HOME AND COMMUNITY-BASED SERVICES WORKING GROUP

FINAL REPORT AND RECOMMENDATIONS

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HOME AND COMMUNITY-BASED SERVICES WORKING GROUP MEMBERS

We are grateful to all those who contributed their time and expertise to deliberate on the issues surrounding the development and expansion of home and community-based services to give West Virginia elders and people with disabilities more choices on where to live.

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ISSUE OVERVIEW

The Home and Community Based Services Working Group was created to advise the Long Term Care Partnership on policies and practices that can promote and support elders to age in place and people with disabilities to live in their homes in the community.

The committee met three times between March and May 2010 to review recommendations of the *"Money Follows the Person" and Long Term Care System Rebalancing Study* prepared in August 2008 by the Public Consulting Group for the State of West Virginia[1]. In addition to the 2008 Study, the working group had the opportunity to recommend and consider other recommendations.

The working group defines Long-Term Care and Home and Community-Based Services as follows.

> Long-term care (LTC) means an array of services and supports used by individuals to meet their health and/or personal care needs. The overall goal of LTC is to help individuals maximize their independence and functioning. Long-term care is not confined to people over age 65. A person of any age may need LTC services.
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> Home and community-based services (HCBS) are all formal (paid) services delivered in the home and community, as opposed to institutional settings. These include personal assistance services, home health, waiver programs, and other services funded by federal and state government, as well as private payers.

Defining HCBS as formal or paid services is <u>not</u> meant to deny or acknowledge that most LTC is delivered in the community by families and friends and that this care has economic value. In developing HCBS, West Virginia also should consider policies that support families in providing care for their elders or children and adults with disabilities.

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[1] Public Consulting Group, "Money Follows the Person" and Long Term Care System Rebalancing Study, August 8, 2008. Prepared for the State of West Virginia, Department of Health and Human Resources, Office of the Ombudsman for Behavioral Health, Olmstead Office.

Home and community-based services are a critical public policy issue for a variety of reasons:

- West Virginia has 398,680 people over age 5 with a disability and the highest civilian rate (23.7 percent) living in the community in the nation. Almost one half (48.2 percent) of people age 65 and older have a disability.[2]

- West Virginia has an aging population, including an increasing number of people over age 85 who are more likely to need services.

- People who need health care and social and personal supports are entitled to as much independence as possible and the right to choose the services that are appropriate and of high quality.

- With some exceptions, the cost of HCBS is beyond the financial means of most West Virginians.

- The development of HCBS in West Virginia has been mostly through government financing, primarily through Medicare and Medicaid with about two-thirds from Medicaid.

- Funding for Medicaid HCBS waiver services is not sufficient to meet the future need.

- Innovative programs, such as the Lighthouse Program through the West Virginia Bureau of Senior Services, offer innovative models for private money or a mixture of public and private money to fund some HCBS services.

- Health reform offers states new opportunities and increased funding (2 percent increase in the Federal Medical Assistance Percentage (FMAP)) to rebalance their service system towards 50/50 – equal spending for HCBS and institutional services.[3]

[2] U.S. Census Bureau 2007, American Community Survey. http://factfinder.census.gov.

[3] All states with less than 50 percent of Medicaid Long Term Care Spending for HCBS will receive 2-5 percent FMAP incentive payments if they have a target of 50 percent spending on HCBS by 2015. Justice, Diane, *Long Term Services and Supports and Chronic Care Coordination: Policy Advances Enacted by the Patient Protection and Affordable Care Act,* National Academy for State Health Policy, Briefing, April 2010.

WORKING GROUP RECOMMENDATIONS

Recommendation 1: Ensure West Virginians can choose from a variety of affordable and quality long-term care services and supports through development of a state plan and financial structure for home and community-based services.

Discussion: The HCBS working group feels that ongoing research, planning and advocacy should be a high priority of the LTC Partnership. The need for ongoing effort is great because West Virginia has one of the highest percentages of elderly and is also one of the poorest states in the nation. Fifteen percent or 279,000 residents were age 65 and older in 2008; by 2015, the age 65 and older population will make up 19 percent (345,420) of the state's population; and by 2030, it will be 25 percent (454,500).[4]

According to the *West Virginia Elder Economic Security Standard Index™*[5], West Virginia has a high percent of elderly who encounter a hard time making ends meet:

- Median household income for elders age 65 and older in 2008 was $26,870. However, 11 percent of adults age 65 and older have annual incomes below the federal poverty guideline ($10,830); 25 percent have incomes below 150 percent of poverty ($16, 245). For adults age 75 and older, 27 percent have incomes below $15,000.

