that were internally investigated. Numerator: Number of deaths with a determined need for investigation that were internally investigated. Denominator: Total number of deaths with a determined need for investigation.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">MCO</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
ASO, OHFLAC	
	Continuously and Ongoing
	Other Specify:

Performance Measure:

G-a-1: Number and percent of substantiated cases of abuse, neglect, exploitation and misappropriation of funds where recommended actions to protect health and welfare were implemented. N-Number of substantiated cases where recommended actions to protect health and welfare were implemented. D-Total number of substantiated cases where there were recommended actions to protect health and welfare.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95%
Other Specify: ASO	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/> ASO, OHFLAC	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

G-b-2: Number and percent of critical incident reviews/investigations that were completed as specified in the approved waiver. Critical incidents related to Abuse; Neglect; Exploitation; and Misappropriation of Funds. N: Number of critical incident

reviews/investigations that were completed as specified in the approved waiver. D:
Total number of critical incident reviews/investigations.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="MCO"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="ASO, OHFLAC"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

G-b-1: Number and percent of critical incidents that were reported within the required time frames as specified in the waiver application. N: Number of critical incidents reported in the required time frames as specified in the waiver application. D: Total number of reported critical incidents in the specified areas.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="MCO"/>	Annually	Stratified Describe Group: <input type="text"/>

	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px;">ASO, OHFLAC</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

G-c-1: Number and percent of instances of unapproved restraint, seclusion or other restrictive interventions with a prevention plan developed as a result of the incident.
Numerator: Number of instances with a prevention plan developed as a result of the incident. **Denominator:** Total number of instances that required development of a prevention plan developed as a result of the incident.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="MCO"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: ASO	Annually
	Continuously and Ongoing
	Other Specify:

- d. Sub-assurance:** *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i.** Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

All information related to this assurance is collected and monitored by BMS, the ASO, and the MCO. The ASO will collect and monitor this assurance using the MCO IMS and will collect and monitor this assurance using results of MCO reported incidents, Provider reviews, and CSEDW recipient record reviews. Provider issues/concerns such as failure to meet requirements are addressed immediately upon identification by the ASO and/or MCO respectively, and then reported to BMS with the outcome. Provider issues and concerns can also be addressed with the BMS Program Manager directly. Providers may be required to submit Corrective Action Plans addressing identified issues that must be approved by the ASO and/or the MCO.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: ASO	Annually
	Continuously and Ongoing
	Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The ASO and the MCO are responsible for monitoring the quality of CSEDW services and implementing and evaluating quality improvement strategies. The CSEDW QIA Council utilizes an evidence-driven Quality Improvement System (QIS) and incorporates a broad base of stakeholders in active roles in the process.

Discovery and remediation activities focus on the collection of data necessary to monitor the quality indicators established to provide evidence related to the CMS assurances and sub-assurances. Specific data sources include provider monitoring, claims data, incident management reports, contract oversight meetings and reports, people/family focus groups and interviews, and other stakeholder feedback and input.

The primary mechanism for involving stakeholders in the CSEDW's quality improvement initiative is the CSEDW QIA Council. The Council strives for a minimum of fifteen (15) members comprised of at least five (5) current program participants (or legal representatives), CSEDW agency staff/providers, advocates, foster parents providing care to CSEDW members and other interested stakeholders. The Council serves as a forum for people and/or their parent/legal representative/foster parents and the public to raise and address program issues and concerns affecting the quality of Waiver services and to make recommendations to BMS.

The Council:

1. Reviews findings from discovery activities
2. Recommends program priorities and quality initiatives
3. Recommends policy changes
4. Monitors and evaluates the implementation of Waiver priorities and quality initiatives
5. Monitors and evaluates policy changes
6. Serves as a liaison between the Waiver and its stakeholders
7. Establishes committees and work groups consistent with its purpose and guidelines

The purpose of the CSEDW QIA Council is to provide guidance and feedback to BMS in the development of an ongoing quality assurance and improvement system for the CSEDW program. The Council works with BMS to develop and strengthen the CSEDW program through the following methodologies:

- Collect data and assess member experiences in order to assess the ongoing implementation of the CSEDW program, identifying strengths and opportunities for quality improvement.
- Act in a timely manner to remediate specific problems or concerns as they arise.
- Use data and quality information to engage in actions that lead to continuous improvement in the CSEDW program.

