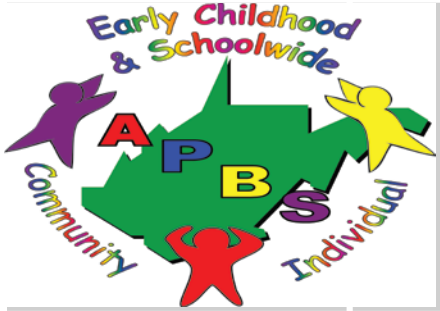
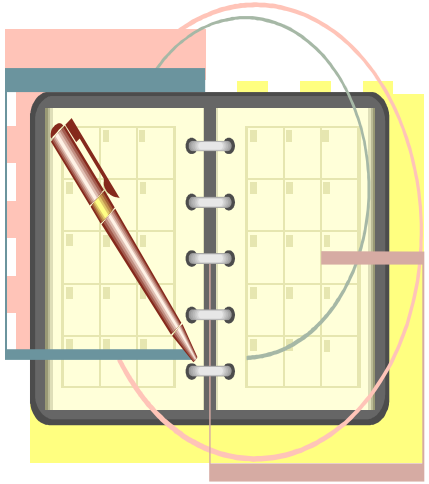


WV I/DD Waiver Training for Providers

2011

WV I/DD Waiver Agenda

- Eligibility, Rights, Responsibilities, Discharge and Appeal
- Staff training requirements
- IPP/IDT
- Service Delivery Models
  - Traditional
  - Participant-Directed
    - Agency With Choice (AwC)
    - *Personal Options* Fiscal/Employer Agent (F/EA)



WV I/DD Waiver Agenda

- Public Partnerships, LLC (PPL)
- I/DD Waiver General Changes and Available Services
- WV Association for Positive Behavior Support (WV-APBS) Application Process
- Transition Plan
- Purchasing on the CareConnection®
- I/DD Waiver Forms

Eligibility, Rights, Responsibilities, Discharge and Appeal

Initial Eligibility Determination Process

- Submit application (WV-BMS-I/DD-1) to APS Healthcare
- APS will contact the applicant and provide them with a list of Independent Psychologist Network (IPN) members
- The applicant chooses a psychologist and works with the psychologist to schedule the appointment within 14 days

Initial Eligibility Determination Process

- Initial eligibility assessments will be completed by an Independent Psychologist (IP), who is a member of the Independent Psychologist Network (IPN) using the Independent Psychological Evaluation (IPE)

- The IPE may include:
  - Background information
  - Mental status examination
  - A measure of intelligence
  - Adaptive behavior
  - Achievement
  - Other documentation deemed necessary – i.e. verification of medical diagnosis, IEP, etc.

Initial Eligibility Determination Process

- The IP completes the IPE and submits it to APS within 60 days of the initial application
- APS will verify the IPE is complete, signed/dated and will forward to the Medical Eligibility Contracted Agent (MECA)
- The MECA will verify clinically (diagnosis, deficits, etc)

Initial Eligibility Determination Process

- Once received, the MECA has 30 days to make a medical eligibility determination

- <u>Timeline Summary</u>:
  - 60 days for IP to submit IPE
  - 30 days for the MECA to make a determination
  - 90 days total between application and determination

Initial Eligibility Determination Process

- The applicant will be notified of the determination of the MECA in a Notice of Decision letter

- If determined medically eligible, the applicant will receive an informational packet describing the program and Service Options

Initial Eligibility Determination Process

- Within 90 days of receiving a slot, member will receive Freedom of Choice (WV-BMS-I/DD-2) form (may be less than 90 days if a slot becomes available sometime throughout the year-other than 7/1)
  - Choice between ICF/MR or I/DD Waiver
  - Choice of Service Coordination agency
  - Choice of Participant-Directed and/or Traditional Services

Initial Eligibility Determination Process

- Once determined medically eligible and notified that a slot is available, the applicant must apply for financial eligibility at their local DHHR prior to enrollment
- Provider must verify that both medical and financial eligibility are established prior to being reimbursed for services provided
- If determined ineligible, the applicant has 90 days to appeal with the Board of Review

Re-eligibility Determination Process

- Medical eligibility must be re-determined annually
- APS will conduct the functional assessment which will be used to determine the individualized budget and annual medical eligibility
- APS will forward the assessment to the MECA
- The MECA will determine medical eligibility annually based on this functional assessment

Re-eligibility Determination Process

- Agencies will continue to complete recertification packets through October 1, 2011
- Any DD1 (former DD14) signed before 10/1/2011 will access “old” process; if signed 10/1/2011 or after, will access “new” process
- Beginning October 1, 2011, the assessments completed by the SSFs will be sent to PC&A for review for annual medical eligibility

Member Rights

- The right to choose between ICF/MR or I/DD Waiver
- The right to choose Service Coordination agency
- The right to choose Participant-Directed and/or Traditional Services
- The right to have multiple providers
- The right to voice dissatisfaction with services
- The right to a Medicaid Fair Hearing

Member Rights

- Providers must:
  - Ensure that a member is not discharged unless a viable discharge/transfer plan is in place that effectively transfers all services the member needs to another provider or providers and is agreed upon by the member and/or their legal representative and the receiving provider or providers

Member/Family/Legal Rep Responsibilities

- Member may be discharged from the I/DD Waiver Program if not compliant with responsibilities:
  - Be present during Interdisciplinary Team Meetings (IDT)
  - Participate in annual functional assessments which will determine medical eligibility and budget
  - Comply with I/DD Waiver policies including monthly SC home visits
  - Implement portions of the Individual Program Plan (IPP) for which they have accepted responsibility
- Maintain a safe environment for employees to work

Member/Family/Legal Rep Responsibilities

- Report suspected fraud to Medicaid Fraud Control Unit:
  - MFCU is charged with investigating suspected Medicaid fraud and making applicable referrals for prosecution
  - Investigate alleged abuse, neglect and financial exploitation of persons who receive Medicaid

Member/Family/Legal Rep Responsibilities

- Examples of Medicaid Fraud:
  - Billing for services while abusing, neglecting, exploiting the member
  - Billing for services that never occurred
  - Double-billing
  - Billing for unnecessary services

Member/Family/Legal Rep Responsibilities

- If Medicaid Fraud is suspected, you must contact the Medicaid Fraud Control Unit at:

  1-888-FRAUDWV (1-888-372-8398)

  (304) 558-1970

  https://www.wvdhhr.org/oig/mfcu/secRepFrd/

- Reports of fraud can be completed via:
  - Phone
  - Online reporting form
  - In writing

