Comments for Chapter 513

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES WAIVER (IDDW)

Effective Date: 4/1/21

Number	Date Received	Comment	Status Result Change/No Change-explain
1	3/9/21	Pg 41-42: The order of purchase was revised in 2019 that had Service Coordination purchased first to ensure the person remains eligible for the program. Also, Direct LPN was considered a Direct Care Service and Indirect LPN was separated for Professional Services in the order. The order for Case Management and LPN in the current draft manual did not reflect that revision of the order of purchase.	Changed to: -CM services must be purchased first, followed by Direct-Care Services in the following order if the IDT wishes to purchase any of these services: Person-Centered Support Services, Day Services, Electronic Monitoring, Direct LPN Services, and Respite Services. -Professional Services may be purchased next in the following order if the IDT wishes to purchase any of these services: RN, BSP, Indirect LPN, any of the specialty therapies (ST, PT, OT and DT), Transportation.
2	3/9/21	Pg 42, "a progress note is still required to document the team member's participation in the meeting.": Case management is no longer doing progress notes, and it is a "progress log" per the most recent Kepro provider call and the Case Management service description.	Changed to: "the progress log must be updated to document the team member's participation in the meeting."

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3	3/9/21	Pg 45, "When a member transfers from one residential provider to another or from one day setting to another, a seven-day IDT meeting must occur to outline the services," Clarifications before the draft manual were that the transfer meeting is not the seven-day IPP on the IDD-4, that the Initial IPP is the only meeting that can be held with the IDD-4. Suggested edit for clarity: "a full IPP Meeting on the IPP (WV-BMS-IDD-5) must be held within seven days of the transfer to outline the services..."	No change
4	3/9/21	For Family and Home-Based PCS, the statement "7,320 units/1,830 hours (based upon average of five hours per day)" is not accurate. 7320 units are for an average of 5 hours per day for 366 days and comes out to an average of 5.013698630136986 hours per day in a 365-day year. This has been an error for several manuals and causes errors/delays with purchases.	No change, however, the expectation is that the units total no more than 5 hours per day unless it is a leap year.
5	3/9/21	Case Management and CM acronym consistency that I found. More edits might be required.	No change: See following comments.
6	3/9/21	Pg 38, "The service coordinator (SC) provider may reject the referral only if:.."	Change: Change “SC” to “CM”
7	3/9/21	Pg 51, "receipt of participant-directed services (i.e., common law employer, Personal Options, UMC, SC, BMS),"	Change: Change “SC” to “CM”
8	3/9/21	Pg 52, "of the participant- directed budget to the member, representative, SC, and BMS; and"	Change: Change “SC” to “CM”

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9	3/9/21	Pg 115, "The member/legal representative may choose to transfer to a different SC provider at any time and for any reason."	Change: Change “SC” to “CM”
10	3/9/21	Pg 116, "Failure to abide by Conflict of Interest policy and standards will result in the loss of Caser Management"	Change: Change “Caser” to “Case”
11	3/9/21	Pg 117: Suggestion to add after the Day Habilitation visit that the CM only meets with the member at a Supported Employment site as issues that require monitoring/advocacy to ensure placement at the job site.	No change
12	3/9/21	Pg 119: All of the areas that were listed in the prior manual are listed as not being billable. Are any of the activities/responsibilities billable outside of the monthly visit? Why list these any longer? For example, under PMPM, both a voicemail activity and holding an IPP are both equally not billable.	Change: Removed what isn’t billable.
13	3/9/21	Pg 125, Pg 127: "The maximum annual units of transportation miles [...] 9,600 units (based upon average of 800 miles per month)". Registration Coordinators with Kepro are currently implementing prorating for this service for a daily average of 26.3013698630137 miles per day. I recommend reflecting this to prevent errors with purchases	No Change, however, the expectation is no more than 9600 units regardless of how many days are in the year.
14	3/12/21	Page 8, List of self directed services, Should the new self directed services of therapy and EAA be in this list?	Change: Yes, changed to include new participant directed services.
15	3/12/21	For individuals who were not using amounts of SC to correspond with the current rates I am concerned that members will loose other needed services. Case Management should be like the PPL Resource Consultant.	No change: The PMPM rate is based on the average rate for case management services prior to its implementation and will remain at one unit per

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			month for every member on the IDD Waiver Program. BMS acknowledges there may be times where case managers are exceeding prior months' workloads, however, other months may require far less attention, essentially balancing the workload. Members can access the Exceptions process if the budget is not sufficient to meet their needs.
16	3/12/21	Case Management, Although I understand that the rates for CM were determined based on past data, I am not sure that the rates that it was based off of were sufficient and/or being billed at accurate levels. My agency found it vey difficult to account for all CM time based on the multi-tasking nature of the job. CMs are professional staff and if we want to provide this service well, with limited roll over they will have to have reimbursement rates that support the service I know this is a “what if”, but I am especially concerned about keeping staff in this position if the minimum wage increases occur as suggested.	No change: The PMPM rate is based on the average rate for case management services prior to its implementation and will remain at one unit per month for every member on the IDD Waiver Program. BMS acknowledges there may be times where case managers are exceeding prior months' workloads, however, other months may require far less attention, essentially balancing the workload. Members can access Exceptions process if budget is not sufficient to meet their needs.

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17	3/12/21	Page 9 and page 43, Order of purchase, Previously SC services (or at least some portion of them) were purchased before direct care services. Is it accurate the CM services would be purchased after direct care? I have been told in the past that the order of purchase continues into other services as RN and indirect LPN, BSP, IPP planning, Therapy and miles. Would this still be true? If so, believe the manual should include it. I would prefer that it not be included past CM as the team should be able to choose which services are most important to the member in the short term while awaiting the exceptions process.	Duplicate (comment 1)
18	3/12/21	Page 11 and 28, Case Management, I don't see reference to the required training via the public learning system or the Social worker exception. I see reference to training on conflict of interest and professional ethics. These are in the online training. Are they separate requirements or considered as part of the online training requirement.	Change: Added CFCM Certification to 513.3.12 CM Staff Qualifications, page 28 and removed the training requirements on page 11.
19	3/12/21	Page 25, BSP I, I am not sure if this is eligible to change at this time, but I believe the grace period for BSPs to work under supervision while awaiting a class should be 1 year. I teach one of the few curriculums that are available. I have noticed that when BSPs in training take the class, which is aimed at Positive behavior support they frequently do not know waiver terminology, their basic duties, how to write goals, or how to think analytically. The other thing I see is that a lot of people who take the class within their first 1-2 months of employment as a BSP quit before the process is finished. I believe that having BSPS in training able to take the class a few months later would increase their understanding and implementation of Positive Behavior Support and therefore improve services for Waiver members. This change might also help with the issue of having very few training options currently available in the state.	No change at this time, however, BMS may explore this recommendation.

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20	3/12/21	Page 42, IDT, I think that the state should consider, based on lessens learned from Covid precautions some limited ability to attend meetings via phone/video call as a billable function.	No change: No change at this time, though currently, due to the pandemic, this is allowable. Once the pandemic subsides, a final decision will be made.
21	3/12/21	Page 43, IDT, Recommend adding that in the event that a signature can not be obtained to document a minimum of 2 attempts. I assume this will be easier with face to face meetings, but particularly with CFCM it has proved very difficult to get signatures from some professional staff.	No change: Signatures are required.
22	3/12/21	Page 45, Transfer of services, It isn't clear if a transfer from self directed to traditional or vice versa warrants a 7 day and 30 day meeting.	No change: However section has been tweaked to make clearer.
23	3/12/21	Page 49, Self-direction, I continue to believe that people who have chosen self directions should be able to roll over unused units/funds into a future month for at least the services of respite and home based PCS. Having a hospitalization, or staff who is out, or a change in a vacation plan, doesn't lessen the need for services. It most likely causes the family to need a break in future months.	Change: Removed this requirement.
24	3/12/21	Page 53, BSP, Another valuable Covid lessen is that phone/video assessment can be an effective tools for BSPs. I do not believe it should be the only tool and would likely need a limit or be misused.	No change: No change at this time, though currently, due to the pandemic, this is allowable. Once the pandemic subsides, a final decision will be made.
25	3/12/21	Page 85, Goods and services, In the sentence that reads … the 1000 units ($1000_ per member's IPP year …. In combination with tradition EAA- vehicle	No Change: The $1000 limit applies to the