The MCO will receive and/or report incidents from providers or MCO staff within 24-hours becoming aware of the incident. The incident is entered into the MCO incident management system (MCO IMS). The MCO reviews reports and initially follows up with the provider to administer technical assistance (i.e. review timelines and policy). The MCO verifies that investigations are completed by the provider within appropriate timelines and that appropriate referrals have been made to APS or CPS, law enforcement, etc. The MCO compiles information on a monthly basis and provides reports to BMS. Although the report is sent to BMS on a monthly basis from the MCO, the MCO is responsible for reporting all critical incidents to BMS within 48 hours of the occurrence as an informal report. The MCO also generates monthly reports to identify and monitor incident trends. On a quarterly basis, information is reviewed by the CSEDW QIA Council for possible suggested policy/procedural changes.

The Council will work with BMS, the ASO, MCO, and CSEDW providers to ensure that the CSEDW supports the desired outcomes outlined in the six (6) focus areas of the Quality Framework developed by CMS:

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers and governments by developing and spreading new health care delivery systems.

The QMR, which incorporates data from discovery and remediation activities, is reviewed and analyzed by BMS staff through regular meetings with contractors. The report is also reviewed quarterly with the QIA Council in

order to identify trends and to monitor the effectiveness of quality improvement activities.

Quality improvement priorities are identified through data analysis and stakeholder input, and are incorporated in the annual Quality Management Plan. Updates on the goals and objectives of this plan are reviewed at each quarterly Council meeting and guide the efforts of the Council and staff. The Quality Management Plan is evaluated on an annual basis and revised as necessary to reflect current quality issues.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: CSEDW Provider Agencies, ASO, MCO	Other Specify:

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The CSEDW Quality Improvement System (QIS) is designed to: 1) Collect the data necessary to provide evidence that all CMS assurances and sub-assurances are being met, and 2) Ensure the active involvement of stakeholders in the quality improvement process. The primary sources of discovery include provider reviews, incident management reports and complaints, administrative reports, oversight of delegated administrative functions, and stakeholder input.

Provider Reviews:

The primary means of monitoring the quality of CSEDW services are provider reviews conducted by staff from the ASO and the Office of Health Facility Licensing and Certification (OHFLAC).

To become a CSEDW Agency, an agency must apply for a Certificate of Need (CON) through an expedited Summary Review process and be approved by the WV Health Care Authority. Then, the agency must obtain a Behavioral Health License through OHFLAC. Licensure of a new agency involves an initial onsite OHFLAC review followed by a six-month comprehensive on-site review (as necessary) to ensure all certification standards are substantially met.

OHFLAC licenses are issued as follows:

- An initial six (6) month license shall be issued to CSEDW agencies establishing a new program or service for which there is insufficient individual participation to demonstrate substantial compliance with certification standards.
- A provisional license shall be issued when a CSEDW agency seeks a renewal license, and is not in substantial compliance with certification standards, but does not pose a significant risk to the rights, health and safety of the CSEDW program individual. It shall expire not more than six (6) months from date of issuance, and not be consecutively reissued, unless the provisional recommendation is that of the WV fire marshal.
- A renewal license shall be issued when a CSEDW agency is in substantial compliance with certification standards and shall expire not more than two (2) years from date of issuance.

The ASO performs on-site provider reviews annually to validate certification documentation. One hundred percent (100%) of Providers are reviewed each year via an on-site review to validate certification documentation. Targeted on-site provider reviews may be conducted based on Incident Management Reports and complaint data.

A statewide representative sample of files are reviewed every 12 months. Files are reviewed by staff of the ASO using the Quality and Utilization Review Tool. This tool has been developed to ensure that the critical data necessary to monitor CMS assurances are collected. Random sampling ensures that a 10% representative sample is reviewed from each provider to include employee and member files. A 10% review will be completed with a minimum of 10 employee and member files.

Another key source for monitoring the quality of CSEDW services is the MCO Incident Management System (MCO IMS). All incidents are tracked, including: 1) Simple Incidents, 2) Critical Incidents, and 3) Abuse, Neglect, and Exploitation. The online system gives CSEDW agencies the ability to generate specific reports to identify and monitor trends. All CSEDW providers are required to report all incidents to the MCO IMS.

The MCO also operates a toll-free hotline allowing people to contact them directly to report and address concerns with their services. CSEDW members and families are informed about reporting concerns and how they can access the Member and Family Liaison through the MCO Member Handbook. Data from these calls are compiled and analyzed for trends. The MCO also employs a Member & Family Liaison to whom people and their parent/caregiver/legal representative/foster parents may report concerns with their services. The Liaison is responsible for providing education and assistance to the person/parent/caregiver/legal representative/foster parents and periodically compiles aggregate reports regarding concerns/complaints, which are analyzed for trends.