Member/Family/Legal Rep Responsibilities

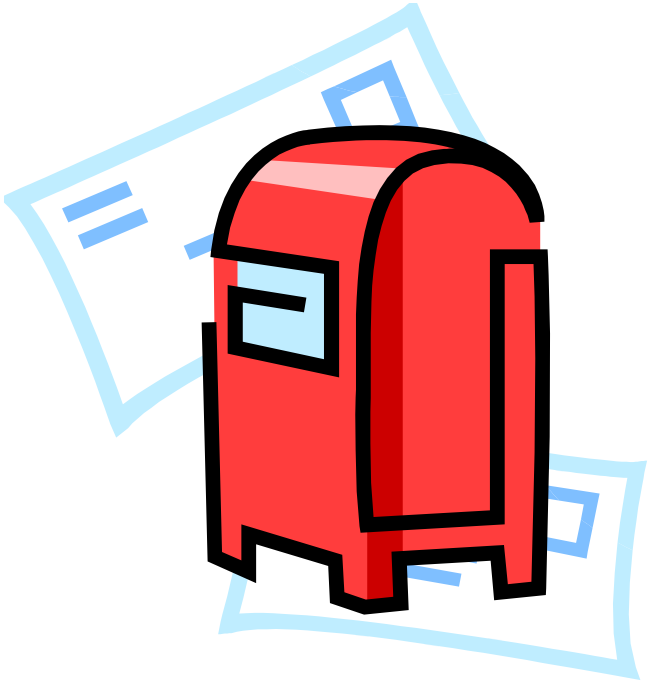
- All people providing services are mandated reporters
- If abuse/neglect is suspected, contact:
  - Adult Protective Services
    1-800-352-6513
  - Child Protective Services
    1-800-352-6513
  - Local County DHHR Office

Member Grievance/Complaints

- Members/Legal Representatives have the right to access the Medicaid Fair Hearing process consistent with state and federal law

Member Appeals

- If medical eligibility is denied/terminated, APS Healthcare will forward a Notice of Decision and a Request for Hearing form to the member or their legal representative



Member Appeals

- To appeal, the member/representative must submit the Request for Hearing form to the Board of Review within 90 days of receipt of the Notice of Decision
  - The applicant may have a psychological evaluation completed by a member of the IPN (selected by the member) at the expense of the Bureau for Medical Services (BMS)

Member Appeals

- If medical eligibility is terminated and the member/representative wishes to continue existing services throughout the appeal process, the Request for Hearing form must be submitted within 13 days (otherwise, services will cease)

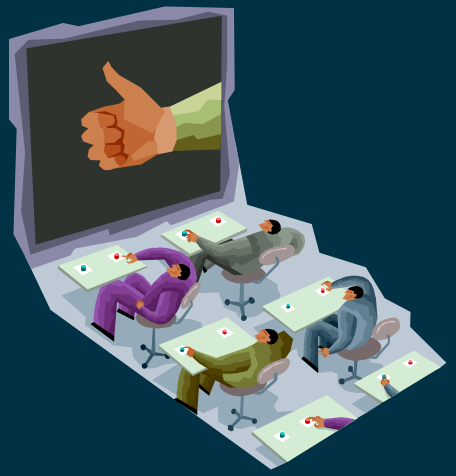
- When a member/representative chooses to petition the circuit court following the final appeal decision of a Medicaid Fair Hearing, services being appealed are not continued while petitioning the circuit court

Member Discharge from Program

- Income or assets exceed limits (not financially eligible)
- Not medically eligible
- Voluntary termination
- Member is deceased

- Failure of member/guardian to comply with policy (assessments, IDTs, home visits)
- Not accessing direct support services for 180 consecutive days

Staff Training Requirements



Staff Training Requirements

- All agency staff (excluding contracted extended professionals) having direct contact with members must meet the qualifications listed below:
  - Acceptable CIB (WV State Police fingerprint CIB initially and then every 3 years thereafter)
  - Acceptable NCIC (Federal fingerprint initially if applicant has lived out of WV in past 5 years)
  - Protective Services Record Check (not req for Personal Options) www.wvdhhr.org/bcf

Staff Training Requirements

- Continued:
  - Cannot be on the list of excluded individuals maintained by the Office of the Inspector General http://exclusions.oig.hhs.gov/
  - Must be over the age of 18
  - Must have the ability to perform the tasks

Staff Training Requirements

- Documentation of training initially and annually as mandated by OHFLAC including:
  - Treatment policies and procedures
  - Consumer Rights
  - Emergency Procedures, such as Crisis Intervention and restraints
  - Emergency Care to include Crisis Plans or Emergency Disaster Plans
  - Infectious Disease Control

Staff Training Requirements

- Continued:
  - Heimlich maneuver
  - Cardiopulmonary Resuscitation (CPR) through the American Heart Association (AHA) or American Red Cross (ARC)
  - First Aid through the American Heart Association (AHA) or American Red Cross (ARC)
  - Member-specific needs (including special needs, health and behavioral health needs)
  - Recognition, documentation, and reporting of suspected abuse/neglect and exploitation
  - Agency staff who function as Approved Medication Assistive Personnel (AMAP) must have high school diplomas or the equivalent and be certified AMAPs

Individual Program Plan (IPP)/ Interdisciplinary Team (IDT) Meeting

IPP/IDT

- At a minimum, the IDT consists of:
  - The member
  - The legal representative and/or Participant-Directed representative, if applicable
  - The member's Service Coordinator
  - Representatives of all I/DD Waiver agencies/providers that provide services for the individual
  - A Medley Advocate if the member is a Medley Class Member

IPP/IDT

- Other team members may include:
- Professionals:
  - Therapeutic Consultant (TC)
  - Behavior Support Professional (BSP)
  - Registered Nurse (RN)
  - Physical Therapist
  - Occupational Therapist
  - Speech Therapist
  - Registered Dietician

IPP/IDT

- Continued:
- Direct Service Providers:
  - Day Habilitation providers
  - Person-Centered Support workers
  - Respite providers
  - Supported Employment providers
  - LPNs (when the member receives 8 hours or more nursing in one day)

IPP/IDT

- Continued:
  - Service providers from other systems such as: the local education agency/public schools, Division of Rehabilitation Services (DRS), or Birth to Three (provided that no duplication of service exists)
  - Family Based Care Specialist (when member resides in a Specialized Family Care Home)
  - Advocate (when applicable)
  - Involved parties such as: friends, extended family, the representative payee and the individual's significant other

IPP/IDT Meetings

- Initial IPP: Developed within 7 days of intake
- 30-day IPP: Plan is finalized within 30 days of intake
- Transfer IPP: Member transfer from one SC agency to another
- Critical Juncture IPP: When there is a significant change in the member's life
- Annual IPP: Annual plan with IDT reviews every 90 days (or 180 with team approval)