		and home. Strike the word traditional to indicate that personal option EAA codes would be included in that maximum.	combination of both Traditional and *Personal Options* Services
26	3/12/21	Page 89, Family PCS=PO, Indicate that this is a service for family members who live in the home. What if a non family member lived in the home? Which code would they bill?	Change: Family PCS PO has been changed to "Person Centered Support Personal Options." The service codes are S5125-UA for staff who live with the member, and S5125-UA-UK for staff who do not reside in the same home with the member. The personal options vendor will be responsible for selecting the correct modifier when submitting claims.
27	3/12/21	Page 30, Incident reporting, I think having the provider agency including PPL input incidents makes sense, but what if the SC discovers an incident at the home visit that wasn't previously reported. Would they provide information to the provider agency or input?	No change
28	3/12/21	Page 118, Case Management, Does the CM log still include clinical outcome? Concerned that the requirement may be beyond the form.	Change: The clinical outcome requirement has been removed.
29	3/12/21	The limitation of two one-way trips per day was eventually removed from the previous manual. This limitation has been added back to the proposed manual. Will this daily limitation be in place again or will agencies be okay as long as they remain within the 520 annual unit cap?**Q41: In Section 513.21.3 Transportation Trips, the third bullet indicates that the service limit is 520 trips annually; however in the WV I/DD Waiver Services, Units, Rates and Limitations sheet, the limit is 730. Which one is correct?**	No change: The current manual states "The maximum units of Transportation Trips cannot exceed two one-way trips per day or 520 trips annually." This is correct and is not a change for the updated manual. A updated Services, Units, Rates, and

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			Limitations sheet will be available in the near future.
30	3/15/21	*I am a parent of a waiver recipient. I would like to say that it is a great blessing for my son to be in the waiver program. However, since this is the time to make comments, I would like to focus on areas of improvement that I can think about. Most parents in the waiver program have family situations that are very stressful and demanding. Therefore, I think that I would like to focus my comments on areas where cutting down on the paperwork turned in would reduce stress for the parent. Here are some thoughts:*	No change: BMS thanks you for your positive feedback.
31	3/15/21	1. When fill out formA0160U1 (Miles), I have to write redundant information and difficult to track information. Travel from and to boxes that do not allow a simple sound trip check makes for a lot of waste of paper and writing of full addresses more than once. It becomes tedious. Additionally, having to write the odometer reading for every trip becomes a nightmare as I must remember to check before or after each trip what the millage is. If my son is stressed, that is the least of my worries and I might be more tempted to simply rely on maps to tell me what the millage was. I feel that the parent is already limited by the allowed number of miles per month and the odometer reading is absolutely unnecessary. Why not try something like to/from/round trip/total miles. I usually go beyond the allowed miles so for me it is a formality to write all this.	Change: The odometer reading requirement has been removed.
32	3/15/21	2. Some youth like to go on car rides and visit places. Why limit the family to 30 miles beyond the state lines. The problem with my area of West Virginia, is that is a tri-state area and deeper parts of West Virginia are too far. Some youth on waiver attend schools beyond that 30 mile range. why not give us 150 miles from home?	No change
33	3/15/21	3. I am not sure how much respite providers get paid these days, but the last time I was able to have a respite provider I hoped that I could pay them twice the amount even if that meant having them for less hours. The advantage of this	No change

		is that sometimes they have to be trained and it would be nice to have intensives to keep them. I can not even hope to have one because the situation is not easy at the moment.	
34	3/15/21	4. I hear something about not being able to have both a service coordinator and a behavioral person from the same agency. That does not make sense and it makes the life of the parent difficult. Let us keep all services from the same agency if we wish. Life is hard.	No change: CMS requires that services be free of conflicts of interest.
35	3/15/21	5. A few years ago, we had to record what happens every 15 minutes and have programs to account for that. I am grateful that he programs are simplified and that this is no longer the case.	No change: BMS appreciates the positive feedback.
36	3/15/21	The change log on pages 152-153. Personal Options Dietary Therapy listed incorrectly as section 513.2.5 it should be 513.12.5. Personal Options Occupational Therapy listed incorrectly as section 513.2.2 it should be 513.12.6.	Change: Thank you, the change log has been corrected.
37	3/15/21	513.19.1 Case Management (Traditional Option) Paragraph 2, last sentence: The member will have choice of case management agency and choice of provider agency(s); however, at no time can the case management agency provide other services for that member, whether those services be funded by Medicaid or another funding source. I believe a recent conference call clarified that behavioral health services such as counseling and psychiatric could be provided by a CM agency.	Change: Sentence changed to: "… at no time can the case management agency provide other Home and Community Based services for that member, whether those services be funded by Medicaid or another funding source."

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38	3/15/21	513.19.1 Case Management (Traditional Option) Paragraph 4, second sentence: At a minimum the agency case manager… Some clarification – is this referring to specifically the case manager? If so, it would help to get rid of the word agency. Alternatively, is this meant to be referring to the case management agency? Or, is it meant to be the owner of the case management agency and the assigned case manager?	Change: This is referring to the case manager but added language that it also applies to the agency owner.
39	3/15/21	513.19.1 Case Management (Traditional Option) · Bulleted list of case management activities beginning on page 116, third bullet: Provide oral and written information about the IDDW provider agency's rights and grievance procedures for members served by the agency or provide linkage to other agencies' rights and grievance procedures. I think the following changes would make it clearer that the CM agency is not responsible for providing other agencies' rights and grievance procedures - Provide oral and written information about the case management agency's rights and grievance procedures for members served by the agency and/or provide linkage to other agencies' rights and grievance procedures.	Change: The bulleted list of CM activities has been updated.
40	3/15/21	513.19.1 Case Management (Traditional Option) Bulleted list of case management activities continuing onto page 117, fifth bullet: Upload the ISP, the Demographic/cover sheet and signature page into the UMC's web portal within 14 calendar days of the IDT meeting. NOTE: No services will be prior authorized until the current IPP is loaded into the web portal. Currently, the UMC is also requiring the upload of the IHP/TA and Schedule. Our agency always uploads the crisis plan – so this may be another item required for upload by the UMC. In addition, a DD9 must be uploaded if nursing services requested.	Change: Changed language to "upload any required documentation into the UMC's web portal within 14 calendar days…"

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41	3/15/21	*Side note on the DD9: The RN description should include expectations for the RN when it comes to the DD9. As it stands, there is no reference to it at all. RNs are having a lot of difficulty completing the DD9 accurately, maybe it is not solely the fault of the RNs, perhaps the fault is in the form.*	Change: Added hyperlink to DD9, DD9 checklist, and DD9 instructions on BMS website. Added FAQ 5 to RN limitations and caps.
42	3/15/21	513.19.1 Case Management (Traditional Option) The manual specifically states, that the budget sheet from the CareConnection must be distributed when finalized. Does this mean it is no longer a requirement to attach to the IPP? In addition, there is no mention of the PPL budget. Does this mean this is no longer a requirement – attached to the IPP or distributed whenever PPL provides it? If still requiring this, can this be the responsibility of PPL?	No change: If the budget is not finalized by the time the IPP is required to be distributed, case managers would attach the current budget to the IPP and update when finalized – PPL already does this.
43	3/15/21	513.19.1 Case Management (Traditional Option) Documentation requirement for CMs on page 118, the second to last bullet point: Clinical outcome and/or result of the service provided. This is not in the current CM log. Also, the service code is a current requirement in the CM log, but is not mentioned in this list. Does the service code really need to be in the CM log or can this be removed?	Change: 1) Duplicate (removed outcome from log) 2) Yes, added column for service code.
44	3/15/21	513.19.1 Case Management (Traditional Option) Limitations/Caps, page 118, 1st and 2nd bullets: The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2. If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized. Would this even be applicable to this service since 12 units have to be purchase regardless?	No change: Twelve units of CM must be purchased first, and if other services do not fit within the budget, the Exceptions process may be accessed.