Reports:

BMS management staff will receive and review the following contract reports:

- (1) MCO Monthly Program Report, Monthly Discovery and Remediation Report, Monthly Activity Report, semi-monthly Tracking Report, and ad hoc reports as requested;
- (2) Claims Vendor routine reports on claims data and ad hoc reports as requested;
- (3) Eligibility Vendor Monthly Report and ad hoc reports as requested; and
- (4) MCO Reports

Contract Oversight Meetings:

BMS management staff conducts monthly oversight meetings with each of its contractors to monitor performance and address identified issues/concerns.

Quality management data collected through discovery method is compiled using the Discovery and Remediation Report Template and reviewed at least monthly by BMS and the MCO at its contract meetings. The Discovery and Remediation Report is also compiled and reviewed quarterly by the CSEDW QIA Council. A comprehensive report summarizing the findings of provider reviews is compiled at the end of each review cycle, reviewed and analyzed by CSEDW staff, and presented to the QIA Council for review and analysis.

The QIA Council:

The QIA Council is the focal point of stakeholder input for the CSEDW and plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies. The Council should be comprised of 15 members with at least five (5) being current or former CSEDW members (or their parent/caregiver/legal representatives) and meets on at least a quarterly basis.

The Council provides BMS, the ASO, MCO, and CSEDW staff feedback and guidance regarding quality improvement initiatives. The Council reviews and analyzes data, identifies trends and priorities, and develops the annual Quality Management Plan in which specific quality improvement goals and objectives are established.

The Council may establish work groups consisting of Council members and others wishing to participate in the process to address specific improvement goals and objectives.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The goals and objectives outlined in the Quality Management Plan are continuously monitored by the CSEDW QIA Council, with regular updates being provided at each quarterly meeting. The CSEDW QIA Council also monitors the Quality Management Plan on a monthly basis, as additional data is collected and aggregated related to Critical Incidents and other quality of care concerns. An annual planning meeting is held to review progress toward the goals and objectives of the plan and to update the plan as indicated by quality management data.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

- b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for

waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

A statewide representative sample of files are reviewed to verify documentation of services billed. When the CSEDW agency's documentation does not support services billed or when services have been provided by unqualified staff, the CSEDW agency is required to submit Corrective Action Plans, which must be approved by the MCO and BMS. MCO Program Integrity reviews would address any services billed without supporting documentation or provided by unqualified staff. The MCO would then recoup funds paid out for any services deemed inappropriate. The MCO may recoup funds either through a direct reimbursement from the Provider to the MCO or the MCO may offset any amount owed against future payments to the provider. The MCO may coordinate with the provider as to the preferred approach, given small v. large providers will have to be handled differently in many cases. The MCO provider representatives are available to any provider for billing questions to help prevent the recoupment process from having to occur due to inappropriate billing. The Medicaid Program (which would include the CSEDW) is audited annually under the WV Statewide Single Audit, which is conducted by Ernst & Young, LLP.

The MCO will be responsible for administering any post-payment review process as the administrator of services, but the State also has an Office of Program Integrity that reviews encounters that have been submitted to the State by the MCO, and is also responsible for reviewing payments of services and coordinating with the MCO on issues that may have been missed. Program Integrity is a joint effort between the State, MCO and provider community. Traditionally, the MCO will implement pre-payment review processes so that issues are addressed prior to payment and claim corrected and resubmitted by the provider, but may also implement post-payment review process via desk review. As a part of the post-payment review, the MCO will review claims, medical records, billing charts, and cross reference against federal and state policy and billing documents, such as CPT guidelines, HCPCS guidelines and utilization management materials established by the State specific to CSED services. To do this, the MCO will seek records from the provider to determine if the services documented in the records align with the services billed for. In doing so, the MCO will be able to recognize if improper payment was made for the service, fraudulent activity is occurring through excessive errors in mismatch between medical record and claim, or medical necessity not being met. The MCO may also conduct onsite reviews of the provider.

At this time, a defined number of providers is unavailable given the unknown pool of potential providers, but the MCO would select a number of files that would allow for a 95% confidence interval for their review. Through the repayment review process, the MCO is constantly reviewing billing practices, as their systems will account for inappropriately submitted claims and direct the provider to resubmit based on edit checks. With post-payment review, the MCO may employ a variety of schedules based on the provider. If there is a history of billing issues, the MCO may do monthly or quarterly post-payment reviews. If the provider has consistently submitted "clean claims" and no previous findings have been identified, these may be conducted on an annual basis. The MCO will be required to establish a post-payment review process that it will communicate to its provider network, and is subject to state review.