Anchor Date

- Formerly known as “fixed date”
- Start date of the service year
- IPP meeting will need to be within 30 days prior to Anchor Date
- For new members, this will be the first day of the month after medical eligibility is established

Anchor Date

- BMS has approved up to a 9-month extension on eligibility dates
- This will allow APS to align current members' fixed IPP dates with eligibility dates
- This will be the "Anchor Date" for all existing members

IPP/IDT

- The 60-day window in which to conduct Annual IPPs has been reduced to the 30 days prior to the Anchor IPP date

- <u>Example</u>: If the Annual Anchor date is July 1, then the Annual IPP meeting must be conducted between June 1st and July 1st

IPP/IDT

- If unavoidable circumstances prevent the IDT from meeting and developing the annual IPP prior to date due, the SC may request to continue services from the existing plan
- APS Healthcare must approve any “Requests to Continue Services” (WV-BMS-I/DD-12) and must include a specific end date

IPP/IDT

- If the member chooses self-directed services, the monthly spending plan must be attached to the IPP when the monthly spending plan is available
- IPP must have a direct correlation between the assessments and the ISP
  - Assessed needs must be addressed

IPP/IDT

- Services purchased/ provided must be:
  - Based on assessed need
  - Agreed upon by the IDT
  - Included in the IPP

Service Delivery Models:

1. Traditional
2. Participant-Directed
    a. Agency with Choice
    b. *Personal Options*

Service Delivery Model

- Member may choose to change service delivery models at any time throughout the service year
  - This must be indicated on the I/DD-2 Freedom of Choice Form
- Member may also change from any service delivery model to another
  - Ex. – Traditional/Personal Options → Traditional/AwC
  - or Traditional/Personal Options → Traditional

I/DD-2 Freedom of Choice

- **Traditional**: Traditional Services are provided through an agency (The Agency employs/manages support staff)
- **Traditional and Agency with Choice**: The agency and member (or representative) co-manages support staff - the agency provides Financial Management Services (FMS)
- **Traditional and Personal Options**: Member (or representative) is responsible to manage support staff - WV's contracted Fiscal/Employment Agent serves as the FMS
- **I am unable to choose at this time:** Member automatically defaults to current service delivery model

Traditional Service Delivery Model

- The Provider agency has the responsibility to secure, hire, discipline, manage, set work schedule and set wages for staff
- Provider agency is responsible for making sure staff have required credentials/ training
- Staff are employees or contractors of the Provider agency

Traditional Service Delivery Model

- The way services have been provided (with or through an approved I/DD Waiver Provider agency) is considered the “Traditional Service Delivery Model”
- All services (except Participant-directed Goods and Services) are available under this model

Participant-Directed

- Participant-Direction is a person-centered service delivery system where individuals have greater choice and control over the services they receive and the individuals who provide them

- Members will have options to exercise employer authority and/or budget authority
  - Employer Authority: Control over the Participant-Directed Services and the individuals and organizations who provide them
  - Budget Authority: Control over how the participant-directed portion of the budget is spent

Participant-Directed

- Participant-Direction increases choice and control but also increases responsibility
- Members may direct their own services with or without the assistance of a legal or non-legal representative

Participant-Directed

- All program members will have the opportunity to direct their services with the following exceptions:
  - Participant-Directed Services will not be available to individuals living in OHFLAC licensed residential settings
  - Individuals and/or their representatives that do not follow policies/procedures pertaining to Participant-Directed Services may be required to return to the traditional option for service delivery

Participant-Directed

- Only the following services may be Participant-Directed:
  - Transportation
  - Person Centered Support Services
  - Respite Care
  - Goods & Services (PDGS)
    - To access PDGS, the member must also access at least one other type of PDS during the budget year – i.e. PCS, Respite, and/or Transportation

Participant-Directed

- There are two Financial Management Service (FMS) models available to support the use of Participant-Directed Services:
  - Agency with Choice (AwC)
    - The I/DD Waiver provider serves as the fiscal agent and is the employer of record
    - The member and/or their legal representative along with the AwC provider have a co-employer relationship
  - *Personal Options*
    - The personal options vendor serves as the fiscal agent and the member serves as the employer of record

Agency with Choice

- Under this model, the provider and the member/legal representative enter into a co-employer arrangement
- The provider is the primary employer of record, while the member/ representative is the secondary or managing employer of the member's qualified support workers

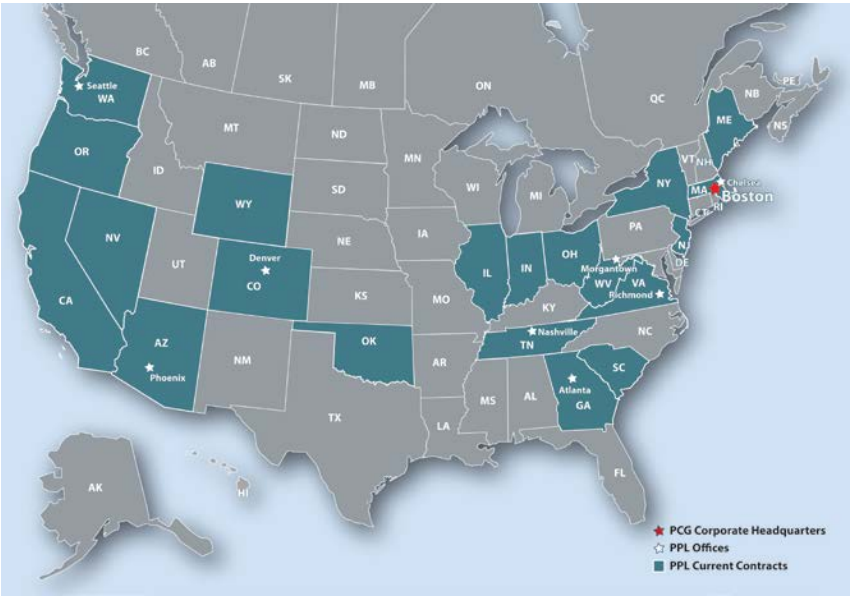
I/DD Waiver Traditional and Participant-Directed Service Delivery Model Crosswalk

WV I/DD Waiver
Personal Options

About Public Partnerships, LLC

- PPL is the largest provider of financial management services for self direction in the US
- PPL was founded in 1999 to focus exclusively on the financial and management operations of participant-directed services.
- PPL manages payroll services for 40,000 participant-directed employees.