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45	3/15/21	513.19.1 Case Management (Traditional Option) Limitations/Caps, page 119, 1st bullet point, last sentence: The "transfer-from" case management agency may have up to 30 days after the effective date of the transfer to complete an agency discharge summary or other documentation related to the transfer. I think this should be removed or made clear, that they would be unable to bill for services after the effective date of transfer.	Change: Yes, language has been changed to, "transfer from agency must finalize documentation related to member services but will not be able to bill during this time."
46	3/15/21	513.19.1 Case Management (Traditional Option) There are many bullets stating what a CM cannot bill for. Would it be more accurate to state that CMs are not responsible for…?	Duplicate (comment 12)
47	3/15/21	513.19.1 Case Management (Traditional Option) Limitations/Caps, page 119, 2nd to last bullet: Case management cannot be billed for the entire calendar month if a home visit did not occur within that calendar month unless an approved WV-BMS-IDD-12 is on file. The WV-BMS-IDD-12 must be approved within the calendar month the home visit did not occur. Is this accurate? The last time this was discussed, I thought it was stated that due to EVV, CM could not be paid if a HV was not completed. I believe it was going to be looked into – was a process to developed to ensure agencies are paid if there is an approved DD12?	Change: Removed language that requires the DD12 to be submitted within the month the Home Visit did not occur.
48	3/15/21	513.2 Provider Enrollment and Responsibilities Page 11. Maintain written policies and procedures to avoid conflict of interest (if agency is providing case management and other services) that must include at a minimum: Education of case managers on general Conflict of Interest/Professional Ethics with verification; Annual signed Conflict of Interest Statements for all case managers and the agency director; Process for investigating reports on conflict of interest complaints; Process for reporting to BMS; and Process for complaint to professional licensing boards for ethics violations. Is this still needed with current changes to policy?	Duplicate (comment 18)

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49	3/15/21	Provider Enrollment and Responsibilities Page 13, 4th bullet point: *Case managers are also required to receive initial and annual training in Conflict-Free case management.* Still necessary?	Duplicate (comment 18)
50	3/15/21	Provider Enrollment and Responsibilities I could not find the requirements for CM training.	Duplicate (comment 18)
51	3/15/21	513.17.2.2 Home-Based Agency Person-Centered Supports (Personal Options) Currently, there are staff who do not live in the home that bill Family PCS (Personal Options). Will these authorizations continue until the next annual?	Change: The Home-Based Personal Options code has been removed. Person Centered Support Personal Options will now be billed for services provided by staff who live both inside and outside of the member's home.
52	3/15/21	513.17.2.2 Home-Based Person-Centered Supports (Personal Options) Documentation requirements (page 95) are traditional services requirements (DD7). The requirements should be the same as Respite (Personal Options).	Change: Removed whole section (513.17.2.2)
53	3/15/21	513.17.2.2 Home-Based Agency Person-Centered Supports (Personal Options) Limitations/Caps, 3rd and 4th bullet refer to *Traditional Home-Based Participant-Directed Support*. *Traditional* should be removed.	Change: Removed whole section (513.17.2.2)
54	3/15/21	513.12.5-513.12.8 Personal Options Therapy Services Are the documentation requirements for therapy services really going to be the same as traditional therapy services?	No change: Yes, but PPL will not be responsible for maintaining therapist's notes. The therapists will be required to produce the notes for annual quality reviews.
55	3/15/21	513.12.5-513.12.8 Personal Options Therapy Services Limitations/Caps, last bullet points for all four therapies refers to therapists as agency staff.	Change: Removed "agency" from language.

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56	3/15/21	513.14.3 &513.14.4 Environmental Accessibility Adaptations Home & Vehicle (Personal Options) Pages 74 & 75. Documentation: IDDW provider must maintain all of the following documentation in the member's file. Language is confusing. This makes it sound like only the provider of the service (PPL) is responsible for maintaining documentation; however, earlier it states, Documentation including dated and itemized receipts of the completed adaptation must be maintained by the case management provider and the Personal Options vendor.	Change: Updated language to state that the Case Manager must be informed that the service was completed.
57	3/15/21	513.14.3 &513.14.4 Environmental Accessibility Adaptations Home & Vehicle (Personal Options) Pages 74 & 75, last bullet point in the Documentation section. Verification by the IDDW provider that the approved EAA was completed as approved. However, previously the following was stated, If approved, the Personal Options vendor is responsible for ensuring the adaptation to the home is completed as specified prior to receiving payment and/or paying contracted vendor(s).	Change: Changed "IDDW provider" to "Personal Options vendor."
58	3/15/21	513.14.3 &513.14.4 Environmental Accessibility Adaptations Home & Vehicle (Personal Options) Pages 75 & 76, last bullet point in the Limitation/Caps section. The case management agency must not pay EAA funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service. This should state the Personal Options vendor must not pay EAA funds…	Change: Updated language to state, "the Personal Options vendor must not pay EAA funds…"
59	3/15/21	513.4 Reporting Requirements Page 30. The following is new information and is not listed in the change log. I just happened to notice this when checking for the change to case load limits (listed in the change log) for section 513.4. For members that receive services through the Traditional Service Option, the agency(s) delivering services to the member will be responsible for reporting incidents to the IMS. For members that receive services through the Personal Options Service Option, the assigned resource consultant will be responsible for	Change: Added 513.4 to change log. Included policy clarification 91 in new policy

		reporting incidents to the IMS. Prior to conducting the member's monthly home visit, the case manager will contact the Service Agency and/or Resource Consultant to determine if incidents have been reported since the previous monthly home visit. During the monthly home visit, the case manager will review the incident(s) with the member/legal representative and determine if the incident(s) require changes to the member's service plan. Critical Incidents, particularly those pertaining to a crisis or reports of alleged abuse, neglect or exploitation of the member are to be reported to the case manager by the service agency and resource consultant within 24 hours of the agency/resource consultant being made aware of the critical incident. If the CM witnesses an incident, would they notify the service provider/personal options provider to report the incident?	
60	3/15/21	Are there any other changes that are not in the change log?	No change: The public comment period has resulted in additional changes to the policy manual. These changes are now reflected in the change log.
61	3/18/21	Overall - This Document lists the effective date as April 1st, 2021, but you are accepting public comments until April 9th, 2021. Please adjust this to reflect when the final document with edits will be accepted and released.	No change: BMS is continuing to accept comments until April 9, 2021, however, policy is retroactive to April 1st, 2021.
62	3/18/21	Section 513.2.3 - Fully support the idea of QMS. Can you clarify how participants will be able to access the QMS and what reporting will be provided (Monthly, Quarterly, Annually) to show progress on open QMS items?	No change, however, BMS may implement a provider scorecard in the future.
63	3/18/21	Section 513.2.3.1 - Are the quality assurance standards reviewed annually and are they available for review? How can a participant view collected results of monitoring?	No change, however, this information is shared at the Quality Council.

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64	3/18/21	Section 513.2.3.2 - QIA council sounds like a great resource. Where can the IDDW performance indicators be reviewed as they are the basis for the councils decision making?	No change, however, the Discovery & Remediation report is shared at every council meeting.
65	3/18/21	Section 513.2.3.3 - What is the defined cycle for provider review? Annual, Bi-Annual? I see where the provider receives the final report, but how do participants request this report? It seems that this would be a valuable asset in making provider choice decisions.	No change, however, BMS may implement a provider scorecard in the future.
66	3/18/21	Section 513.2.3.4 - Can we add that participants should be notified of deficiencies and corrective action plans? They should be given the option to change providers if the corrective action is not performed in a timely manner. This should be focused on the participant, rather than provider payments.	No change, however, BMS may implement a provider scorecard in the future.
67	3/18/21	Section 513.2.3.6 - Can either full or redacted copies of provider self review be made available to participants? Similar to action plans, it would be very helpful to understand the level of training and number of resources available from a provider.	No change, however, BMS may implement a provider scorecard in the future.
68	3/18/21	Section 5.13.4 - This seems to be focused on the provider, rather than the participant. Is there a process for a caregiver or participant to directly report issues or is that what the #800 is used for?. This may be difficult as defined if the issue pertains to the provider or the case mgt staff. What solution is being leveraged for the WM IMS? Are there plans to open this system up for direct self service entry?	No change, however, caregivers or participants may report suspected abuse and neglect using the 800 number. There are no plans to open the IMS to individual participants at this time.
69	3/18/21	Section 513.8 - Do participants have access to the UMC web portal as listed?	No change. There are no plans to open the UMC web portal to individual participants at this time.