The State also requires CSEDW providers to secure an independent audit of their financial statements annually. Further information about this requirement can be found here: https://ohflac.wvdhhr.org/Content/Resources/BH-Required_Documents.pdf.

Electronic Visit Verification Additional Information:

- The EVV model selected by the state (provider choice, MCO choice, state-mandated external vendor, state-mandated internal system, open vendor, or other)
- BMS has procured an EVV solution following the open vendor model and will contract with a single EVV vendor while allowing providers to use alternate EVV vendors at their own cost, if they so choose. Upon selection of an EVV solution, BMS will establish the requirements for data collection or exchange with alternate EVV systems.
- Methods for capturing the six required data elements specified in the Cures Act: (i) the type of service performed; (ii) the individual receiving the service; (iii) the date of the service; (iv) the location of service delivery; (v) the individual providing the service; and (vi) the time the service begins and ends.
- The EVV system will verify: (i) the type of service performed; (ii) the individual receiving the service; (iii) the date of the service; (iv) the location of service delivery; (v) the individual providing the service; and (vi) the time the service begins and ends. For services requiring EVV, direct care staff and Wraparound Facilitators will use the system to check-in at the beginning of the visit. After the visit, the member or authorized representative will use the system to verify the correct visit has been provided. The state is currently seeking a vendor to provide these services, and methods of collecting the data are expected to include a web-based application, phones, and other device options.
- The WV EVV system is expected to be fully implemented/operational in the April 2021 time frame.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

I-ai-1: Percent of clean claims paid for CSEDW services within the timeframes specified in the contract. Numerator- Number and percent of clean claims paid for CSEDW services within the timeframes specified in the contract. Denominator- Total number of clean claims submitted for CSEDW services.

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div></div>
Other Specify:	Annually	Stratified Describe Group:

MCO		
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: MCO	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

I-ai-2: Percent of CSEDW claims paid using the correct rate as specified in the Waiver application. Numerator- Number and percent of CSEDW claims paid using the correct rate as specified in the Waiver application. Denominator- Total number of CSEDW claims paid.

Data Source (Select one):**Financial audits**

If 'Other' is selected, specify:

Responsible Party for	Frequency of data	Sampling Approach(check
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<i>data collection/generation (check each that applies):</i>	<i>collection/generation (check each that applies):</i>	<i>each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <div></div>
<i>Other Specify:</i> <div>MCO</div>	<i>Annually</i>	<i>Stratified Describe Group:</i> <div></div>
	<i>Continuously and Ongoing</i>	<i>Other Specify:</i> <div></div>
	<i>Other Specify:</i> <div></div>	

Data Aggregation and Analysis:

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other Specify:</i> <div>MCO</div>	<i>Annually</i>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

I-b-3: Capitation rates inclusive of CSEDW members will be certified and approved by CMS. Numerator – number and percent of capitation rates inclusive of CSEDW members certified and approved by CMS. Denominator – number of capitation rates inclusive of CSEDW members.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Managed Care Actuarial Rate Certification Documents

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Other Specify: <div>MCO</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>MCO</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information

regarding responsible parties and *GENERAL* methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Evidence relating to this assurance is collected through the MCOs' prior authorization systems and through the MCOs' Quality and Utilization Review process. All providers must initially submit request for and receive prior authorization through the CSEDW recipient's applicable MCO prior to billing for any Waiver service. Any issues identified at the prior authorization stage are identified and resolved immediately (prior to services being authorized). This sometimes leads to a request by the MCO for the provider to submit additional information/documentation to support the request for service authorization.

All information relating to this assurance is collected through the review of files by the MCO and the review and analysis of claims data. Evidence collected via claims data is reviewed and analyzed by BMS and the claims processing entity in order to identify any system issues. The Mountain Health Trust is WV's contractual agreement between each MCO and DHHR, and BMS is beginning specialized managed care for children and youth; both outline expectations for Medicaid service execution; this contract will ensure that CSEDW services and billings are provided as defined in the waiver. The MCO is expected to meet or exceed all objectives and standards, as set forth in the contract. All areas of responsibility and all contract requirements will be subject to performance evaluation by DHHR. The MCO agrees that failure to comply with all provisions of the Contract may result in the assessment of remedies and/or termination of the Contract, in whole or in part.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: MCO	Annually
	Continuously and Ongoing
	Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability**I-2: Rates, Billing and Claims (1 of 3)**

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

All CSEDW services are administered through a capitated model via the State's 1915b waiver authority for specialized managed care and are integrated into the Per Member Per Month (PMPM) for members enrolled in the CSEDW program.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billings flow directly from Waiver providers to the MCOs claims payment system (included in the PMPM).