PPL has contracts in 20 states & the District of Columbia serving about 36,000 individuals with a variety of needs



Public Partnerships in West Virginia

Since February, 2007 PPL has been contracted by the WV Bureau for Medical Services to provide Financial Management Services (FMS) and Resource Consultant services for the Aged and Disabled Waiver (ADW) program.

The ADW Personal Options program has grown from 15 participants in July, 2007 to 875 participants in July, 2011. (18% of active ADW members.)

Public Partnerships in West Virginia

- Resource Consulting
  - Information and Assistance
  - Employer & Employee Enrollment
  - Assisting in Spending Plan Development
  - Monitoring and Reporting
- Fiscal/Employer Agent Services
  - Accounting
  - Verification of Provider/Vendor Qualifications (CPR, CBC)
  - Payroll
  - Accounts Payable
  - Tax Services
  - Reporting
- Customer Service

WV IDD Waiver Personal Options Services

- Person-Centered Supports
- Respite
- Transportation
- Participant-Directed Goods and Services (PDGS)

Participant-Directed Goods and Services

Participant-Directed Goods and Services (PDGS) are services, equipment or supplies not otherwise provided through the Waiver program or through the Medicaid State Plan that address an identified need in the IPP.

Participant-Directed Goods and Services

- Limited to $1,000 per member's IPP year in combination with Traditional Environmental Accessibility Adaptations- Vehicle and Home and Participant-Directed Goods and Services-AwC
- To access PDGS the member must also access at least one other type of participant-directed service during the budget year—i.e. PCS, Respite and/or transportation
- PDGS cannot be accessed as a means of reimbursement for items or services that have already been obtained and not been pre-approved by the *Personal Options* F/EA

Benefits of Directing Your Own Services

- Budget Authority
  - You decide how to spend your participant-directed budget
  - No unit caps on Transportation, PCS or Respite
- Employer Authority
  - You hire and train your own workers
  - You determine your workers' schedules and work hours
  - You decide how much to pay your workers within a range of minimum wage to the Medicaid rate for the service (i.e. PCS and Respite = $7.25 - $9.88 per hour)

Personal Options

What have you heard about directing your own services?

Responsibilities

RUMOR	FACT
You won’t be able to handle the responsibilities of directing your own services.	PPL will assign a Resource Consultant to assist you with your responsibilities. You may also appoint a representative to help you with your responsibilities.

Responsibilities

RUMOR	FACT
If you make a mistake directing your own services, you could lose your Waiver slot.	If you experience difficulties directing your own services, you will not lose your slot. PPL may recommend that you appoint a representative or transfer back to traditional services.

Access to Participant-Directed Services

RUMOR	FACT
You can only access participant-directed services if you're unable to obtain services through a traditional service provider.	Participant-directed services are available to all I/DD Waiver members except those that live in homes licensed by OHFLAC.

Access to Participant-Directed Services

RUMOR	FACT
You may not direct your own services if you are under 18 years of age or an adult with a legal representative.	Any I/DD member may self-direct except for those living in a licensed home. Some members may require the assistance of a representative.

Changing Service Models

RUMOR	FACT
If you change to a participant-directed service model you won’t be allowed to return to the traditional service model.	You have the right to change your service model at any time and for any reason. Your Service Coordinator and PPL will assist you with the transition to prevent gaps in service.

Benefits

RUMOR	FACT
If you choose to direct your services you will lose your benefits—i.e. SSI.	The service model you choose does not impact your benefits. Your workers' wages may impact <u>their</u> benefits but the same is true for workers employed by traditional service providers.

Budgets

RUMOR	FACT
If you choose to direct your own services, your individualized budget amount will be decreased.	Your individualized budget amount is not affected by the service model you choose. Directing your own services does not alter your ability to negotiate the amount of your individualized budget.

Budgets

RUMOR	FACT
If you choose to direct your own services, you will receive cash for your participant-directed budget.	Personal Options participants do not receive cash. They exercise budget authority over an annual participant-directed budget.

Hiring Workers

RUMOR	FACT
If you choose to direct your own services, you will not be allowed to keep your existing workers.	You may hire your existing Residential Habilitation, Adult Companion and Respite workers if they choose to work for you and meet all qualifications.

Hiring Workers

RUMOR	FACT
If you choose to Personal Options, your workers will be employees of PPL.	Workers are employed by the program member. PPL acts as the “agent of the employer” for payroll and tax purposes.

Hiring Workers

RUMOR	FACT
If you choose to Personal Options, your legal guardian will no longer be allowed to be paid for providing services to you.	Legal guardians are <u>not</u> restricted from being paid workers. Only under certain circumstances and with safeguards may a participant's appointed representative also be a paid worker.

Hiring Workers

RUMOR	FACT
Your workers' hours and wages will be cut if they choose to work for you instead of working for a traditional provider agency.	Personal Options services are not subject to the caps on traditional services. You decide your workers' wages/hours. May work more than 40 hours but not eligible for overtime pay.

Taxes

RUMOR	FACT
If you direct your own services, your workers will have to pay more taxes.	Your workers' taxes will not increase unless you choose to pay a higher wage or increase their hours.

Traditional Supports

RUMOR	FACT
If you choose to direct your own services, you will lose the support of your Service Coordinator and/or Therapeutic Consultant.	Self-directing members may continue to access all traditional services including Service Coordination and Therapeutic Consultant.

Where do you start?

To begin directing your own services you must first complete a Freedom of Choice form which is available through your Service Coordinator, APS Healthcare or the Bureau for Medical Services (BMS).

Where do you start?

- Once you choose the Personal Options FMS Model, you will be referred to PPL and one of our staff will contact you to provide information, answer questions and inform you of the enrollment process.
- If during the enrollment period you change your mind about Personal Options, you only have to complete a new Freedom of Choice form indicating you wish to remain in the Traditional model.

Where do you start?

- Next, you must hold an IDT meeting
  - Annual Team Meeting
  - Critical Juncture Meeting
- At the meeting you will choose the types and amounts of traditional and participant-directed services that are necessary to meet your assessed needs.

Where do you start?

- Following the team meeting, your Service Coordinator will submit your requested services to APS Healthcare for review and authorization.
- Once your participant-directed budget has been authorized by APS Healthcare, you will meet with a PPL Resource Consultant to complete employer/employee enrollment and to develop your spending plan.

Employer & Employee Enrollment

- Your Resource Consultant will provide you with an Employer Packet and an Employee Packet which contain all the forms necessary for you to begin directing your services and hiring your workers.
- During your initial meeting, your Resource Consultant will provide training and assistance regarding the completion of Employer/Employee packets.

Spending Plan

- Your spending plan identifies the types and amounts of participant-directed services that you choose to meet your needs.
- The spending plan also identifies the wage you choose to pay each of your workers so that you can see exactly how your participant-directed budget will be used.