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70	3/18/21	Page 152/153 - Please adjust the change log entries for recent updates to reflect actual date rather than April 1st (future date). Conversely, update these dates to reflect once the document is accepted as final with edits.	Duplicate (comment 61)
71	3/18/21	I am writing to express concerns in a comment on the proposed IDDW five-year renewal application. Specifically I would like to address the proposed change to eliminate caseload limits for case management services. I am concerned that this change coupled with a monthly fee schedule potentially opens up the system for agencies to abuse this by taking on more clients for case management than they can comfortably serve. This could possibly negatively impact these vulnerable clients if their case managers are too busy ensuring all the home visits are done on their large caseload so the agency can get reimbursed for this service rather than ensuring other necessary follow up & linkage that each client needs is provided. I realize the purpose of annual reviews & audits are to address these potential issues. However, this could still result in clients not receiving the level of service they require from a case manager for months before this is discovered during an annual review.	No change: Though the caseload limit has been removed, Kepro will run reports on caseloads and BMS will closely monitor.
72	3/18/21	I am a parent of a special needs daughter. She is 38 years old. I am being forced to choose between changing the person that Handles her programs or the person whom Ismy support person and does everything she can to make sure she has the best life. In the area I live there are very minimal options and will cause confusion and turmoil in our life. Why is having the same services with the same company be a conflict of interest? My daughter was in the hospital fighting for her life not long ago. Because both providers work in the same circle they were able to convey and communicate my daughter's condition. So when I turned in my billing for her programs she was aware of her conditions. If there were 2 different companies involved the same communication and understanding would not be possible. Because of the pandemic she has not went with her worker, whom she has become close with. I would need to hire a different person from a separate agency. Which would mean her worker would	No change: This is a federal mandate, however there are geographical exceptions if there are no other providers in the region.

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		need to change whom she works for and take and $8 an hour cut . I hope you seriously take into consideration we live in a remote area. We DO NOT live in Charleston or any other big city and our options are extremely limited which WILL AFFECT MY DAUGHTER NEGATIVELY!! Thank you for your time in this matter	
73	3/23/21	513.2.2 page 18 Office Criteria: The eight contiguous counties has not been part of the IDD Waiver manual before. Was this included in error? If not, will agencies with a statewide CON still be exempt?	No change: This only applies to CM only agencies and there are no agencies with statewide CONs for CM only.
74	3/23/21	513.8 page 41-42 Individual Program Plan : The order in which services are to be purchased does not include the provision for case management to be purchased first. Will that provision not be permitted in this manual?	Duplicate: (comment 1)
75	3/23/21	513.17.3 page 97 Licensed Group Home Person Centered Support: First paragraph contains outdated information regarding the transition plan and contains expired dates of 2016 and 2019	Change: Removed old dates
76	3/23/21	513 page 10, 513.19 page 119 Provider Enrollment and Responsibilities: Page 10 states Health and Safety training must be conudcted by an RN, BSP or case manager. However, limitations/caps on page 119 state case management cannot be billed for training agency staff and QSW (s). Case Managers will still be able to provide training on the Crisis Response Plan when there is no one else on the team, correct?	No change: That is correct and the non-billable services have been removed and replaced with a list of duties.
77	3/23/21	Provider Enrollment/Responsibilities, Conflict of Interest: This section indicates if the legal rep does not attend the annual functional assessment, their signature has to be obtained on the DD2 within 10 days. Current policy indicates the case manager is to obtain the legal rep's signature in this scenario. Will the case	No change: Yes.

		manager still be responsible for obtaining the signature in this new policy manual?	
78	3/23/21	513.9.2 pages 48-29 Participant Directed Service Option: Regarding the allowable financial authority exchanges, can the system in place to monitor these exchanges be explained? Is there a way to hard stop the exchange? Exchanges not permitted per the exchange graphic have occurred with some self-directed members. In addition, it is often difficult for the case management agency to monitor utilization of self-directed services when changes do occur. The spending plan does not indicate the exchanges and utilization is unclear.	No change, however, BMS is following up with the FEA vendor for Personal Options to confirm policy restrictions are being followed.
79	3/23/21	IDD waiver needs to provide therapies to children on waiver to provide access. My daughter has Down Syndrome and her occupational therapy is extremely important to her development.	No change: This is a federal mandate, however, therapies are still accessible to children through other state plan services.
80	3/25/21	Please leave the Service Coordination with the Residential and BPS. With the SC being in the same origination as the BPS and the residential services it makes it better for communication, working together as a team and providing services for the client. I have a client that I have been worker with for a few year that the SW is separated from the other services and the client it left out. The client needs are not met like my other clients are when everything in with one organization. It is so important that we meet the needs of the clients and not the need of the organizations. So please I am asking for the sake of all the clients out there that are depending on everyone that helps them, that are their voice do not separate the services. Keep them in one organization. Let be there for the client.	No change: This is a federal mandate, required by CMS.
81	3/25/21	Remove CM documentation requirements from policy manual—particularly the clinical outcome. Since the PMPM rate is specifically tied to the CM home visit,	Duplicate (comment 28)

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		CM case notes are being replaced by a "log". Need to check with OHFLAC to make sure removing doc requirements won't conflict with their regs but if the CM log isn't considered a case note, maybe OHFLAC will have not need to review the logs at all.	
82	3/26/21	5113.19.1, 117 Case Management: Regarding the CM being required to meet every other month with the member and their support staff at the day hab facility or pre-voc center. If this is not completed, will it have any impact on the monthly billable event similar to the home visit? If so, will the approved DD12 also cover this service in order to bill the event.	No change: Approved DD12s will cover this service. Facility Based Dayhab visits do not have an impact on the Per Member Per Month (PMPM) rate.
83	3/26/21	513.19.1, 119 Case Management: The policy manual lists several things the CM cannot bill for. How does this correspond to the monthly billable rate? How will it be monitored in terms of the ability to bill the monthly rate? The CM will have to engage in those services billable or not in order to assist and serve the member adequately. Should a provider agency develop their own system of documenting these non-billable activities? Such as a non-billable log?	No change: The PMPM rate is tied to the monthly-home visit, however, CMs are expected to complete the monthly CM log.
84	3/26/21	513.2.4, 23: Provider Agency Certification: This only applies to independent case management agencies who will be providing no other waiver services, correct. Provider agencies providing case management plus direct care services would continue to follow the provider enrollment and responsibilities, correct?	No change: Yes, agencies that provide both case management and direct care services must follow the provider enrollment and responsibilities. Licensed agencies are not required to be certified.
85	3/26/21	Can BMS add to CFCM sections - The CM agency may be held liable for any loss incurred by the residential agency due to CM agency's negligence?	Change: Agencies must have an MOU that addresses these liability issues. Added to CFCM section of policy.