Appendix I: Financial Accountability**I-2: Rates, Billing and Claims (2 of 3)**

- c. Certifying Public Expenditures (select one):**

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Each claim is subjected to a series of edits to ensure that the member is eligible on the date of service, that the CSEDW agency has a valid enrollment status, and that the service is eligible for payment. If the claim passes these initial edits, further assurances are provided through prior authorization of Waiver services based on the person's approved ISP. Post-payment review activities are conducted by the MCO and BMS to ensure that services are provided as defined in the waiver. All information relating to this assurance is collected through the review of files by the MCO and the review and analysis of claims data. Evidence collected via claims data is reviewed and analyzed by BMS and the claims processing entity in order to identify any system issues.

The Mountain Health Trust is WV's contractual agreement between each MCO and DHHR, and BMS is beginning specialized managed care for children and youth; both outline expectations for Medicaid service execution; this contract will ensure that CSEDW services and billings are provided as defined in the waiver. The MCO is expected to meet or exceed all objectives and standards, as set forth in the contract. All areas of responsibility and all contract requirements will be subject to performance evaluation by DHHR. The MCO agrees that failure to comply with all provisions of the Contract may result in the assessment of remedies and/or termination of the Contract, in whole or in part.

Electronic Visit Verification (EVV) Information:

- Currently, it is expected that the State will use a post-payment system to evaluate the presence and validity of EVV data as well as relevant claim matching.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (select one):

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Payments are made to the MCO on a PMPM; the monthly payment is based on a capitation roster effective the first of the month.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

All services included in the waiver will also be included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

No. *The state does not make supplemental or enhanced payments for waiver services.*

Yes. *The state makes supplemental or enhanced payments for waiver services.*

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS.

Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

There is no reduction or return of the monthly capitated payment to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the

delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer

(IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

Children living in TFC homes are excluded from receiving this service under the Waiver. Please note waiver services may be furnished to children in foster care living arrangements but only to the extent that waiver services supplement maintenance and supervision services furnished in such living arrangements and waiver services are necessary to meet the identified needs of the children. Waiver funds are not available to pay for room and board and supervision of children who are under the state's custody. Respite services are provided in out-of-home settings but the state does not make any room and board payments for this service.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	102576.00	21521.00	124097.00	186855.00	21521.00	208376.00	84279.00
2	102579.00	22167.00	124746.00	186855.00	22167.00	209022.00	84276.00
3	102579.00	22832.00	125411.00	186855.00	22832.00	209687.00	84276.00
4	102587.00	23517.00	126104.00	186855.00	23517.00	210372.00	84268.00
5	102587.00	24222.00	126809.00	186855.00	24222.00	211077.00	84268.00

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Hospital	
Year 1	2000		2000
Year 2	2250		2250
Year 3	2250		2250
Year 4	2500		2500
Year 5	2500		2500

Appendix J: Cost Neutrality Demonstration

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Estimate for average length of stay (ALOS) is derived from research conducted that showed twelve (12) months would be the most appropriate timeframe; WV's limited historical claims experience is impacted by the PHE. The ALOS was set at 365 to reflect a high level of need when members first come onto the waiver, as the priority population has been institutionalized in PRTFs or residential care facilities for significant lengths of time. The CSEDW team anticipates this population will require 365 days to integrate back into their homes and communities to allow time to respond fully to treatment. This ALOS does take into account that members will be coming onto the waiver for different reasons with different levels of need, as well as that members will age out or no longer need services.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

The estimates for Factor D are derived from projected trends of claims experience adjusted for anticipated increases in utilization and definition of service.

WV used the ASO data from the original waiver application as well as research and analysis of other states' relevant waiver experience, focusing on states with similar demographics to project trends of claims experience and to adjust for the anticipated increase in utilization. WV used a blend to estimate units per user, and took into account age demographics and acuity in the target populations.

The State decided against trending utilization forward due to confidence that the number of units per user have been adequately defined based on existing data. WV will reevaluate after Year 1 and adjust based on that experience. Unit costs were estimated by extrapolating current fee-for-service codes and rates. WV decided not to trend utilization forward given the uncertainty of legislative appropriations and CSEDW provider reimbursement rates were kept constant as a conservative approach.