- The average Social Security benefit per retiree is $13,644. One in four West Virginians age 65 and older has only social security income.

- Minimal cost of living in West Virginia for a healthy senior without a mortgage payment is $14,832; with a mortgage it is $20,616.

- Elders who need personal and health supports in their home require an additional $6,014 to $31,574 per year for six to 36 hours per week of support services.

Consequently, a high percent of elderly will need the financial supports of Medicaid or other publicly funded programs such as the Lighthouse Program[6] to age-in-place. Financial eligibility

[4] Projections of the Population, By Age and Sex, of States: 1995-2025. U.S. CensusBureau: http://www.census.gov/population/www/projections/stproj.html.
[5] The West Virginia Elder Index, June 2010. http://www.wvltcpartnership.org/security.htm.
[6] See Appendix for description of Lighthouse program.

for the Medicaid Aged and Disabled Waiver (A/D waiver) services is approximately 300 percent of Supplemental Security Income (SSI) level or about $2,100 per person.

In 2010, a waiting list of 1,800 medically eligible seniors and 400 people with disabilities caused the West Virginia Legislature and the governor to inject a one-time supplement of $7.5 million to add new waiver slots for a total of 8,156 slots for state fiscal year 2011. While the state's aging population will increase by more than 66,000 by 2015, the state's five-year plan for waiver slots is projected to decrease to 5,864 by 2015.

Next Steps:

- Create a standing committee of the Long Term Care Partnership to plan for a sufficient number of HCBS for elders. The standing committee will study and make recommendations to the governor and the Legislature on the following:

    - Budget and plan for A/D waiver slots to meet the actual need of those elders financially and medically eligible through 2015.

    - Change "one size fits all" Medicaid policy to permit tailoring of waiver services to meet individual need and provide more choice.

    - Identify, provide a rationale, and need for adoption by Medicaid of program innovations such as the Program for All-inclusive Care for the Elderly (PACE), payment for adult day care services, and assisted living[7].

    - Expand opportunities for participant direction to all Medicaid and state-funded HCBS, including the personal care option under the Medicaid State Plan.

    - Develop strategies to foster and support personal, non-funded care and relationships by neighbors and others; i.e. caregiver support groups, respite care, etc.

    - Review LTC provisions in national health reform and recommend adoption of new opportunities in West Virginia as appropriate.

    - Develop a strategy for communication to encourage West Virginians to purchase LTC insurance in the private sector and through the federal government as available under the Community Living Assistance Services and Supports (CLASS) Act

[7] See Appendix for description of PACE, adult day care, and assisted living.

provisions in national health reform. Make West Virginians aware of tax deduction for purchase of LTC insurance.[8]

Recommendation 2: Promote HCBS by eliminating all institutional bias in state law, policy, procedure and practice.

Discussion: Nationally and in West Virginia most funding for long-term comes from Medicare and Medicaid[9]. Private financing makes up a small percent of LTC spending.

Overwhelming consensus, reinforced by numerous legal decisions, exists that the elderly and people with disabilities have a right to remain in the community and receive the care they need in order to function as independently as possible. For more than 30 years, the federal government has supported this consensus by providing states with clarification, guidance, increased flexibility, and support to implement community-based services and reduce reliance on institutions.

West Virginia has taken advantage of some of this new flexibility but could do much more to move the state towards a more balanced service system where at least 50 percent of all Medicaid LTC funding is for HCBS.

Next Steps:

- Support the work of the Olmstead Council of the Inspector General of Department of Health and Human Resources to study, review and plan for implementation of the 19 areas of institutional bias in the Olmstead Council Report, *Long Term Care Institutional Bias in West Virginia,* May 2010.

- Work towards passing H.B. 4544, the Community-Based Services Act[10], introduced in 2010 to reduce the reliance on institutional care and eliminate barriers that prevent or restrict the flexible use of Medicaid funds in the most integrated settings.