Paperwork

- Each of your workers will be required to submit to PPL a timesheet and transportation invoice for the services provided to you during each pay period.
- If you receive Therapeutic Consultant or Behavior Support Professional services, your workers may also be required to document training activities.

Ongoing Support

- Your PPL Resource Consultant will contact you each month to ensure your spending plan continues to meet you needs
- A *"Family Friendly Report"* will be made available to you each month so you can see how your budget is being spent
- PPL's web portal allows you to access your information at all times
- Electronic time sheets and transportation invoices prevent errors and delays in workers' paychecks

Satisfaction

- PPL strives to ensure participants are very satisfied with their financial management and Resource Consultant services.
- Participant satisfaction is measured and monitored by BMS on a regular basis.
- PPL offers a toll-free Customer Service number for participants and their workers.
- A formal grievance procedure is available for participants that want to file a complaint regarding PPL's services.

For More Information

If you have questions or wish to request additional information, please contact PPL:

- Public Partnerships, LLC, 601 East Brockway Avenue, Morgantown, WV 26501
- Email: pplwvidd@pcgus.com
- Phone: 1-877-908-1757

I/DD Waiver General Changes and Available Services

Psychologist Information

- New services do not include a code for Psychologists to participate in IPPs
- Psychologists *can* continue to participate in IPPs (by billing the Psychologist IPP code only) through the remainder of the member's service year, if noted on the member's current IPP by billing the remaining units of IPP Development-Psychologist

General Service Changes

- Annual and triennial psychological evaluations previously completed by the psychologist are eliminated
  - A member may have psychological evaluations, if needed, completed by accessing the State Plan
  - The IPN Psychologist will complete Independent Psychological Evaluation for initial eligibility determination by the MECA
  - APS will complete functional assessment annually for re-eligibility determination by the MECA

General Service Changes

- Person-Centered Support Services Replaces:
  - Agency Residential Habilitation
  - Community Residential Habilitation
  - Adult Companion
  - Community-Based Day Habilitation
- Facility Day Habilitation is a separate code
- Day services are no longer required for adults
- Members may receive up to 416 units/104 hours annually of Physical Therapy, Occupational Therapy and Dietary Therapy combined

General Service Changes

- <u>Nursing Changes</u>:
  - RNs and LPNs are allowed to bill for travel time to ISS/Group Homes and licensed day program sites in order to perform medication administration activities only

  - Annual Nursing Assessments are no longer required

All Direct Care Services (excluding Respite) under the Traditional Service Option-Combined

- Members in Natural Family/Specialized Family Care Home Settings eligible for public education may receive a max of 11,680 units/2,920 hours annually (average of 8 hours per day)
- Members in NF/SFCH setting not eligible for public education may receive a max of 17,520 units/4,380 hours annually (average of 12 hours per day)
- Members in an ISS or GH setting may receive a max of 35,040 units/8,760 hours annually (average of 24 hours per day)

All Direct Care Services (excluding Respite) under the Traditional Service Option-Combined

- **Public Education Services** are defined as school services for students through the end of the school year when the student turns twenty-one (21) years of age or the student has met graduation requirements for a standard high school diploma as defined by the Individuals with Disabilities Education Act (IDEA) and WV policy 2419

Behavior Support Professional

- Oversees all areas of Positive Behavior Support services:
  - Develops Positive Behavior Support Plans, Protocols and Guidelines
  - Assesses and evaluates behavioral data to monitor the effectiveness of the Positive Behavior Support Plan
  - Trains providers to implement Positive Behavior Support Plans

Behavior Support Professional

- Continued:
  - Develops methodology for intervention with the member
  - Presents proposed restrictive measures to the agency's HRC if no other professional is presenting the same information
  - Attends and participates in IDT meetings and annual functional assessments
  - Member may have only one Behavior Support Professional

Behavior Support Professional

- 960 units/240 hours annually in combination with Therapeutic Consultant Services
- Member is limited to one BSP or TC if receiving all services from a single provider
- If member receives direct care services from more than one I/DD Waiver provider, the member/legal representative is responsible for choosing which provider will provide BSP services (if applicable)

Behavior Support Professional

- BSP Staff Qualifications:
  - Bachelor of Arts (BA) or Bachelor of Science (BS) degree in human services field –and-
  - Two years experience in the I/DD field –and-
  - Documented evidence of enrollment in the Applied Positive Behavior Support (APBS) standards of practice coursework/training

Behavior Support Professional

- Board Certified Assistant Behavior Analyst (BCaBA) Certificate –and-:
  - Bachelor's degree –and-
  - One year experience working with individuals with I/DD –and-
  - Completion of the WV-APBS Network’s three hour overview of Positive Behavior Support

- Board Certified Behavior Analyst (BCBA) Certificate-Master's degree –and-:
  - One year experience working with individuals with I/DD –and-
  - Completion of the WV-APBS Network’s three hour overview of Positive Behavior Support

Provider Agency Application Process for Positive Behavior Support (PBS) Training Approval

PBS Training Development and Approval

- Behavior Support Professional Services provisionally (pertains to those who currently provide BS or BA):
  - **Enrollment Application:** serves as letter of intent indicating how the agency intends to meet qualifications for their staff to provide Behavior Support Professional
    - This application should be submitted to APS Healthcare

PBS Training Development and Approval

- To meet qualifications, agencies must either:
  - Submit training and receive approval of WVAPBS Network
  - Have staff trained by another agency whose PBS training was approved (enrolled/completed by timeline set in manual-6 months)
  - Have staff enrolled in training for completion of Board Certified Analyst or Board Certified Assistant Behavior Analyst credential

PBS Training Development and Approval

- Complete the Application for Positive Behavior Support Training Approval (Questionnaire and Review Tools)

- Submit the application and all parts of PBS training electronically:
  wvapbs@gmail.com

PBS Training Development and Approval

- Upon review by the WVAPBS Leadership team the application and an approval or denial letter will be returned to you in electronic format (This must be maintained for agency records)
- Providers are responsible for maintaining training records
- WV APBS Network has accepted responsibility of approving developed curriculums

Positive Behavior Support in WV

- The provisional qualification process is the first step toward a unified approach to positive behavior support practice in West Virginia
- All providers are encouraged to pursue the Positive Behavior Support Endorsement when it becomes available

Positive Behavior Support in WV

- The WV Statewide Positive Behavior Support Endorsement process is currently being developed by the WV APBS Network and its affiliates with implementation expected by 2015

Behavior Support Professional

- Develops skills and maladaptive behavior training programs
  - Trains direct care employees
  - Develops positive behavior support plans
  - Develops adaptive behavior plans
- Active treatment is not a requirement in services, however, assessed needs must be addressed in the IPP
  - The need for active treatment is still required for ICF/MR and Waiver eligibility