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86	3/30/21	I am writing in response to the news that children under 21 may no longer be able to access their therapy services through Waiver and with our Waiver budgets. Our child needs speech, occupational therapy, and physical therapy services to remain through the Waiver program the way they have been delivered so far, because any disruption of therapy will result in him backsliding. Even if services are arranged through another process, we are very concerned for the gap that may arise. We have had issues in the past where therapy was disrupted and his decline in skill level was immediate. The continuity of care he receives through providers coming into our home is invaluable because it is in his home environment and he performs better. Therapy services that take place outside our home are difficult for him because he struggles to transfer those skills to different environments, so he really needs to learn them in the location that he uses them most often. Our son is nonverbal, and practicing communication skills is essential to his growth and quality of life. His progress tends to be slow, so anything that disrupts the process tends to set him back even further. Additionally, we serve as a foster family for other children in the community and our therapist supporting our son's interactions with the other children in our home is essential to ensuring the dynamic of our whole family runs smoothly. In the past our son has received services through Medicaid, and the 20 visit limit was applied to him. He quickly lost the few skills he had gained. Often it takes him several sessions to build a relationship, anticipate the flow/structure of therapy, really engage in the therapy, and to make progress. We're worried traditional Medicaid requirements around measurable progress may cause him to be prematurely discharged, if he is not able to show skill growth quickly enough. We feel strongly that therapy services for our son should be in the home, flexible in what they can address (since our family's and his needs are diverse and ever-changing), and allow for the plateaus we know he tends to have in gaining skills.	Duplicate (comment 79)

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87	3/30/21	Why have the budget "spends" not been corrected yet? The current "spend" we are using is over 5 years old. This means many of the CM's have to go to exceptions for the client's needs to be covered. If we update the spend and base it even on the 2019-2020 budget year, it would greatly help reduce the number of exceptions that come through Kepro and BMS. For example; one of my clients has a spend of 24k, he needs over 60k a year so he can be taken care of appropriately while his parents work. We cannot get another spend on him due to he has not had a drastic enough change in his life. If we can update the spends to reflect more recent years, it would help alleviate the pressure of so many exceptions that need completed yearly. My client would no longer need exceptions once or twice a year, he would only need his Kepro assessment. I know of several people who live in ISS's or group homes who have the same problem. The WV IDD Waiver spends for budgets are out-dated and need fixed.	No change: New budget methodology will begin on July 1, 2021.
88	3/31/21	I think the new rates of pay for Case Management (CM) are a joke. Case Management, formerly known as Service Coordination (SC), is the only mandatory service for all Waiver Consumers. The new rate of pay is based off the average of how much was billed over the last year. When it was brought to the table by BMS, they offered a rate of $338 per member per month. Agencies across the state agreed to this change, with little to no argument. Then BMS suddenly states the rate is going to be $200 for Natural Family Members and $250 for ISS/Group Home Members. This is a very large decrease in what was discussed and agreed to in the beginning. CM's have more to do than any other service offered in IDD Waiver. There are several mandatory services we are forced to do that are un-billable. An example of this is new slot members. A CM has to coordinate with the family, help them obtain financial eligibility, set up their initial IPP, walk them through the services they will need or want. None of this is billable until you hold the first, the Initial IPP. Yet as soon as they are referred to the agency a CM must care for their needs. Most agencies have CM Supervisors to take care of the non-billable members and their needs. This supervisor does not bill most of the time. They are unable to supervise several	No change: Various proposed rates were discussed during planning meetings but ultimately $200/$250 was determined based upon service utilization in prior years.

		CM's and carry a full case load. Here is where it gets even more difficult for the agencies and the CM's. We must maintain an office. This office will need electric, internet, phones, computers, the ability to maintain and safely store protected information. You need someone to Direct the agency, someone to supervise the CM's, an office assistant/receptionist, just to name a few necessary employees for an agency. None of these employee's will be able to bill, therefore their jobs the office and the overhead for the company/agency is already in the hole. Most people need health insurance, but many CM agencies can't offer insurance because they do not make enough money via CM billing. Now you want us to lower what we are worth and still work just as hard if not harder. We may have to work harder, take on a larger case load, so we can bill the PMPM rate and make enough to keep the agency afloat. So our quality of work will take a huge hit. Our stress levels will go up as we try to maintain the original quality of care with more people than we can honestly serve so we can bill an amount that was averaged from what was billed out. So Pat Nesbit; you have taken the amount billed out by SC's over the last year. You said you know how much we do and this was the fairest amount of money. If this is so, why does Kepro require SC's to have a supervisor review all documents such as DD5's and Addendums to ensure they are accurate and that they are not missing any pertinent information? Thus, the Supervisors are making it easier for Kepro to review the uploaded documents so the budgets are not held up in documentation requests; closures; and rejected units. Kepro and BMS demand many things from SC's. However, it feels like you could care less about the SC's and the agencies themselves. You want so much, but you're not willing to pay for it? Should we all take pay cuts and lose our health benefits, so that the average billed out will suffice? I do not understand how you can sit back and say you are being fair in the slightest. Not only did you give us a false amount to obtain our agreement, but you lowered it without thinking of anything but averages. We do more than BSP's and yet they have continually made more each unit billed out. So you took our already under paid unit price and averaged what we billed for a year taking nothing into account for what is demanded of SC's and their agencies. How	

		about BMS stop the covid-19 clarification calls every two weeks and actually think about what it takes to run an agency? I doubt anyone at BMS is going to take a pay cut or lose their state benefits, or even lose their job when the agency doesn't make enough to pay them, or they get so sick because they had to double their caseload and are being run ragged by the fact they suddenly need to bill double to keep living. I have been a Service Coordinator for IDD Waiver for 2 years. I was a Case Manager for 2 separate medical offices for 4 years. I had less work to do in the medical practices than I do with IDD Waiver. I even did the medical billing at both offices and all the prior authorizations. Both were specialty practices which meant every visit had to be prior authorized. Don't get me wrong I love my job, I love the people I work with, I love my clients. But there are days when I am woken by my phone going off because a client had an emergency at 6 am. I have been called as late as 11:57 pm because one of my clients eloped and the family needed assistance. I don't always get to clock in and bill for emergencies and I can't just say, "oh I'm sorry, I can't help you until tomorrow or later today when I can clock in and bill for helping you". That would be unethical. So I am on-call 24/7; and much of this is un-billable time. I strive to provide the best care possible no matter what time of day or night. Our guys deserve the best. I know many other SC's who have the same work ethic I do, and we barely make enough to cover our bills. Now, it seems like BMS is saying, "Screw You SC's, you should be happy you have a job these days". If Case Managers are going to be a mandatory service, then at least pay us what we are worth. I am not asking for a raise in pay, I am asking that BMS not drive the company I work for into the ground by acting like the billable services are the only ones that ever mattered. If BMS needs more than 1 person to run it, and BMS employees need supervisors and you all get paid, then if you are going to offer an amount of money, actually stick with it. Don't pretend overhead doesn't exist, because BMS is sure making enough money to provide for their overhead. Kepro is certainly making enough money to provide for their overhead. How about for once, stop thinking about averages and start thinking about what you demand from the	

		agencies that work with waiver. Then ask yourself, how much is it going to cost to keep the agencies and staff from running into the ground? How much is a fair wage? How much does the agency need to keep working day and night, ensuring the best service is provided for our members?	
88	3/31/21	My daughter, Xxxxxx Xxxxxx is a client of waiver. From my understanding we are at risk at loosing our Occupational Therapy that Xxxxxx gets weekly My daughter is not able to attend school and this is the only service she has that is helping her. Xxxxxx is very severe and her budget has room for this service. I just don't understand why you would take these services away without more of a comment period. The cutbacks for years has hurt the very ones this program was designed for ....the severe. Please reconsider billing for Medicaid for those that are under 21. Most OT's can't work for what they are willing to pay.	Duplicate (comment 79)
89	3/31/21	Where do I start? My son Xxxxx is 13 years old and he is Autistic, has global developmental delays, micro-chromosome deletion, Apraxia, and learning disabilities. This is a diagnosis that will live with him FOREVER! It affects not only him but his family. It changes your daily life and how you approach the simplest tasks, like going to the grocery store or taking a vacation. These simple acts for most people become a huge ordeal for an Autistic family. There is sensory overload, crowds, noise, and unpredictability for these children. The planning involved for these activities is extensive. From making sure the hand dryer in the bathroom isn't too loud, the availability of a family restroom, what order to visit the stores, when to eat dinner so it isn't too loud and crowded; and the list goes on and on.	Duplicate (comment79)