- Request that the Bureau for Medical Services (Medicaid) submit a State Plan Amendment with a target of 50 percent of Medicaid LTC spending for non-institutional supports by 2015.[11]

[8] See West Virginia Code 11-21-12c.
[9] See Appendix for description of Medicare and Medicaid.
[10] Available at: http://www.legis.state.wv.us/Bill_Text_HTML/2010_SESSIONS/RS/Bills/hb4544%20intr.htm.

- Develop for use as an educational document for the Legislature a five-year Medicaid budget with annual increases in HCBS spending to a goal of 50 percent by 2015.

- Review, identify, publicize and prepare to implement new opportunities available under national health reform to move towards a more balanced LTC system. Opportunities Include the Community First Choice Option, which allows states to provide community-based attendant services and supports to additional populations and income groups while receiving a 6 percent increase in the FMAP.

Recommendation 3: Promote HCBS by changing legislation governing the administration of medication to permit more flexibility for unlicensed but trained personnel to administer medication in community settings.

Discussion: West Virginia is behind many other states in restricting the ability of non-licensed personnel, approved medication assistive personnel (AMAP), to pass medication to elderly and people with disabilities in the community if such individuals are receiving services through Medicaid. People who pay privately for support services in their home and community do not have such restrictions.

Restricting the administration of medication to professional licensed personnel is a major obstacle that restricts the individual's right to live in the community, adds to the cost of care, and thus, should be resolved as quickly as possible. While some issues have been recently addressed through policy by the Office of Health Facility Licensure and Certification (OHFLAC), concerns about liability on the part of professionals overseeing AMAP remain and should be addressed through legislation.

In addition to allowing trained non-licensed personnel to pass medication in homes and community settings, related issues to consider, discuss, and resolve include (1) exempting service providers from provisions of the Nurse Practice Act when individuals self-direct their service; (2) permitting trained service provider staff to give G-tube feedings; (3) redefining "self-administration of medication" to accommodate individuals who are physically unable but could otherwise self-administer; and (4) exploring the use of AMAP for people served through the A/D Waiver.

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[11] See FN 3. Under national health reform legislation passed in 2010, West Virginia can receive a 2 percent increase in its FMAP by submitting such an amendment. The State Balancing Incentive Program goes into effect October 1, 2011.

Next Steps:

- Support further discussion with the nurses association, OHFLAC, advocates and other stakeholders on updating legislation to permit trained, non-licensed personnel to pass medication.

- Approach the chair of the West Virginia House of Delegates Senior Citizen Issues Committee to create a working group on this issue.

- Introduce and pass legislation in the 2011 Legislative Session addressing this topic.

Recommendation 4: Convert ICF-MR beds to community-based Medicaid waiver services[12].

Discussion: In the 1980s, West Virginia began to aggressively close its institutions for people with developmental disabilities. One means of doing this quickly involved the creation of Intermediate Care Facilities (group homes of six to eight beds) for persons with Mental Retardation (ICF-MR). ICF-MR beds are no longer considered state-of-the-art for people with disabilities because they congregate and segregate the residents. People living in ICF-MR facilities could live in more typical homes and be more integrated into the community with appropriate support.

West Virginia has approximately 515 ICF-MR beds housing people with moderate to severe retardation. Group homes range in size from four to 24 beds. The average annual cost per person in an ICF-MR facility is $123,000 per person (not including acute care). The average cost per person on waiver services is $55,000. Because of their greater disability, it is estimated that waiver services for residents of ICF-MR homes would be higher than the $55,000 average and could even approach the current $123,000 per person average.

While converting ICF-MR beds to waiver services will not necessarily save large amounts of Medicaid dollars, it will improve the lives of residents and should, therefore, be a goal for public policy in West Virginia.

[12] See Appendix for description of MR/DD Waiver services.

Next Steps:

- Convene a working group of the Long Term Care Partnership on reducing and converting ICF-MR beds and ask the working group to:

  - Identify alternative uses for current group homes.

  - Profile individuals in group homes to determine level of care and feasibility of living in community with waiver services.

  - Develop a five-year plan for re-directing ICF-MR dollars to waiver services.

  - Present plan to Legislature in 2011.

Recommendation 5: Change the current assessment process for long-term care consumers to (a) ensure that options/benefits counseling is occurring at the time of potential facility admission; and (b) utilize the presumptive eligibility or fast track initiative.