Behavior Support Professional

- Member must require this level of support
  - Member must currently exhibit maladaptive behaviors so severe that the adaptive functioning and ability to receive adaptive training is limited or impossible unless maladaptive behaviors are reduced or eliminated –or-
  - Member may have a history of behaviors beyond one year that have resulted in severe life threatening situations such as fire setting or arson or sexual assault or offending behaviors that result in bodily harm to others or self
- Members have the option to receive informal habilitation programming through natural supports
- Limit: 240 hours per IPP year combined with Therapeutic Consultant

Behavior Support Professional: Individual Program Planning

- Replaces the former IPP Development code
- Limited to 4 events per member's service year
- Must be present during the IPP meeting in order to bill (attending by phone is not billable)

Crisis Services

- Under emergent circumstances, which place the member's or others' health and safety at risk, crisis service may be immediately implemented without prior authorization up to a maximum of 72 hours
- 2:1 staff/member ratio
- Limit: 336 hours/IPP year

Dietary Therapy

- Nutritional assessment and therapy for diseases that have a nutrition component
  - Preventative health and diet assessment
  - Weight management
- Limit: 104 hours/IPP year combined with Physical Therapy and Occupational Therapy

Electronic Monitoring

- Oversight and monitoring within the residential setting through off-site electronic surveillance
- Unit = 1 Hour
- Service may be provided in the adult member's family residence, a licensed group home and in any ISS
- All systems or companies used or contracted by the I/DD Waiver provider must meet the standards set by BMS
- Must be pre-approved by BMS before providing any services

Electronic Monitoring

- Any member wishing to access this service must first be assessed and approved by the I/DD Waiver provider's Human Rights Committee (HRC)
- The approval of the HRC must be documented and attached to the member's IPP
- SC must conduct a home visit that includes a programmatic review of the system, as well as, a drill at 7 days of implementation, again at 14 days, and at least quarterly thereafter (in addition to the normal required monthly home visit)

Electronic Monitoring

- The I/DD Waiver provider has stand-by intervention staff who meet the following standards:
  - Responds by being at the member's residential living site within 20 minutes or less from the time an incident is identified by the remote staff and the stand-by staff acknowledges receipt of the notification by the remote staff
  - The IDT has the authority to set a shorter response time based on individual member needs

Electronic Monitoring

- Continued:
  - Assists the member in the home as needed to ensure the urgent need/issue that generated a response has been resolved
  - Each time an emergency response is generated, an incident report must be submitted to the West Virginia Incident Management System (WV IMS) by the I/DD Waiver provider

Electronic Monitoring

- May not be used in Specialized Family Care Homes
- Must be approved by BMS

- May not be used to monitor direct care staff
- May not be billed at the same time any other direct care service is billed for a member

Environmental Accessibility Adaptation: Home and/or Vehicle

- Environmental Accessibility Adaptations are physical adaptations to the home or vehicle
- Must be documented on the member's IPP
- To maximize the member's accessibility to the home or vehicle

Facility-Based Day Habilitation

- Structured program that uses meaningful and productive activities designed to promote the acquisition of skills or maintenance of skills for the member outside the home
- Limit: 6,240 units or 1560 hours/IPP year
- Staff to member ratios for this service are 1:1-2, 1:3-4, and 1:5-6
- Staff may not be a family member or any other individual who lives in the member's home

Occupational Therapy

- Evaluation and training in areas of fine and gross motor
  - Self care training
  - Sensory training
  - Assistance and training for adaptive aids
- Limit: 104 hours/IPP year combined with Physical Therapy and Dietary Therapy

Participant-Directed Goods and Services

- Participant-Directed Goods and Services (PDGS) are defined as services, equipment or supplies not otherwise provided through the waiver and meets the following requirements:
  - An item or service that would decrease the need for other Medicaid services and/or increase a member's safety and opportunities in the community
  - The member does not have the funds to purchase the item or service or the item or service is not available through another source

Participant-Directed Goods and Services

- Continued:
  - PDGS are purchased from the Participant-Directed budget
  - The need for PDGS must be documented in the IPP
  - PDGS must be pre-approved by *Personal Options* or AwC and purchase must be documented by receipts or other documentation of the goods or services from the established business or otherwise qualified entity or individual
  - Member must access at least one other PDS – i.e. Respite, Person-Centered Supports

Participant-Directed Goods and Services

- Limit: 1000 units ($1,000) per IPP year in combination with Traditional Environmental Accessibility Adaptations- Vehicle and Home

Participant-Directed Goods and Services

- Examples of exclusions include:
  - Goods, services or supports covered by the State Plan, Medicare, other third-parties, including education, home-based schooling and vocational services
  - Goods, services and supports available through another source
  - Medications, vitamins and herbal supplements
  - Personal hygiene items
  - Refer to I/DD Manual for a complete list

Person-Centered Support

- Person-Centered Support (PCS) services consist of training and/or support activities that enable the member to live and inclusively participate in the community

- PCS combines Agency Residential Habilitation, Community Day Habilitation & Adult Companion Services

Person-Centered Support: Agency

- Agency staff may not be any individual who lives in the member's home
- Member ratio codes for this service are 1:1, 1:2, 1:3 and 1:4
- PCS: Agency is not available while the member is hospitalized (except when the behavioral needs of the member arise due to the temporary to change in environment)
- PCS: Agency is not available in nursing homes, psychiatric hospitals or rehabilitative facilities

Person-Centered Support: Family

- Must be a family member (excluding spouse) who lives in the member's home or a Specialized Family Care provider delivering the service in a SFC home
- Person-Centered Support (PCS) services consist of training and/or support activities that enable the member to live and inclusively participate in the community
- 1:1 and 1:2 are the only codes available in the member’s family residence and in Specialized Family Care Homes

Person-Centered Support: Limitations

- PCS (all types)
  - Not available in nursing homes, psychiatric hospitals or rehabilitative facilities

Physical Therapy

- Screening, assessment and treatment designed to preserve and improve your independence
  - Gross and fine motor skills
  - Range of motion
  - Strength
  - Muscle tone
- Limit: 104 hours/IPP year combined with Dietary Therapy and Occupational Therapy

Respite

- Designed to provide assistance/relief to the primary caregiver
- Not available in medical hospitals, nursing homes, psychiatric hospitals or rehabilitative facilities
- Ratios for this service are 1:1, 1:2, and 1:3
- Only 1:1 or 1:2 ratios are allowed to be utilized in a member's family residence or in a Specialized Family Care Home
- Limit: 1,728 hours/IPP year