To do this, the CSEDW team reviewed data provided by the ASO for the original application. WV estimated the number of users for each service in each waiver year by analyzing ASO data showing the target population's age, demographics and acuity, and then age/educational requirements and/or appropriateness for each service. We have assumed service utilization consistent with the Year 3 projections from the original waiver application and adjusted the utilization proportionally for increases in available waiver slots.

By Year 3 of the original waiver application, the priority population of institutionalized children/youth should have been addressed, thus the next target group would reflect a preventative approach and more maintenance level utilization.

In estimating utilization for each service, WV considered the number of CSEDW slots, age demographics (e.g., school-aged or not), acuity, and moving from the initial target population of currently institutionalized children/youth to the preventative population. WV is one of the hot spots of the opioid crisis nationally, and thus families in the target populations are under exceptionally high stress; the number of children in out-of-home placements is disproportionately high and reflects the impact of the opioid epidemic. The two hours of Family Therapy would be conducive for whatever treatment modality the Child and Family Team selects; one hour is for family therapy and the other for individual.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for Factor D' are derived from projected trends of claims experience adjusted for anticipated increases in utilization. The source for estimating Factor D' was a three-year (SFY 2016-2018) claims trend analysis for children receiving services in a PRTF. The analysis segregated PRTF and non-PRTF costs. The non-PRTF costs were used for Factor D'. The basis for the 3% annual trend projection is an estimate of medical inflation indices utilized in the State's overall budgeting procedures.

WV does not have experience suggesting Factor D' would be larger than Factor G'. For the cost neutrality analysis, WV is assuming similar length of stay (LOS) amounts for Factors D and G. The similar length of stay for the cost neutrality analysis is the basis for assuming Factors D' and G' would not be variable in the level of intensity, complexity and duration.

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for Factor G are derived from projected trends of claims experience adjusted for anticipated increases in utilization. WV has experienced and expects to maintain budget neutrality for Factor G. The source for estimating Factors G and G' was a three-year (SFY 2016-2018) claims trend analysis for children receiving services in a PRTF. The analysis segregated PRTF and non-PRTF costs. The source for the institutional costs for the CSEDW population was a three-year (SFY 2016-2018) claims trend analysis for children receiving services in a PRTF.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for Factor G' are derived from projected trends of claims experience adjusted for anticipated increases in utilization. The source for estimating Factors G and G' was a three-year (SFY 2016-2018) claims trend analysis for children receiving services in a PRTF. The analysis segregated PRTF and non-PRTF costs. The source for the institutional costs for the CSEDW population was a three-year (SFY 2016-2018) claims trend analysis for children receiving services in a PRTF. The basis for the 3% annual trend projection is an estimate of medical inflation indices utilized in the State's overall budgeting procedures.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.

Waiver Services	
In-Home Family Support	
Independent Living/Skills Building	
Job Development	
Respite Care, In-Home	
Supported Employment, Individual	
Wraparound Facilitation	
Assistive Equipment	
Community Transition	
Family Therapy	
Mobile Response	
Non-Medical Transportation	
Peer Parent Support	
Respite Care, Out-of-Home	
Specialized Therapy	

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (5 of 9)****d. Estimate of Factor D.**

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Family Support Total:							64972800.00
In-Home Family Support		15 minutes	2000	1920.00	16.92	64972800.00	
Independent Living/Skills Building Total:							12750000.00
Independent Living/Skills Building		15 minutes	850	1500.00	10.00	12750000.00	
Job Development Total:							1494000.00
Job Development		15 minutes	200	1500.00	4.98	1494000.00	
Respite Care, In-Home Total:							2160562.50
Respite Care, In-Home		15 minutes	375	1150.00	5.01	2160562.50	
Supported Employment, Individual Total:							1503000.00
Supported Employment, Individual		15 minutes	200	1500.00	5.01	1503000.00	
Wraparound Facilitation Total:							17220000.00
Wraparound Facilitation		15 minutes	2000	600.00	14.35	17220000.00	
Assistive Equipment Total:							600000.00
Assistive Equipment		\$1.00	600	1000.00	1.00	600000.00	
Community Transition Total:							2100000.00
Community						2100000.00	
GRAND TOTAL:							205151925.00
Total: Services included in capitation:							205151925.00
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							2000
Factor D (Divide total by number of participants):							102576.00
Services included in capitation:							102576.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							365

