

## **IN-HOME PERSONAL CARE SERVICES**

**Exemptions from Certificate of Need (CON) which require submission of information to the Health Care Authority (Authority).**

**Specialized Family Care Provider which meet the following criteria, will not be required to address the standards.**

**West Virginia Code § 16-2D-11(b)(13) states: A person providing specialized foster care personal care services to one individual and those services are delivered in the provider's home;**

**The exemption application is available on the Authority's website at: <https://hca.wv.gov/certificateofneed/Pages/Exemptions.aspx>.**

### **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 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.

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 Specialized Family Care Providers are not required to obtain a 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. If a provider has not provided In-Home Services for the previous 12 months, the Provider is required to complete the CON application again.

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

### **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, nurse practitioner, or registered nurse 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.

E. Specialized Family Care Providers: A West Virginia Department of Health and Human Resources (WVDHHR) foster care program funded and administered by the Bureau of Children and Families, Division of Children and Adults. Currently the Specialized Family Care Program serves Medley Class Members and At-Risk individuals who qualify for the Title XIX I/DD Home and Community Based Services (HCBS) or the Medicaid Personal Care Program. At-Risk refers to children age 18 years old or younger who are at risk of becoming institutionalized and who are in the custody of the WVDHHR. At-Risk also refers to adults who are at risk of institutionalization. These adults may be their own legal guardians or may have a legal guardian.

### III. . **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. The Applicant must provide the projected population of the proposed service area for the current year and the projected 5 year population.

The Authority is responsible for the development of and maintaining the Need Methodology for In-Home Personal Care Services. The Need Methodology will be revised at least twice annually.

The development of the Need Methodology is presented in narrative form below:

1. As reported by BMS, the Authority will provide the average number of Medicaid residents per county for the most recent fiscal year.<sup>1</sup>

2. The average number of the most recent fiscal year of residents who are receiving Medicaid per county is multiplied by 3.0%. This number represents the projected number of Medicaid residents who are currently receiving or may be eligible to receive PC services for the previous fiscal year.

3. The average number of residents, per county, currently receiving or have received In-Home Personal Care services as reported to the Authority from BMS for the previous reporting period.<sup>2</sup> This number is then subtracted from the projected number of Medicaid residents who are currently receiving or may be eligible to receive PC services.

The Need Methodology is broken down below:

(1) Total Number of Residents receiving Medicaid per county:

(2) Total Number of Residents receiving Medicaid per county multiplied by 3% (this will give the total number of residents who may be receiving In-Home Personal Care services or who may benefit from receiving services.

(3) The total Number of Residents, as reported by BMS, who are receiving In-Home Services is subtracted from the Total Number of residents in step 2.

(4) If there is an unmet need of 25 or more then the County is considered open to additional providers.

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<sup>1</sup> Bureau of Medical Service Medicaid Individuals by County for the most recent fiscal year, 2022.

<sup>2</sup> Bureau of Medical Services will submit a report of residents by county for the most recent fiscal year twice a year to the Authority.

(5) If a new provider has been approved within the previous 12 months, the Authority will subtract 25 from each applicable county proposed.

#### IV. **QUALITY**

All applicants shall document that they will be in compliance with all current applicable Medicaid requirements 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, as applicable:

- A. Administrative:
- B. Nursing:
- C. Direct Care:
- D. Direct Care Worker Qualifications:
- E. Initial and Annual Training Requirements:
- F. 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 WVDHHR designated website: WV Clearance for Access: Registry & Employment Screening (WV CARES).
- G. Fingerprinting:
- H. Employment Fitness Determination:
- I. Provisional Employees:
- J. Responsibility of the Hiring Entity:
- K. Change in Employment:
- L. Provider Agency Certification:
- M. Conflicts of Interest:
- N. Specialized Family Care Providers (SFCPs):
- O. 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.

## VII. **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. Submit audited financial reports for the most recent two (2) fiscal years. If audited financial reports are not prepared, submit the following financial statements: (1) statement of revenues and expenses; (2) balance sheet; (3) statement of changes in fund balances; and, (4) statement of cash flows for each of the last two (2) fiscal years. If a Form 10-K is required to be submitted to the U.S. Securities and Exchange Commission by either the applicant or a related entity, submit the Form 10-K for the preceding two (2) years. The Form 10-K may be submitted on CD.

2. Provide a preliminary financial feasibility study including, at a minimum, pro forma financial statements to include a three (3) year projection of revenues and expenses for the project. If revenues do not equal expenses by the end of the third year, identify other sources of revenue or income which will subsidize the deficit.

## VIII **OTHER**

A. An applicant for the provision 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.

B. 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 (BMS). 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.