Respite: Crisis Site

- Respite: Crisis Site Services are to provide temporary substitute care for an individual who is in need of an alternative residential setting due to behavioral needs or lack of supports
- 30 day maximum stay
- May only be provided in BHHF Crisis sites
- Under emergent circumstances which place the member's or others' health and safety at risk, crisis services may be immediately implemented without prior authorization up to a maximum of 72 hours

Service Coordination

- Designed to ensure accessibility, accountability and continuity of support and services
- Perform the same function for all of their members, regardless of which service delivery model the member chooses
- Present member's proposed restrictive measures to the Human Rights Committee if no other professional is presenting the same information
- Comply with reporting requirements of the WV IMS
- Participate in annual functional assessments

Service Coordination

- Limit: 872 units/IPP year
- Up to 4 units of Service Coordination per month per member served may be billed to review provision of services in order to verify the member receives services as indicated on the IPP and within program parameters
- There is no longer a monthly cap
- There is no IPP Development code (attending the IDT is regular SC code – Units were increased from 840 to cover dev code)

Service Coordination

- Service Coordination cannot be billed for the entire calendar month if a home visit did not occur within that calendar month (unless exception approved in advance by APS Healthcare and documented on WV-BMS-I/DD-12)

Skilled Nursing

- Licensed Practical Nurse: monitoring, direct nursing care, etc.
  - More than two hours/day requires prior authorization and that the nurse provide direct-care support
  - Max of 11,680 units/2920 hours (Average 8 hours/day) can be prior authorized
  - May bill travel time to/from ISS, GH, licensed DH site only to administer medication
- Registered Nurse: nursing services outside the scope of an LPN
  - Max of 120 hours/year can be prior authorized
  - IPP Planning: may bill to attend team meetings

Speech Therapy

- Screening, assessment and direct intervention to improve speech and hearing disabilities
- 96 units/events per year for members below age 24
- 48 units/events per year for members age 24 and over

Supported Employment

- Services that enable the member to engage in paid, competitive employment, in integrated community settings
- Limit: 8,320 units/2,080 hours/IPP year
- This limit is combined with other direct care services available through the Traditional Option

Therapeutic Consultant

- Develops training plans and provides training in the person-specific aspects and method of a plan of intervention or instruction to the primary care providers
- Skills Specialist = Therapeutic Consultant
- Behavior Specialist, Behavior Analyst, Behavior Analyst Psychologist = Behavior Support Professional if enrolled in a WV APBS Network approved curriculum

Therapeutic Consultant

- Active treatment is not a requirement; however, assessed training needs must be addressed in the IPP
- Members have the option to receive informal habilitation programming through natural supports
- Limit: 960 units/240 hours in combination with BSP per IPP year

Therapeutic Consultant: Individual Program Planning

- Member is allowed 2 Therapeutic Consultants (if from different agencies)
- 4 events per member's service year
- More than one Therapeutic Consultant may bill for this service during an IDT meeting, however there is still an annual limit of 4 events

Transportation Miles

- Transport to the site of a planned activity or service which is addressed on the IPP and based on assessed need

- 9,600 miles annually (average of 800 miles/month)
- Non Emergency Medical Transportation may be available through the local DHHR but cannot duplicate Waiver transportation www.wvdhhr.org
- The IPP must specify the number of miles per service
  - Ex: Up to 100 miles per month shall be used for transporting the member to and from their job location

Transportation Trips

- 4 one way trips per day or 874 trips annually in agency vehicle
  - Must have original capability to seat at least 8 but fewer than 16 passengers
- The member's IPP must specify the number of trips per service
  - Ex: Up to 20 trips per month shall be used for transporting the member to and from his job location

Administrative Changes

- Providers will be required to complete quarterly self reviews
  - Submit to Erica Workman at eworkman@apshealthcare.com
- Providers must submit incident reports through the WV IMS www.wvdhhr.org/bhhf/waiver/waiver_ims/

Reporting Requirements

- I/DD providers must utilize the WV IMS to track the types of incidents listed below:
  - Simple Incidents
  - Critical Incidents
  - Abuse, Neglect and Exploitation Incidents
- SCs may bill for entering incidents into WV IMS for those members on their caseload

Reporting Requirements

- Contact Pat Nisbet for Incident Management System username and password assistance

  Patricia.S.Nisbet@wv.gov

Transition Plan

Transition Plan

- A Crosswalk has been developed to associate new rates with old codes
- Molina will update their system to allow new rates as of October 1, 2011
- This will allow members to continue to access services on their current plan without making changes (but Providers can be paid at new rates)

Transition Plan: ARH→CRH

- Providers who have classified community residential habilitation (CRH) providers as agency residential habilitation (ARH) providers will need to roll back any unused ARH units to allow appropriate billing through Molina
  - Ex: If you have been authorized 100 units of ARH and used 60 units, then 40 units will need to be rolled back

Transition Plan: ARH→CRH

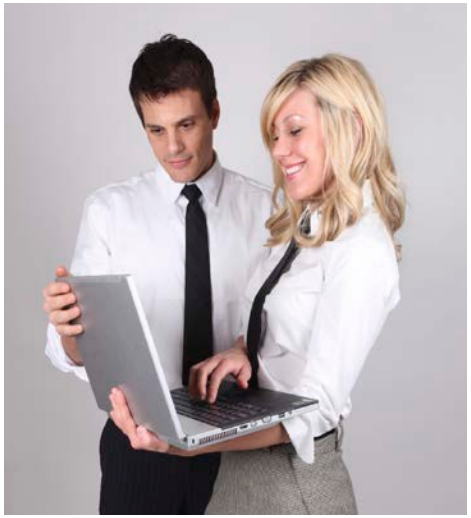
- After rollback of ARH units, SC will need to purchase CRH units, so that the appropriate code/rate will be accessed through Molina
- Applies **ONLY** to those agencies that have classified CRH providers as ARH providers
- Does not require a Critical Juncture meeting

Transition Plan: DH

- Continue to bill the DH or PV code(s) for the member until either the Annual or Critical Juncture.
- Services provided 10/1/2011 and after - Submit the new rate for this code to Molina for payment (ex. Code for DH 1:1 is T2021U4. Bill T2021U4 with a rate of $4.98 per unit
- At Annual IPP or Critical Juncture: If the member is accessing Day Habilitation primarily in the community, this would equate to Person-Centered Support
- At Annual IPP or Critical Juncture: If the member is accessing Day habilitation in a facility, this would equate to Facility-Based Day Habilitation

Transition Plan

- Members will have the option to stay with the services currently on the IPP until their next Annual IPP
  - With this option, members will be phased-out of the “old” services by September 30, 2012



