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Chairman

Karen L. Bowling, Cabinet Secretary
West Virginia Department of
Health and Human Resources

Board Members
Sonia D. Chambers
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November 3, 2016

Ms. Maureen Lewis
West Virginia Secretary of State
Bldg. 1, Suite 157-K
1900 Kanawha Blvd. East
Charleston, WV 25305-0770

Via E-Mail (MLewis@wvsos.com)

Re: Publication of Notice of Second Public
Comment Period for In-Home Personal
Care Standards

Dear Ms. Lewis:

Enclosed please find a **Notice of Second Public Comment Period** to be published in the State Register on Friday, November 4, 2016. Also enclosed is a copy of the proposed Certificate of Need Standards as required by West Virginia Code §16-2D-6(a).

Thank you for your assistance in this matter.

Sincerely,

A handwritten signature in blue ink, appearing to read "James L. Pitrolo, Jr.", written over a large, circular blue scribble.

James L. Pitrolo, Jr.
Chairman

Enclosures



NOTICE OF SECOND PUBLIC COMMENT PERIOD

Proposed Certificate of Need Standards

The West Virginia Health Care Authority (HCA) has scheduled a second public comment period to receive comments on the following proposed Certificate of Need Standards:

- **In-Home Personal Care Standards**

Written comments may be submitted in care of Timothy E. Adkins, Director of Certificate of Need, via email at TAdkins@hcawv.org or at the address set forth below and must be received no later than **5:00 p.m. on Wednesday, November 9, 2016**. Copies of the proposed Standards set forth above have been filed with the Secretary of State. The Standards may be viewed at the Authority's website, www.hcawv.org, or copies may be obtained by contacting Janet R. Huffman, Paralegal, at (304) 558-7000 or toll-free at 1-888-558-7002.

Date: November 3, 2016

A handwritten signature in blue ink, appearing to read "James L. Pitrolo, Jr.", is written over a horizontal line. The signature is highly stylized and cursive.

James L. Pitrolo, Jr., Chairman

IN-HOME PERSONAL CARE SERVICES

I. INTRODUCTION

These standards address the necessary criteria which must be met to obtain a Certificate of Need (CON) to provide in-home personal care (PC) services for Medicaid and Non-Medicaid residents. PC services are available to assist an eligible member to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs) in the member's home, place of employment or community. Services may not solely involve ancillary tasks such as housekeeping or assistance with chores. There are no age restrictions for members receiving PC services.

In order to provide PC services under West Virginia Medicaid, a provider agency must have a CON from the West Virginia Health Care Authority (Authority). Existing In-Home Personal Care Service Providers who are currently providing or have provided PC services within the past 12 months, including Senior Centers, WV Licensed Comprehensive Behavioral Health Care Centers and other Hartley Core Providers, and Specialized Family Care Providers are not required to obtain CON if: (1) the agency is a Bureau of Senior Services (BoSS) Certified In-Home Personal Care provider and has a valid Provider Number for PC services; and, (2) the agency only provides PC services within its service area as it exists as of the effective date of these Standards.

These standards are not applicable for the provision of in-home PC services provided by a member of the recipient's family.

Recommendations for state regulatory, planning and payor agencies:

One aspect of the analysis is a coordinated review by regulatory, planning and payor agencies for state government. The Authority, in reviewing CON applications, takes into consideration the programmatic and fiscal plans of the Bureau for Medical Services. A recommendation is requested from the agency on each application. The recommendations are based on the respective agency's programmatic and/or fiscal plan. All recommendations will be taken into consideration; however, the Authority has final approval on all applications.

II. DEFINITIONS

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

B. **Direct Access:** Physical contact with a resident or beneficiary or access to the resident or beneficiary's property, personally identifiable information (PII) or financial information.

C. Instrumental Activities of Daily Living: Skills necessary to live independently, such as the ability to shop for groceries, handle finances, perform housekeeping tasks, prepare meals, and take medications.

D. Personal Care: Services available to assist an eligible member to perform ADLs and IADLs in the member's home, place of employment or community. To be medically eligible for PC services, Medicaid members must have three deficits according to most current Pre-Admission Screening (PAS) signed by a physician, physician assistant, or nurse practitioner, and requires hands-on assistance/supervision/cueing in ADLs/IADLs. Members can receive a maximum of 210 hours of service per month based on assessed needs. There are no age restrictions for members eligible for PC services. However, PC services do not replace the age appropriate care that any child would need. PC services are medically necessary activities or tasks which are implemented according to a nursing plan of care (POC) developed and supervised by a Registered Nurse (RN). These services enable members to meet their physical needs and allow them to remain in their home and community.

III. INTRODUCTION TO NEED METHODOLOGY

All CON applicants must demonstrate with specificity that: (1) there is an unmet need for the proposed service; (2) the proposed service will not have a negative effect on the community by significantly limiting the availability and viability of other services or providers; and (3) the proposed services are the most cost effective alternative.

A. Applicants must delineate the proposed service area by documenting the expected area in which individuals will be served. The minimum service area will be a county. Applicants may also consider contiguous counties as part of the service area. A new CON will be required to expand services into an additional county or counties.

1. For Medicaid PC services, the Authority will provide, by age cohort and county, the projected number of residents who may be eligible beneficiaries.