		Xxxxxx has trouble communicating and interacting with people. We have utilized occupational, physical, and speech therapies since he was one year old. These therapies help him develop skills to be able to interact with people in the community and to be able to participate in activities that allow him to be included socially with the world, not just his own home and family. Could you imagine if you were isolated in life like many Autistic people are? What if you were only accepted by your family and only allowed to participate in very few social events in your life? One of the most important purposes of therapy is to help with inclusion by teaching how to behave in society, daily living skills, and sensory processing techniques, just to name a few. All of the therapies have given us a life line as Xxxxxx has gotten older. He was non-verbal until the age of 7. He had Speech therapy for over 6 years before he was able to make sounds to eventually form small words. And at age 13 he can now string 3 and 4 words together to form small sentences. We are still working on social interactions and responding to people when they talk to him, how to engage in conversations with peers, etc. But can you imagine where he would be today without Speech therapy? How would he be able to navigate the world without words? How many people do you know that know sign language? Not many. How many people would interact with someone that can't speak and take the time to slow down and interact? Not many. How frustrating is this for an Autistic person? Very frustrating! We continue weekly Speech sessions because he has so much more to learn. And repetition and exposure will help him learn more words, understand inferences in language, develop the skills for answering who, what, when, how, and	

		why questions, reading comprehensions skills, and so many more important skills. Occupational Therapy occurs weekly in our home and it is so important to keep it in our home because it is more realistic to learn skills that he is going to use at home in the home. Why is it most beneficial in the home for him? Because he needs to be able to utilize the kitchen that he will be cooking, the bathroom that he will be using on a daily basis, the dining room table that he will be eating at, etc. Learning these skills in a facility then trying to transfer what you learned to your home environment is harder and slower for an Autistic child and change is not often met with reception in these kiddos. Private Occupational therapists educate on strategies for self-care and independence but also sensory processing and emotional regulation where the school based therapists do not. School therapists only focus on the school environment like writing his name in class, cutting with scissors, and his pincher grasp skill to name a few. School therapy is only two times a month if you are lucky. And as your child gets older they continually cut the amount of time your child receives in the school system due to caseloads, not the needs of the individual child. Occupational therapy has been so important to Xxxxx, especially as he has become a teenager and he has so many emotions that he doesn't understand and can't articulate how he feels or why he feels that way. Our therapist helps Xxxxx identify his emotions, why he is feeling that way, and that it's ok to feel that way but how is it socially acceptable to react to that feeling. My son bites his hands, smacks his head, and often reaches out to physically shake whoever is near him when he is	

		upset. His therapist has been working on this for a year now and his behaviors have lessened and we have less meltdowns. He thinks before he reacts now because of strategies she has taught him. Sensory processing is another daily struggle for him. Our therapist works on this in many ways. Sensory input is the main strategy she implements and it has been a huge help for him. She gives him fidget bands on the chairs he sits in, gives deep pressure to calm him and proprioceptive input to help him organize his senses and avoid overload and to help him function throughout the day. During the sessions they work on yoga moves to help with spatial awareness and focus; not to mention, balance, posture, and core strength. All of these tactics are NOT used in school based therapy. Physical therapy is another weekly therapy for us. Our therapist has helped with endurance, muscle strength, weight management, muscle toning, and other health benefits. These are daily living benefits and foundational concerns not therapy based solely on the school environment. School therapists only work on skills that affect getting from class to class safely, necessary range of motion to get up and down the bleachers, skills needed to be able to participate in gym class games such as kicking, throwing, and catching balls, running in a pattern, completing exercises with the class, etc. Private Physical therapy is necessary for Xxxxxx as he continues to grow and develop. As a parent you want to fix the problem and make the world easier and nicer for your child. I diligently push and follow through with weekly therapies. Yes, life gets busy but my son NEEDS weekly therapy to continue to improve. How can I fail him by not providing this service? I	

		won't live forever so I need to prepare my son with as many life skills that I possibly can. This includes weekly therapies for Speech, Occupational and Physical. These will all teach him things to become more independent and self-reliant as he gets older. Progress takes time. You can NOT put a magic number on the sessions that are needed to make your child "fit" into society. When we were awarded a slot on the IDD Waiver program we were told this program was to help our child since he had chronic disabilities. Medicaid was to be used for other patients that had restorative needs not needing extensive rehabilitation services like Xxxxxx needs. Autism isn't a knee replacement diagnosis that can be "fixed" in 8 sessions. Autism is a way of life. Autism is a disorder that the person needs skills taught to them that doesn't come naturally like it does to typically developing children. Daily life is hard for an Autistic person and therapy helps them cope, understand, and learn things to make life a little more normal for them. Right now we are able to get one hour private weekly sessions for Brayden in Occupational, Physical, and Speech therapies. If you change the policy and only allow us to bill through Medicaid not IDD Waiver we are dropping down to 20 sessions a year. Is that 20 sessions for each therapy or will that be shared? Do you realize that this will be over an 80% reduction in services? (We currently get 104 sessions a year for OT and PT combined). If you think that school based therapy is a good supplement, think again. The school based therapy does not provide the same needs. When children are under the age of 21, it is the prime time to teach new skills because they want to learn, they want to try their best,	

		and they so desperately want to fit in. Help them reach these goals to the best of their ability and don't change the policy. Please let us continue to bill IDD Waiver for weekly therapy sessions. Don't take the lifeline away from our children PLEASE. Also in rural WV the accessibility to therapy is an issue in our area. There are not enough therapists and the wait lists are huge! If you take away the home-based therapy as an option, this problem will just get worse. This means children will go without their needed therapies. Please don't do this to our children.	
90	3/31/21	Another thing that I don't think people understand about the program is the Respite services. The definition of respite is "a short period of rest or relief from something difficult or unpleasant." I don't think anyone would argue that for a special needs child and their family that life is difficult and often unpleasant. These Respite hours are so important to families with special needs children. Why is there a policy in place that we must plan a month in advance of exactly how many hours will be used for the next month? Do emergencies not happen to families with special needs? These families probably have more than the typical family yet we aren't allowed to use any hours for Respite unless we plan for them. What if I have to have surgery that I didn't know about? What if we have a death in the family? What if my husband gets in a serious accident at work? Please remove this rule and allow us to use the hours that we have purchased throughout the program year as we need them. Please remove the monthly budgeting that ties our hands if we need more hours once the month starts. What happens to the unused money in our budget? Where does it go? Please help our families out and lift this rule, please allow us to utilize the Respite hours how we need them	Duplicate (comment 23)

		and how they will best benefit our family and give us the respite that we so need and deserve.	
91	3/31/21	With all due respect your math for Case Management is flawed and will put any agency that is just case management services as a not viable option for the communities we are servicing. During this covid time we aren't even doing face to face home visits and the rate you are trying to implement would not cover the cost of business much less make owning this type of business as a viable option. Your math is averaging 12 units per consumer a month and that isn't accurate at all, I would also argue that the rate should be the same rather the consumer is in their home with family or in a residential facility, Many months the consumers at home have more units used for case management services then residential consumers. I did the math for our agency alone and during the month of Feb 2021 we have 147 consumers and the average units used were 16, and that is without face-to-face home visits or meetings and face to face those things take longer. It is unrealistic to expect people with college educations to work for less then $16 dollars an hour, here is also no method for milage reimbursement, no method of reimbursement for translation services, there is no room for growth and we would be doing our consumers a disservice if we give our case managers a bigger case load of 30 especially once face to face monthly home visits and bi monthly day visits resume. I would also like to note the math BMS used to come up with these figures did not at all take into consideration all of the expectation a Service Coordinator is expected to do that isn't a billable service. So when BMS ran the numbers based on units billed during the 2018/2019 service year there wasn't any way to account for that. I would argue that even with BMS suggested overage in averages to try to be fair they didn't account enough for this, mileage, actual services rendered, overhead cost and everything else that is entailed to provide this professional services. Any provider agency has always been aware they are losing money on their Service Coordination service but had other recourses to make up that funding. As a stand-alone conflict free agency	Duplicate (comment 87)