Transition Plan

- If accessing new services, the member is subject to the new policy manual and <u>all</u> applicable rules
- At no time should the IPP reflect “old” AND “new” services

Transition Plan

- A face-to-face team meeting (Critical Juncture) must be held for the following reasons:
  - If all team members do not agree on services that the member receives
  - If the member receives a brand new service
    - Ex: If member has never accessed Supported Employment services before
  - If the member requires a greater amount of services than is on the plan (increase in number of units)

Transition Plan

- A face-to-face team meeting (Critical Juncture) must be held for the following reasons:
  - If the member is going to have a new goal implemented
  - If the member chooses to go with a Participant-Directed option (AwC or *Personal Options*)

Transition Plan

- If the member accesses new services prior to the expiration of their service year, the Service Coordinator must roll back current authorizations prior to purchasing new services
- Effective October 1, 2011 and greater, new services will be available to purchase and old services may no longer be purchased

Transition Plan

- Only under special circumstances, exceptions to authorizing “old” services can be granted after 10/01/2011:
  - Service date must have occurred prior to 10/1/2011
  - IPP start date must have been prior to 10/01/2011
  - Must be deemed an “exception” by APS (cannot be just because provider failed to purchase previously)

Transition Plan

- In summary, members may continue services on their current plan through the remainder of their service year unless needs change or a Critical Juncture needs to occur
- If they have the need for a Critical Juncture, SC must roll back all auths for “old” services and purchase “new” services to get through the remainder of the member’s service year

Purchasing on the CareConnection®

Purchasing

- IDT convenes and identifies all needed
  - Services,
  - Providers,
  - Units and
  - Supports
- SC enters all chosen services in CareConnection®

Purchasing

- Registration Coordinators will review services for appropriateness:
  - Within budget?
  - Within service limits?
  - Within program parameters (ex. max # hours/day depending on living arrangement)?
  - Has the team met the member's health and safety needs?

Purchasing

- Even when the member chooses participant-directed services, the total amounts of services entered in the CareConnection® cannot exceed the living arrangement maximum direct care units (ex. 8 hrs/day + Respite for child)

- If PD, the cost for these services is bundled and will be considered the "Participant-Directed Budget"

Purchasing

- The authorizations for services will be then be forwarded to either AwC or PPL and either the agency (AwC) or Resource Consultant (PPL) will contact the member to develop a participant-directed spending plan
- This spending plan will be attached to the member’s IPP

Purchasing

- IDTs must make every effort to purchase services within the member's assigned budget
- Registration Coordinators cannot exceed service limits when authorizing services
- Negotiating services in excess of the assigned budget should only be for those members identified as "outliers"

Purchasing

- Once approved by APS, service referrals go to all selected providers
- Selected providers either accept/reject service referrals
- If accepted, the provider will receive an authorization for payment

WV I/DD Waiver Forms

WV I/DD Waiver Forms

- Agencies that wish to computerize any of the forms may do so
- The forms cannot be altered and must be utilized (if applicable)
- It will be required that some forms are uploaded into the CareConnection®

WV I/DD Waiver Forms

- **WV-BMS-I/DD-1 Application**
- **WV-BMS-I/DD-2 Freedom of Choice**
  (Replaces the DD-7/7A)
  - Choice of I/DD Waiver or ICF/MR
  - Choice of I/DD Waiver Service Coordination Provider
  - Choice of Service Delivery Model
- **WV-BMS-I/DD-3 Monthly/Bi-Monthly SC Visit**
  - One form for all Home and/or Day Visits
  - More narrative than previous version

WV I/DD Waiver Forms

- **WV-BMS-I/DD-4 Initial IPP**
- **WV-BMS-I/DD-5 IPP**
  - Includes Service Delivery Options (Traditional, Participant-Directed)
  - Meeting minutes
  - Specific section for medications
  - Service Plan (Waiver services and Natural Supports)
  - Habilitation plan and task analysis are combined
  - PBS plan
  - Crisis plan
  - Participant-directed spending plan (if applicable)
  - Signature sheet

WV I/DD Waiver Forms

- **WV-BMS-I/DD-6 Certificate of Training** (formerly DD13)
- **WV-BMS-I/DD-7 Direct Support Documentation for Traditional and AwC**
  - Service Log (documents time spent per code/per staff person)
  - Direct Support Progress Note (optional and used to identify if something out of the ordinary occurs during service provision)
  - Transportation Log

WV I/DD Waiver Forms

- **WV-BMS-I/DD-8 Request for Environmental Accessibility Adaptations (EAA) and Goods & Services (G&S)**
- **WV-BMS-I/DD-9 Request for Nursing Services**
- **WV-BMS-I/DD-10 Transfer/Discharge**
  - Mimics required fields on the CareConnection® when transferring or discharging a program member

WV I/DD Waiver Forms

- **WV-BMS-I/DD-11 Notification of Member Death**
- **WV-BMS-I/DD-12 Request to Continue Services** -Serves to document requests for:
  - An eligibility extension
  - An exception to conducting the monthly SC home visit or day visit
  - IPP exceptions (outside of timelines, member or legal representative unavailable)

WV I/DD Waiver Forms

- **WV-BMS-I/DD-13 Annual Functional Assessment Data Modification Request**
  - Formal request that the ASO modify information collected during the member's annual functional assessment
  - All information submitted to the ASO must be in writing, and this form must be completed in its entirety prior to the ASO considering your request
  - May only be completed by the member or the legal representative

WV I/DD Waiver Contacts

WV I/DD Waiver Contacts

SERVICE	COMPANY	PHONE NUMBER	FAX NUMBER
I/DD Program Manager	Bureau for Medical Services	304-356-4904	304-558-4398
Administrative Services Organization (ASO)	APS Healthcare, Inc.	866-385-8920	866-521-6882
Claims Processing	Molina Medicaid Solutions	888-483-0793 (for Providers) 304-348-3380 (for Members) 877-902-1206 (Help desk)	304-348-3380
Medical Eligibility Contracted Agent (MECA)	Psychological Consultation & Assessment (PC&A)	304-776-7230	304-776-7247
Fiscal Employer Agent (F/EA) *Personal Options*	Public Partnerships, LLC (PPL)	877-908-1757	304-296-1932

Wrap Up

- Questions/Comments?
- Please complete satisfaction survey before leaving
- Thank you and have a safe trip home!
- The Chapter 513 I/DD Waiver Services Manual can be found at

  http://www.dhhr.wv.gov/bms/Pages/default.aspx
- WV I/DD Waiver Website

  http://www.dhhr.wv.gov/bms/hcbs/IDD/Pages/default.aspx