2. For non-Medicaid services, applicants must;

a. Delineate by county the proposed service area population by age cohort for the first and third year (e.g. 2017 population and 2019 population) that services are to be provided. The age-cohort shall be grouped as follows:

- i. Column A: WV Population Under 5 years
- ii. Column B: WV Population 5-64 years
- iii. Column C: WV Population 65 years and older
- iv. Column D: Total WV Population SUM(A+B+C)

- b. Applicants must document expected utilization for the services proposed to be provided for the population within the proposed service area. Applicants must provide and document the rationale for the projection, which the Authority may accept at its sole discretion.

B. After establishing expected utilization, applicants must document the existing Medicaid and/or non-Medicaid providers within the service area and the extent to which the need is being met by the existing providers in the service area by county and age-cohort. The applicant must conduct a written survey of all existing providers in the proposed service area. The survey must request that each of the existing PC providers, within the proposed service area, submit information regarding the counties in which they provide services and data regarding the number of unduplicated patients served in each county during the most recent twelve-month period. Patients cannot be counted more than once. The Applicant will return the receipt along with all responses to the survey to the Authority. In the event a conflict arises regarding the unduplicated patient count, the survey results provided by the BoSS certified in-home Personal Care provider(s), that also have a valid provider number for In-Home Personal Care services, will be presumed to be valid with respect to the unduplicated patient count.

C. Applicants will deduct the current utilization from the projected utilization by county and age-cohort separately for Medicaid and non-Medicaid populations to determine unmet need. If the total projected PC patients exceed the current utilization by 25 or more patients, then an unmet need exists.

IV. QUALITY

All applicants shall document that they will be in compliance with all current applicable Medicaid regulations regarding pre-admission screening, nursing review of the preadmission screening, nursing POC, personal care daily plan, and personal care daily log, whether or not the applicant proposes to seek Medicaid certification.

All applicants must assure that there is adequate staff in the number and qualifications for the number of recipients served. Staff must meet the following qualifications:

- A. Administrative:
- B. Nursing:
- C. Direct Care:
- D. Direct Care Worker Qualifications:
- E. Initial and Annual Training Requirements:
- F. Specialized Family Care Home:
- G. Criminal Background Checks: All direct access personnel will be prescreened for negative findings by way of an internet search of registries and licensure databases through the WV DHHR designated website: WV Clearance for Access: Registry & Employment Screening (WV CARES).
- H. Fingerprinting:

- I. Employment Fitness Determination:
- J. Provisional Employees:
- K. Appeals:
- L. Responsibility of the Hiring Entity:
- M. Change in Employment:
- N. Provider Agency Certification:
- O. Conflicts of Interest:
- P. Specialized Family Care Providers (SFCs):
- Q. Office Criteria: Providers must designate and staff at least one physical office location within the proposed service area. A post office box or commercial mailbox will not suffice.

V. CONTINUUM OF CARE

All applicants shall have written practices and procedures designed to ensure that the appropriate monitoring of recipients will occur, and that follow-up care/referral is available in the event any complications arise which are beyond the ability of the applicant to treat. It is to be noted that no medical services will be provided by the direct care worker.

The applicant shall document the development of procedures to ensure that the referring physician or the recipient's primary care physician are apprised of services provided in a timely manner.

VI. COST

No CON shall be granted for in-home PC services, unless the applicant demonstrates that the project is financially feasible by the end of the third fiscal year of operation. If the applicant is proposing to serve Medicaid beneficiaries, applications for these services shall not be deemed consistent with the State Health Plan unless the projected costs are consistent with allowable costs provided for in the pertinent Medicaid reimbursement policies.

- A. The applicant must demonstrate the financial feasibility of the project. The factors to be considered must include:
 - 1. Utilization by payer classification; Current and projected rates; Statements of (a) revenue and expenses, (b) balance sheets, (c) statements of changes in fund balances, and (d) statements of cash flow for each of the last two fiscal years; Audited financial statements, if prepared, must be submitted; and, 10-K Reports, if required to be submitted to the Securities and Exchange Commission by either the applicant or a related entity, must be submitted for the preceding three years.
 - 2. A preliminary financial feasibility study which must, at a minimum, include: (a) revenue and expenses, (b) balance sheets, (c) statements of changes

in fund balances, and (d) statements of cash flow for each of the last two fiscal years, the current fiscal year, and future fiscal years prior to the project's implementation, and the first three years after the project's implementation. The financial feasibility study must also include all assumptions used, including projected payer mix, charges and/or revenue for each category of payer.

3. Sources of revenue/reimbursement by payer classification. The applicant must demonstrate the proposal is consistent with applicable payers' fiscal plans.

If the ongoing financial feasibility of the proposed project depends in part on funding from State programs the applicant must either: (a) describe why the proposed project can reasonably expect to receive such financial support in the future, or (b) describe where alternative sources of funding will come from to support the project.

- B. Decisions approving a CON application, based on financial projections which do not include any reimbursement from the Bureau for Medical Services will only be approved for PC services to clients who are not Medicaid beneficiaries. An applicant who is an existing PC provider and proposes to seek BMS reimbursement shall undergo further CON review. The applicant must document a policy regarding charity recipients. The policy must address the issues of a sliding fee scale and/or free care to the extent that such care is financially feasible.
- C. The applicant must demonstrate compliance with W. Va. Code §16-5F-1 et seq., "The Health Care Financial Disclosure Act," and 65 C.S.R. 13, the "Financial Disclosure Rule".

VII. ACCESSIBILITY

Preference will be given to applicants who demonstrate intent to provide services, without regard to the recipient's ability to pay.

VIII. OTHER

An applicant for or provider of in-home PC services must provide additional information, as may be requested by the Authority, including demographics data, financial data, and clinical data for recipients receiving these services.