Discussion: Assessment instruments should provide for strengths-based assessments that support opportunities for diverting and transitioning individuals from institutional to community-based settings. West Virginia's assessment tool and process have been improved in the past several years by providing assessments through an independent contractor. The assessment tool and process could be further improved by including benefits counseling as part of the PAS 2000 assessment tool[13] and providing for an expeditious approval and increased access to HCBS.

Next Steps:

- The Long Term Care Partnership should establish a working group to ask the appropriate state agencies to:

  - Provide for community education on service options available to seniors.

  - Add benefits counseling to the LTC PAS 2000 assessment process for individuals and their families.

[13] See Appendix for description of the PAS 2000.

- Expand presumptive eligibility under Medicaid to community-based services, as well as institutional rehabilitation services.

Recommendation 6: Ensure that new technologies, which support HCBS are identified, reviewed, and if appropriate, adopted in West Virginia

Discussion: As 77 million baby boomers race toward their golden years, the world's leading tech innovators are unveiling a range of futuristic devices. A huge new aging-in-place market is attracting companies like Intel, General Electric, Philips Electronics, Honeywell, Bosch, and dozens of tech startups. The companies say these products, just now being deployed by a handful of health plans and home care agencies, can drastically cut the rate of medical complications that force seniors into hospitals and other intensive care facilities.

A number of groups in West Virginia are working on assistive technology, telehealth, and other technologies. Before taking further action, it would be helpful to know what the groups are doing and how they are promoting the use of such technologies to help elders and people with disabilities remain in their homes and function as independently as possible. In considering and promoting the use of technology, the LTC Partnership should assure that relevant privacy and ethical safeguards are in place.

Next Steps:

- The Long Term Care Partnership should:

  - Meet with the Assistive Technology Systems Advisory Board and other tele-health and technology groups in West Virginia to determine the appropriate approach to the use of technology in HCBS.

  - Create a working group on HCBS and technology to research the literature and identify barriers and opportunities for supporting and promoting the use of appropriate technologies in West Virginia.

REFERENCES AND RESOURCES

H.B. 4613, A bill to amend and reenact 16-50-2, 16-50-3 and 16-504 of the Code of West Virginia, 1931, as amended, all relating to permitting unlicensed personnel to administer medications in certain circumstances; defining terms; and exemptions from licensure. Introduced February 22, 2010 and not passed.

Justice, Diane, *Long Term Services and Supports and Chronic Care Coordination: Policy Advances Enacted by the Patient Protection and Affordable Care Act,* National Academy for State Health Policy, Briefing, April 2010.

Medication Administration and Community-Based Services, Summary of Recommendations. Presentation to the Select Committee on Health, October 13, 2009.

Ng, Terence, MA; Charlene Harrington, PhD, *Medicare and Medicaid in Long Term Care,* PAS Center Webinar, February 2010.

Olmstead Council, *Long Term Care Institutional Bias in West Virginia,* May 2010.

Olmstead Office, *West Virginia Community-Based Services and Supports Reference Guide*, 2008.

Public Consulting Group, "*Money Follows the Person" and Long Term Care System Rebalancing Study, August 8, 2008.* Prepared for the State of West Virginia, Department of Health and Human Resources, Office of the Ombudsman for Behavioral Health, Olmstead Office.

The Elder Economic Security Initiative Program, *West Virginia Elder Economic Security Standard Index™,* June 2010.

APPENDIX

1. Adult Day Care Centers.

(Source: ARCH National Respite Network and Resource Center, www.archrespite.org)

Adult day care centers also known as adult day services, have been providing a form of respite for caregivers for more than 20 years. In 1978 there were only 300 centers nationwide. By the 1980s there were 2,100 centers, and today there are about 4,000 centers nationwide, according to the National Adult Day Services Association (NADSA). NADSA reports that the need for such centers has "jumped sharply to keep pace with the mushrooming demand for home and community based services."

This growth also is due in part to new funding sources such as Medicaid waiver programs, which support alternatives to institutional long-term care and rehabilitation. According to Mary Brugger Murphy, director of NADSA, "many of the people served by adult day centers would have been institutionalized just ten years ago."

Adult day care centers provide a break (respite) to the caregiver while providing health services, therapeutic services, and social activities for people with Alzheimer's disease and related dementia, chronic illnesses, traumatic brain injuries, developmental disabilities, and other problems that increase their care needs. Some adult day care centers are dementia specific, providing services exclusively to that population. Other centers serve the broader population.