		we do not have any other revenue to help compensate for the lack of reimbursement. We feel at $300 per consumer across the board is a fair flat rate and will assist in maintaining college graduated professionals to provide these services. We would also argue that there should be some way to reimburse an agency for special situations requiring untraditional needs to a consumer. Ex providing SC services while transitioning a consumer from ICF to Waiver or While a member is on hold due to unforeseen issues as in not being able to obtain staff to provide direct care services. Maybe a flat fee of $200 per month until services can begin with noting to back up this untraditional time would be a fair flat fee for these types of situations. Please consider everything that is involved with running a standalone conflict free agency, insurance, utilities, building rental, office supplies, taxes and it certainly does not give any room for growth potential as a company to continue to stay open and provide conflict free case management as a whole. The low reimbursement rate will eventually cause the demise of the agencies BMS is currently trying to encourage to open and make the IDD waiver system more person centered and unique to provide services. At ABC we strive to be the best for our consumers and part of being able to be the best is to be able to afford to pay a competitive rate, be able to provide benefits, and be able to maintain a proper case load and not over working a Service Coordinator by giving them to big of a case load to afford to pay them better. Doing this results in burn out, a bad work product, a bad working environment and ultimately the consumer not getting the attention they deserve.	
92	4/1/21	It is unfair to not raise reimbursement rates. BMS continues to require more and more from all waiver providers, from residential providers down to direct care staff without a proper reimbursement rate for any of it. Proper staffing, professional services, and the companies that house them can not continue to provide services without a higher reimbursement rate for services rendered. All aspects of daily living are at an all time high with no end in sight of the inflations that continue to grow. Our families deserve better. Our families deserve for our state to provide them with educated loving staff, who have been trained to	Duplicate (comment 87)

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		provide them the best services West Virginia has to offer. The reimbursement rates barely cover the hourly wage of 1 staff member per hour let alone, overtime, overhead, training, insurances, taxes and everything else that goes with having staff. These rates do nothing to encourage anyone to open these types of businesses and offer the services our individuals deserve. There are lots of companies that the owners can not even draw a profit from because everything goes into trying to keep the company afloat for the consumers. Please consider raising the rates, so the companies can hire quality staff to provide services that our consumers deserve. Please consider raising the rates so our families can afford to hire respite providers that will actually show up and assist the families in a break. Please consider raising the rates so agencies can hire direct care staff with a competitive wage. Please consider raising the rates so we all can provide quality care and not crisis over worked care. Please consider raising the rates so agencies can hire quality professionals who have college degrees and loans to pay off. Please consider raising all the rates for us all so we can service this community in the way it deserves.	
93	4/1/21	Page 13 – Agencies that provide case management services to a member cannot provide any other IDDW or State Plan Medicaid service to that member if provision of those services would result in financial gain, potential financial gain, or job security, whether those services be funded by Medicaid or an alternative funding source. a. This statement is no longer accurate based on Policy Clarification Calls as it has been indicated that outpatient services can be provided. Please provide clarification.	Change: Changed to “cannot provide any other HCBS...”
94	4/1/21	Page 30 – Prior to conducting the member’s monthly home visit, the case manager will contact the Service Agency and/or Resource Consultant to determine if incidents have been reported since the previous monthly home visit. a. If the case manager contacts the agency and/or resource consultant and 1) does not receive a response prior to the home visit or 2) is informed no	Duplicate (comment 59)

		incidents occurred since the last home visit, and they are informed at the visit an incident actually occurred--Who reports this incident in the IMS?	
95	4/1/21	Page 38 - The SC provider is at maximum service capacity and unable to accept referrals until additional case managers are hired. a. How can the case management agency reach capacity when there is no maximum case load? B. Also refers to a service coordinator instead of a case manager.	Change: Removed this statement and changed "SC" to "CM." Though caseload limits have been removed, if a CM agency feels they're at capacity, they can ask Kepro to stop sending referrals.
96	4/1/21	Page 52 and throughout the Draft Manual- There are several places where Service Coordinator (SC) is still being used instead of Case Manager (CM)	Duplicate (comment 5)
97	4/1/21	Pages 41, 91 – 102, and 121 - Person Centered Supports has been interchanged with Participate Directed Supports throughout these pages of the Draft Manual. a. Please clarify as it results in confusion of these services (Home Based Agency PCS (Traditional Option), Home-Base Agency PCS (Personal Option Model, Licensed Group Home PCS (Traditional Option), Unlicensed Residential PCS (Traditional Option) and LPN Services?	Change: Changed all to "person centered supports."
98	4/1/21	Page 94 - Home-Base Agency PCS (Personal Options) a. Should this service title not include Agency since the service is not provided by an agency as directed through PPL?	Change: Removed entire section.
99	4/1/21	Page 117 - The case manager is responsible for the development of the Crisis Plan which is to identify the entity/individual responsible for responding to each type of crisis reflected in the plan and notify all appropriate parties if a member is admitted to a crisis site or state institution. a. Do all Crisis Plans for every member now have to include a plan for a member to go to a crisis site or state	No change: No, not every member's plan would include a crisis site, but for adults who may need a crisis site due to behaviors, this may be appropriate,

		institution? b. Or should this be a separate activity that the Case Manager is responsible for outside of the Crisis Plan?	and the CM should notify all appropriate parties.
100	4/1/21	Page 118 and 119 – Limitations/Caps provides a list of services that cannot be billed by a Case Manager a. With PMPM, why is this list of non-billable activities needed? b. Can the Case Management log include these activities? If not, how will the case manager document "non-billable" activities?	Duplicate (comment 12)
101	4/1/21	I am a COTA and OT bridge student. I work for an occupational therapy company that provides services to children who are under 21 years old through the waiver program. Our therapists are able to address life skills in their home environment and the community. These are services they would not receive otherwise because there are no providers in the area for Medicaid. I currently work for birth to three and my kids who exit the program depend on services with the waiver program to address services in their natural environment that are not solely education-based. I urge you to consider this when making changes to the program.	Duplicate (comment 79) COTA and bridge students cannot bill IDDW OT. The OT who delivers the service must be a fully licensed WV OT who is also enrolled as a Medicaid provider.
102	4/3/21	Regarding the public comment invitation for the Waiver manual changes: My son has been a Waiver recipient for over 25 years. He has autism and is non-verbal, and he requires 100% supervisory care. I am grateful for the help that the Waiver has provided over the years. I have tried to be a responsible and frugal consumer of Waiver services and to remain mindful of the needs of the many people whose situations are far more dire than my own. When I received the email about the public comment request and the attached pdf of the manual, I looked at it briefly but realized that it would be impractical for me to read the manual with any sort of rigor and comment usefully on the changes. Even when I spoke with my case manager and she told me about the pages that highlighted the changes, I had to question whether someone like me, who has a history with the Waiver program but scant familiarity with the work involved in revising the manual, would be able to have enough perspective on the nuances of language	No change: BMS reads and considers all public comments. Often, these comments result in additional revisions to policy. BMS listens to, and even relies on the feedback of IDD Waiver stakeholders to operate the program to its fullest potential. This ensures a commitment to the health and welfare of West Virginia's most vulnerable residents, while still maintaining fiscal responsibility and acting within the regulatory

		and the changing focus in policies to comment intelligently without doing extensive background research. But this is a problem. When I looked at the task and the time frame, I realized it would be impossible, and I gave up. As I think about the needs of other Waiver recipients when I make my own decisions about accessing Waiver services, so also do I think about the probability that many of them are in the same position I am: unable to add a significant paperwork task with no prior notice and a short turnaround time. My conclusion is that there are many people who might have useful input, but their voices are not being heard. On the other hand, over the years I have felt blindsided many times by what have been characterized to me as Waiver manual changes. Each time, the Waiver program administrators with whom I work have been confused, angry, and ultimately unhelpful. The most significant was the firestorm that accompanied the decision a few years ago (again, imperfectly understood by me and poorly explained by the professionals connected to our services) that everyone must be trained to work, and that work placements must employ non-disabled people in the same job. While that would be a delightful world, it is (as those of us actually working in the real world as caregivers or employers cannot fail to see) deeply impractical. The anxiety, ill-will, anger, fear, and confusion engendered by this Waiver manual change can not have been positive for anyone. It certainly was not good for our family. I realize that change is always difficult and that there are bound to be losses connected to it. But my experience with the change connected to Waiver services is that there is always far more upheaval and misdirection than there need be. Perhaps this has to do with how things are communicated, or how or why policies change, or widespread misunderstanding among consumers and providers. But it is exhausting and disheartening, and it certainly erodes trust. I can't help thinking that the call for public comment is one part of the system that is broken. If there is a sincere interest in the experience and the response of the people who are consumers of the Wavier services, shouldn't there be a method of soliciting widespread feedback that doesn't seem so daunting that consumers simply surrender and hope for the best? A cynic would suspect that the call for	measures put in place by the federal government (CMS).