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transition		\$1.00	700	3000.00	1.00		
Family Therapy Total:							74016000.00
Family Therapy		15 minutes	2000	1200.00	30.84	74016000.00	
Mobile Response Total:							22500000.00
Mobile Response		15 minutes	750	1500.00	20.00	22500000.00	
Non-Medical Transportation Total:							1539000.00
Non-Medical Transportation		1 mile	750	3800.00	0.54	1539000.00	
Peer Parent Support Total:							1536000.00
Peer Parent Support		15 minutes	800	192.00	10.00	1536000.00	
Respite Care, Out-of-Home Total:							2160562.50
Respite Care, Out-of-Home		15 minutes	375	1150.00	5.01	2160562.50	
Specialized Therapy Total:							600000.00
Specialized Therapy		\$1.00	600	1000.00	1.00	600000.00	
GRAND TOTAL:							205151925.00
Total: Services included in capitation:							205151925.00
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							2000
Factor D (Divide total by number of participants):							102576.00
Services included in capitation:							102576.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Family Support Total:							73094400.00
In-Home Family Support		15 minutes	2250	1920.00	16.92	73094400.00	
Independent Living/Skills Building Total:							14340000.00
Independent Living/Skills Building		15 minutes	956	1500.00	10.00	14340000.00	
Job Development Total:							1680750.00
Job Development		15 minutes	225	1500.00	4.98	1680750.00	
Respite Care, In-Home Total:							2431353.00
Respite Care, In-Home		15 minutes	422	1150.00	5.01	2431353.00	
Supported Employment, Individual Total:							1690875.00
Supported Employment, Individual		15 minutes	225	1500.00	5.01	1690875.00	
Wraparound Facilitation Total:							19372500.00
Wraparound Facilitation		15 minutes	2250	600.00	14.35	19372500.00	
Assistive Equipment Total:							675000.00
Assistive Equipment		\$1.00	675	1000.00	1.00	675000.00	
Community Transition Total:							2364000.00
Community Transition		\$1.00	788	3000.00	1.00	2364000.00	
Family Therapy Total:							83268000.00
Family Therapy		15 minutes	2250	1200.00	30.84	83268000.00	
Mobile Response Total:							25320000.00
Mobile Response		15 minutes	844	1500.00	20.00	25320000.00	
Non-Medical Transportation Total:							1731888.00
Non-Medical Transportation						1731888.00	
GRAND TOTAL:							230803119.00
Total: Services included in capitation:							230803119.00
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							2250
Factor D (Divide total by number of participants):							102579.00
Services included in capitation:							102579.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							365

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1 mile	844	3800.00	0.54		
Peer Parent Support Total:							1728000.00
Peer Parent Support		15 minutes	900	192.00	10.00	1728000.00	
Respite Care, Out-of-Home Total:							2431353.00
Respite Care, Out-of-Home		15 minutes	422	1150.00	5.01	2431353.00	
Specialized Therapy Total:							675000.00
Specialized Therapy		\$1.00	675	1000.00	1.00	675000.00	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							230803119.00 230803119.00 2250 102579.00 102579.00 365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Family Support Total:							73094400.00
In-Home Family Support		15 minutes	2250	1920.00	16.92	73094400.00	
Independent Living/Skills Building Total:							14340000.00
Independent Living/Skills Building		15 minutes	956	1500.00	10.00	14340000.00	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							230803119.00 230803119.00 2250 102579.00 102579.00 365

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Job Development Total:							1680750.00
Job Development		15 minutes	225	1500.00	4.98	1680750.00	
Respite Care, In-Home Total:							2431353.00
Respite Care, In-Home		15 minutes	422	1150.00	5.01	2431353.00	
Supported Employment, Individual Total:							1690875.00
Supported Employment, Individual		15 minutes	225	1500.00	5.01	1690875.00	
Wraparound Facilitation Total:							19372500.00
Wraparound Facilitation		15 minutes	2250	600.00	14.35	19372500.00	
Assistive Equipment Total:							675000.00
Assistive Equipment		\$1.00	675	1000.00	1.00	675000.00	
Community Transition Total:							2364000.00
Community Transition		\$1.00	788	3000.00	1.00	2364000.00	
Family Therapy Total:							83268000.00
Family Therapy		15 minutes	2250	1200.00	30.84	83268000.00	
Mobile Response Total:							25320000.00
Mobile Response		15 minutes	844	1500.00	20.00	25320000.00	
Non-Medical Transportation Total:							1731888.00
Non-Medical Transportation		1 mile	844	3800.00	0.54	1731888.00	
Peer Parent Support Total:							1728000.00
Peer Parent Support		15 minutes	900	192.00	10.00	1728000.00	
Respite Care, Out-of-Home Total:							2431353.00
Respite Care, Out-of-Home		15 minutes	422	1150.00	5.01	2431353.00	
GRAND TOTAL:							230803119.00
Total: Services included in capitation:							230803119.00
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							2250
Factor D (Divide total by number of participants):							102579.00
Services included in capitation:							102579.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							365