One difference between traditional adult respite, both group and in-home care, and adult day care is that adult day centers not only provide respite to family caregivers but also therapeutic care for cognitively and physically impaired older adults.

Benefits of Adult Day Care: Adult day care allows caregivers to continue working outside the home, receive help with the physical care of a loved one, avoid the guilt of placing a loved one in institutional care, and have respite from what can be a "24/7" responsibility.

The care receiver can also benefit from adult day care. He or she is able to remain at home with family but does not require 24-hour care from the primary caregiver. Adult day care participants also have an opportunity to interact socially with peers, share in stimulating activities, receive physical or speech therapy if needed, and receive assistance with the activities of daily living with dignity.

A day at an adult day care center could include: supervised care; small group and individual activities such as reminiscence, sensory stimulation, music, art, and intergenerational activities; nutritious meals; transportation; case management; recreation and exercise; nursing care;

education; family counseling; assistance with activities of daily living; and occupational, speech and physical therapies. These services are customized to each participant's needs.

Types of Adult Day Care: There are three types of adult day care:

- Adult day social care provides social activities, meals, recreation, and some health-related services.
- Adult day health care offers more intensive health, therapeutic, and social services for individuals with severe medical problems and for those at risk of nursing home care.
- Alzheimer's specific adult day care provides social and health services only to persons with Alzheimer's or related dementia.

2. Assisted Living

(Source: Assisted Living Info, www.assistedlivinginfo.com)

Assisted living facilities are for people needing assistance with Activities of Daily Living (ADLs) but wishing to live as independently as possible for as long as possible. Assisted living exists to bridge the gap between independent living and nursing homes. Residents in assisted living centers are not able to live by themselves but do not require constant care either. Assisted living facilities offer help with ADLs such as eating, bathing, dressing, laundry, housekeeping, and assistance with medications. Many facilities also have centers for medical care; however, the care offered may not be as intensive or available to residents as the care offered at a nursing home. Assisted living is not an alternative to a nursing home, but an intermediate level of long-term care appropriate for many seniors.

Most assisted living facilities create a service plan for each individual resident upon admission. The service plan details the personalized services required by the resident and guaranteed by the facility. The plan is updated regularly to assure that the resident receives the appropriate care as his or her condition changes.

The term used for assisted living facilities differs across the country. Other common terms for these facilities include: residential care, personal care, adult congregate living care, board and care, domiciliary care, adult living facilities, supported care, enhanced care, community based retirement facilities, adult foster care, adult homes, sheltered housing, and retirement residences.

3. Lighthouse Program

(Source: West Virginia Bureau of Senior Services, www.wvseniorservices.gov)

The Lighthouse Program began in 2007 as a result of legislation introduced by Gov. Joe Manchin III and passed by the 78th Legislature of West Virginia to expand senior services throughout the state. By receiving a variety of supportive assistance through the program, older adults are able to remain in their communities and continue to live in the comfort of their own

homes. To be eligible for the program, a person must be at least 60 years of age, medically eligible, and financially eligible based on a sliding fee schedule. The Lighthouse Program provides support in four areas:

1. Personal Care: Grooming, Bathing, Dressing, and Toileting
2. Mobility: Transferring In/Out of bed and Walking
3. Nutrition: Meal Preparation, Eating, and Grocery/Pharmacy Shopping
4. Environment: Light Housecleaning, Making/Changing Bed, and Laundry

4. Medicaid

Medicaid is a state/federal partnership whereby the federal government provides about 75 percent and the state about 25 percent of funding. Federal Medicaid law requires state Medicaid programs to provide institutional services to all eligible individuals as a mandatory benefit and permits (but does not require) states to make services available in the community as an optional benefit.

To qualify for Medicaid, a single older adult must have no more than $2,400 in annual income and $2,000 in assets. The amount for couples is annual income no greater than $3,300 and an asset limit of $3,300. Additionally, a person can qualify for Medicaid coverage if his or her income less allowable medical expenses falls under the income limits listed above (often referred to as the Medicaid "spenddown").

5. Medicare

Medicare is a federal health insurance program for people age 65 and older. Medicare also covers some individuals with severe disabilities and major health problems under age 65. It provides for limited long-term care services in a nursing home and for home health care services Medicare does not pay for personal care services necessary to maintain older adults and other people with disabilities in the community.

