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Health and Human Resources

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September 14, 2016

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

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

Dear Ms. Lewis:

Enclosed please find a **Notice of Public Comment Period** to be published in the State Register on Friday, September 16, 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.", is written over a blue circular stamp or seal.

James L. Pitrolo, Jr.  
Chairman

Enclosures



## NOTICE OF PUBLIC COMMENT PERIOD

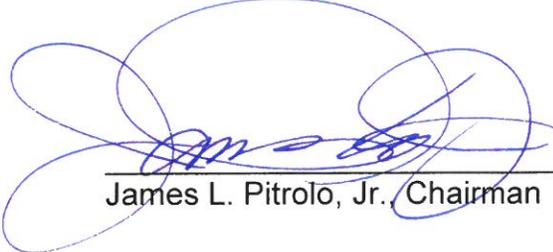
### Proposed Certificate of Need Standards

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

- **In-Home Personal Care**

Written comments may be submitted in care of Timothy E. Adkins, Director of Certificate of Need, at the address set forth below and must be received no later than **5:00 p.m. on October 17, 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](http://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: September 14, 2016



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 West Virginia residents. In-home PC services are provided directly or indirectly by licensed behavioral health agencies, county commissions on aging, and private non-profit and for profit entities. In order to provide PC services under West Virginia Medicaid, a provider agency must have a Certificate of Need (CON) from the West Virginia Health Care Authority (Authority). Exempt from this provision are those Senior Centers who are currently providing in-home personal care services, WV Licensed Comprehensive Behavioral Health Care Centers, and Specialized Family Care Providers.

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. To be medically eligible for PC services, Medicaid members must have three (3) deficits and require hands-on assistance/supervision/cueing in ADLs/IADLs ordered by a physician and be provided by a qualified PC provider(s). Members can receive a maximum of two hundred and ten (210) hours per month based on assessed needs. Services may not solely involve ancillary tasks such as housekeeping or assistance with chores. There are no age restrictions for members of PC services.

**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, The Bureau for Senior Services, and other appropriate state agencies. Each agency is asked for a recommendation 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 (ADLs): 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. Competency Based Curriculum: A training program which is designed to give participants the skills they need to perform certain tasks and/or activities. The curriculum should have goals, objectives and an evaluation system to demonstrate competency in training areas.

C. 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.

D. Direct Care Staff: The individuals who provide day to day care to PC members.

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

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

G. Environmental Maintenance: Activities such as light house cleaning, making and changing the member's bed, dishwashing, and member's laundry.

H. Home and Community Based Services (HCBS): Services which enable Medicaid members to remain in the community setting rather than being admitted to a Long Term Care Facility (LTCF).

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

J. 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.

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

L. Personal Care (PC): 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.

M. Quality Management Plan: A written document which defines the acceptable level of quality and describes how the provider will ensure this level of quality in its deliverables and work processes.

N. Scope of Services: The range of services deemed appropriate and necessary for an individual member. Such services may include but are not limited to prevention, intervention, outreach, information and referral, detoxification, inpatient or outpatient services, extended care, transitional living facilities, etc.

### **III. INTRODUCTION TO NEED METHODOLOGY**

Applicants must delineate their proposed service area by documenting the expected area in which individuals will be served. The need for in-home personal care services will be determined on a county by county basis. More than one county may be included in an application: service areas must consist of contiguous counties. Documentation is required for each county included in the application. The smallest service area for an application shall be one (1) county.

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. More than one county may be included in an application: service areas must consist of contiguous counties. A new CON will be required to expand services into additional new county or counties.

B. Applicants must delineate the proposed service area population by age cohort for the first and third year (i.e. 2017 population and 2020 population) that services are to be provided. The age cohort shall be grouped as follows:

1. Column B; WV Population Under 5 years
2. Column C: WV Population 5-64 years
3. Column D: WV Population 65 years and older
4. Column E: Total WV Population SUM(B+C+D)

5. Column F: Take the Service Area Population age 5-64 (Column C) and age 65 and over (Column D) multiply by 80%. Take that number and multiply by 30%.  
 $F = \text{Column (E)} \times 80\% \times 30\%$ <sup>1</sup>
6. Column G: Multiply the number in column F by 17% to reflect the number of individuals receiving or are eligible to receive Medicaid.  
 $(G=F \times 17\%)$ <sup>2</sup>
7. Column H: Subtract the total number population in Column F by the total number projected to be receiving or are eligible to receive Medicaid Column G to get the number of the Non-Medicaid population.  
 $(F-G=H \text{ (Total Number of Non-Medicaid population)})$

C. Applicants must document expected utilization for the services proposed to be provided for the population within the proposed service area. After establishing expected utilization, applicants must document the existing providers within the service area and the extent to which the need is being met by existing providers in the service area.

1. Column I: Multiply the number in Column H, the Non-Medicaid Population by 33.1% (Penetration Rate)<sup>3</sup>  
 $(I=H \times 33.1\%)$
2. Column J: The number of HCBS recipients for the Year Ending with the proposed service area.<sup>4</sup>
3. Column K: Subtract Column I from Column J. This will be the projected unmet need by county.  
 $(K= I-J)$

D. Upon request the Authority will assist an Applicant with the calculation of the Need Methodology.

#### **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 plan of care, personal care daily plan, and personal care daily log, whether or not the applicant proposes to seek Medicaid certification.

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<sup>1</sup> (F) U.S. General Accounting Office: 80% of the 65+population live at home and 30% of those have deficits in at least 3 ADL's

<sup>2</sup> (G) Bureau for Medical Services (BMS): approximately 17% of the WV population is Medicaid eligible.

<sup>3</sup> (I) BMS/Bureau for Senior Services: Currently 14453 individuals are eligible for In-home Personal Care Services, 4778 of these eligible individuals are receiving services;  $4778 / 14453 = 33.1\%$  penetration rate.

<sup>4</sup> (J) 5,439 residents served in Home & Community Based Waiver Program for year ended 2014. Bureau of Medical Services

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 (SFCPs):**
- 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 appraised of services provided in a timely manner.

#### VI. COST

No certificate of need shall be granted for in-home personal care services, unless the applicant demonstrates that the project is financially feasible by the end of the third fiscal year of operation. No applications for these services shall be deemed consistent with the State Health Plan unless the projected costs are consistent with allowable costs provided for in the pertinent Medicaid reimbursement statutes and regulations.

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.

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".

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.
4. 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.

Decisions approving a CON application, based on financial projections which do not include any reimbursement from the Bureau for Medical Services will be **CONDITIONED** upon the applicant not seeking BMS reimbursement. Applicants who propose to seek BMS reimbursement will apply for a new CON application.

## 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 personal; care 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.