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Therapy Total:							675000.00
Specialized Therapy		\$1.00	675	1000.00	1.00	675000.00	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							230803119.00 230803119.00 2250 102579.00 102579.00 365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Family Support Total:							81216000.00
In-Home Family Support		15 minutes	2500	1920.00	16.92	81216000.00	
Independent Living/Skills Building Total:							15945000.00
Independent Living/Skills Building		15 minutes	1063	1500.00	10.00	15945000.00	
Job Development Total:							1867500.00
Job Development		15 minutes	250	1500.00	4.98	1867500.00	
Respite Care, In-Home Total:							2702143.50
Respite Care, In-Home		15 minutes	469	1150.00	5.01	2702143.50	
Supported Employment, Individual Total:							1878750.00
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							256466313.00 256466313.00 2500 102587.00 102587.00 365

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment, Individual		15 minutes	250	1500.00	5.01	1878750.00	
Wraparound Facilitation Total:							21525000.00
Wraparound Facilitation		15 minutes	2500	600.00	14.35	21525000.00	
Assistive Equipment Total:							750000.00
Assistive Equipment		\$1.00	750	1000.00	1.00	750000.00	
Community Transition Total:							2625000.00
Community Transition		\$1.00	875	3000.00	1.00	2625000.00	
Family Therapy Total:							92520000.00
Family Therapy		15 minutes	2500	1200.00	30.84	92520000.00	
Mobile Response Total:							28140000.00
Mobile Response		15 minutes	938	1500.00	20.00	28140000.00	
Non-Medical Transportation Total:							1924776.00
Non-Medical Transportation		1 mile	938	3800.00	0.54	1924776.00	
Peer Parent Support Total:							1920000.00
Peer Parent Support		15 minutes	1000	192.00	10.00	1920000.00	
Respite Care, Out-of-Home Total:							2702143.50
Respite Care, Out-of-Home		15 minutes	469	1150.00	5.01	2702143.50	
Specialized Therapy Total:							750000.00
Specialized Therapy		\$1.00	750	1000.00	1.00	750000.00	
GRAND TOTAL:							256466313.00
Total: Services included in capitation:							256466313.00
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							2500
Factor D (Divide total by number of participants):							102587.00
Services included in capitation:							102587.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Family Support Total:							81216000.00
In-Home Family Support		15 minutes	2500	1920.00	16.92	81216000.00	
Independent Living/Skills Building Total:							15945000.00
Independent Living/Skills Building		15 minutes	1063	1500.00	10.00	15945000.00	
Job Development Total:							1867500.00
Job Development		15 minutes	250	1500.00	4.98	1867500.00	
Respite Care, In-Home Total:							2702143.50
Respite Care, In-Home		15 minutes	469	1150.00	5.01	2702143.50	
Supported Employment, Individual Total:							1878750.00
Supported Employment, Individual		15 minutes	250	1500.00	5.01	1878750.00	
Wraparound Facilitation Total:							21525000.00
Wraparound Facilitation		15 minutes	2500	600.00	14.35	21525000.00	
Assistive Equipment Total:							750000.00
Assistive Equipment		\$1.00	750	1000.00	1.00	750000.00	
Community Transition Total:							2625000.00
Community Transition		\$1.00	875	3000.00	1.00	2625000.00	
Family Therapy Total:							92520000.00
Family Therapy		15 minutes	2500	1200.00	30.84	92520000.00	
GRAND TOTAL:							256466313.00
Total: Services included in capitation:							256466313.00
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							2500
Factor D (Divide total by number of participants):							102587.00
Services included in capitation:							102587.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							365

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Mobile Response Total:							28140000.00
Mobile Response		15 minutes	938	1500.00	20.00	28140000.00	
Non-Medical Transportation Total:							1924776.00
Non-Medical Transportation		1 mile	938	3800.00	0.54	1924776.00	
Peer Parent Support Total:							1920000.00
Peer Parent Support		15 minutes	1000	192.00	10.00	1920000.00	
Respite Care, Out-of-Home Total:							2702143.50
Respite Care, Out-of-Home		15 minutes	469	1150.00	5.01	2702143.50	
Specialized Therapy Total:							750000.00
Specialized Therapy		\$1.00	750	1000.00	1.00	750000.00	
GRAND TOTAL:							256466313.00
Total: Services included in capitation:							256466313.00
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							2500
Factor D (Divide total by number of participants):							102587.00
Services included in capitation:							102587.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							365