6. PACE

(Source: National PACE Association, www.npaonline.org)

The Program of All-inclusive Care for the Elderly (PACE) model is centered around the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible.

PACE serves individuals who are age 55 or older, certified by their state to need nursing home care, are able to live safely in the community at the time of enrollment, and live in a PACE service area. Although all PACE participants must be certified to need nursing home care to enroll in PACE, only about 7 percent of PACE participants nationally reside in a nursing home.

If a PACE enrollee does need nursing home care, the PACE program pays for it and continues to coordinate the enrollee's care.

Services: Delivering all needed medical and supportive services, the program is able to provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as possible. Care and services include:

- Adult day care that offers nursing; physical, occupational and recreational therapies; meals; nutritional counseling; social work and personal care
- Medical care provided by a PACE physician familiar with the history, needs and preferences of each participant
- Home health care and personal care
- All necessary prescription drugs
- Social services
- Medical specialists such as audiology, dentistry, optometry, podiatry, and speech therapy
- Respite care
- Hospital and nursing home care when necessary

West Virginia does not offer a PACE programs at this time (June 2010).

7. PAS-2000

(Source: West Virginia Bureau for Medical Services, http://www.wvdhhr.org/bms/)

PAS-2000 is West Virginia's common assessment form for nursing facility placement. It is administered by West Virginia Medical Institute (WVMI). In order to qualify for the nursing home benefit under West Virginia Medicaid, an individual must need direct nursing care 24 hours per day, seven days a week and meet the criteria established. WVMI reviews the PAS-2000 for all individuals residing in a nursing home, regardless of payment source. The medical eligibility criteria for the West Virginia Medicaid benefit can be located in Chapter 514.8.2 of the Nursing Facility Manual at: www.wvdhhr.org/bms/Manuals/Common_Chapters/bms_manuals_Chapter_500_NursingFacility.pdf.

8. Waiver Programs

West Virginia has two waiver programs:

Medicaid Mentally Retarded and Developmentally Disabled (MR/DD) Waiver

(Source: West Virginia Bureau for Medical Services, http://www.wvdhhr.org/bhhf/mrdd.asp)

The program provides home and community-based care to mentally retarded and developmentally disabled individuals, as an alternative to receiving such services in an

Intermediate Care Facility for the Mentally Retarded (ICF/MR). All persons who are certified eligible to be in an ICF/MR setting are eligible to participate in the MR/DD Waiver Program. The Program is a healthcare coverage program that reimburses for services to instruct/train, support and assist individuals who have mental retardation and/or related conditions to achieve the highest level of independence and self-sufficiency possible in their lives.

To be medically eligible, an individual must have a primary diagnosis of mental retardation and/or a related condition with substantial deficits in major life areas that requires the same level of intensive instruction and services that are provided in an ICF/MR facility. To be financially eligible, the individual's monthly income may not exceed 300 percent of the current maximum monthly Supplemental Security Income (SSI) payment.

Available services include: case management, respite care, transportation services, skilled nursing services, adult companion services, and environmental accessibility adaptations.

Medicaid Aged and Disabled Waiver (A/D Waiver)

(Source: West Virginia Bureau for Senior Services, www.wvseniorservices.gov)

The program provides in-home and community services to individuals age 18 and older who are medically and financially eligible. Medical eligibility is based on a functional assessment by a medical professional. A medical necessity evaluation request must be completed by the applicant and the applicant's physician. Financial eligibility is determined at the county Department of Health and Human Resources offices; assets cannot exceed $2,000 and income can be no more than $2,022 per month. Policies are described in the Bureau for Medical Services and the A/D Waiver Manual.

Services provided through the A/D Waiver include:

- Case Management – development of a service and support plan by a case management agency that reflects the wishes and preferences of the participant.
- Consumer-Directed Case Management – a participant may choose to direct his own case management.
- Homemaker – long-term direct care and support services (assistance with personal hygiene, nutritional support, and environmental maintenance) that are necessary in order to enable an individual to remain at home rather than enter a long-term care facility.
- Transportation – a participant may be transported by the homemaker in order to gain access to services and activities in the community.
- RN Assessment and Review – a registered nurse will complete assessments of the participant at regular intervals to ensure that the member's plan of care is meeting his/her needs.
- Personal Option– participants are paid a flexible monthly stipend to recruit, hire, and supervise their own workers.

END OF REPORT