		response is merely for show and that there is no sincere hope that consumers will respond. But most of us are people of good will as most of you are, and I believe that effective and helpful communication is our common goal. I have expressed this many times to many professionals connected to the Waiver program, and I have had many sympathetic responses but have seen no systemic changes. Trying to maintain hopefulness, I express it again to you in this letter.	
103	4/4/21	I find it very troubling that the state is constantly trying to save money at the expense of our most vulnerable children. As the grandmother of two children on the autism spectrum, I implore you not to cut Occupational Therapy for those under 21. These children need and deserve all the therapy they can get. Giving these children the services they need now will pay benefits in the future. Again I strongly oppose any cuts in their services!	Duplicate (comment 72)
104	4/5/21	It is my understanding that you are trying to eliminate therapy services to your participates that under the age of 21 years old. This will hinder a lot of your young participates. Medicaid will only pay a certain amount and it is not enough to cover all the therapies these participates need. These participates need therapy at least once a week or more and Medicaid does not cover that much. Also, the schools want to bill Medicaid for these therapy services that they provide. The services the school provides is a joke. They want to do a session with 3 or 4 students at a time and bill for each student. With the school billing Medicaid, then you cannot take them to private providers to get the one-on-one therapy that would be most beneficial to them cause the service as already been billed by the school. This service needs to be looked at more closely and considered to what it will do to our young participates. I thought you all were for helping the Intellectual/ developmentally Disabled to better their self	Duplicate (comment 72)
105	4/5/21	When CM's cannot be reimbursed for providing CFCM services-Case management Agencies are affected by "Service Agencies" not doing what they	No change:

		have stated on the IPP as they will complete and be responsible for—for example, Person has been referred to Company A who stated they have staff for services and then they do not nor do they advertise and then the Person gets put on hold. The CM is still trying to ensure they are safe, advocating for staff and services and possibly a referral to another Service Provider—but because they are on hold the CM agency cannot provide any services or bill. The person really needs CM services but the Service Agency is the problem. There should be some way to avoid them being on hold for this issue.	The CM may still bill with an approved DD12.
106	4/5/21	When CM's cannot be reimbursed for providing CFCM services-There should be some way to reimburse a CM agency for special situations requiring untraditional needs to an individual. Ex providing SC services while transitioning a consumer from ICF to Waiver or new consumer trying to get services provided by PPL or other providers. A lot of time may be spent initiating services, Treatment Planning and referrals.	No change: This may be considered for a future amendment to the application.
107	4/5/21	Costs are high when you are working with other agencies, especially those that are not meeting the standards of care or following the MOU's. There is no penalty for them to do what is responsible—the CM spends a lot of time on these issues. Maybe a flat fee of $200 per month until services can begin would be fair for these types of situations.	No change: The very reason for the required MOU is to address liability issues between agencies. However, CMs can still bill while a member is on hold with an approved DD12.
108	4/5/21	Reference pages 116-118 includes the minimum list of Case Management duties. As one can see this extensive list contains required duties that vary in their roles and responsibilities. Community based and ISS consumers' needs are based on the individual needs therefore designating a fee based on where they live is not reflective of the services that may be provided and reimbursed at one rate. $200 for Natural Families and $250. for ISS consumers is not always reflective of the work that is provided. It is our concern that the quality of services will be affected and those less	Duplicate (comment 15)

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		responsible agencies will provide lower quality services. We feel the PMPM is easier to plan, lessens documentation requirements but the rate is not enough to cover the salary expense and benefits, travel, overhead and some agencies will need to discontinue this service hurting our consumers and their families. These numbers were generated prior to CFCM and working with other agencies therefore this rate does not reflect an appropriate reimbursement. The Appendix also states that this rate will not be reviewed for the next 4 years—no area for inflation, growth or staff recognition.	
109	4/5/21	Staff Review -A 100% review of all staff is excessive especially for large agencies.	No change
110	4/5/21	CM-The absence of a case load cap number concerns me because I foresee some agencies requiring high caseloads to cover costs--- therefore resulting in some providers providing poor quality of care for the individuals, a high turnover for CM's and hiring difficulties.	Duplicate (comment 71)
111	4/6/21	To Whom It May Concern: My name is Xxxxx Xxxxx and I just started my journey as a Case Manager with Intellectually and Developmentally Disabled Consumers in the State of West Virginia. This specific population, as I am sure you are aware, needs special people to stand up and speak for them. They need people to fight for them, the need people to help them get what they need, and what they want. Yes, they have wants just like you and me. They are human beings after all. Some of these consumers have had a hard life. They get to watch everyone else play sports and go to dances. Or paint a beautiful picture, and draw a perfect drawing. Not only from this aspect, some of our consumers have to stay home to be fed with a tube that is surgically placed in the stomach because the way they were born their esophagus does not work properly. Some cannot talk or see so they can not communicate properly with you to tell you what they want	No change: At this time BMS sets the rate for the service but does not set the rate providers pay their staff.

		or need. Some of our consumers that do get to walk and talk and get to go places still have a specialness about them. They still need our attention. Not the pointing and laughing attention that I have seen people do, not young curious children that do not know any better, grown adults partaking. So, you see this is just a small, microscopic glimpse of what it is like in the Intellectually and Developmentally Disabled Population. Now, here is where I come in. I stand up for these people, I fight for these people, I do what ever needs done to make sure they have that the need and want and then some. It isn't all cut and dry or all black and white, there are steps you have to follow and hoops you have to jump through. I have to ask this person for this, and that person for that. Then do home visits every month, with notes about that. There is even times I have to go out in the community to physically do things because the other party will not respond to a phone call or to an email. That is with out being paid any mileage and either time away from my children, or pack them up and take them with me. In such a short time I have spent countless hours doing progress notes, in which is to to document every single thing I have done, or completed, or participated in because that was how I was paid by the hour. Now I am not paid by the hour as of April 1. 2021. As of April 1, 2021, The payments went to one wage one time per month and that wage being anywhere from $200-$250 per client per month. But here is the catch. I'm still doing the same amount of work as before minus the progress notes. BUT....In all actuality, because I am contracted out, that means I only get $100-$125 per month per client for the same amount of work that I have always done? How is that fair? So therefore, because I am only getting one wage one time per month per client which is the dumbest thing I have ever heard of, I will have to pick up several extra clients just to be able to live and make ends meet.	

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		Not to mention the less than stellar attention to detail that the consumers desperately need. So, as with the difference in pay and he abundance of consumers I think its safe to say with everything we Case Managers do, we deserve a little bit more. A little more respect, a little more compassion, a little more payment, and when we say we need things, Especially in this field. We really need them.	
112	4/7/21	Section 513.9.2 Participant-Directed Service Option – Shouldn't the services that are being added to Personal Options model be included here? Dietary Therapy, Occupational Therapy, Physical Therapy, Speech Therapy, Environmental Accessibility Adaptations Home, and Environmental Accessibility Adaptations Vehicle are not listed.	Duplicate (Comment 14)
113	4/7/21	Section 513.12.1 Dietary Therapy (Traditional Option and 513.12.5 Dietary Therapy (Participant-Directed Option, Personal Options Model) – All other therapies include a statement in the Limitations/Caps section that reads "Agency staff may not bill ___ therapy services for completing administrative activities." Is this not also applicable to Dietary Therapy?	Change: Included this statement under limitations and caps of both traditional and participant directed dietary therapy.
114	4/7/21	General question regarding therapies – If Members under the age of 21 are now being required by the Centers for Medicare and Medicaid Services (CMS) to receive therapies through EPSDT rather than the Waiver, should that not be spelled out in this Policy Manual? The Waiver allows a combined maximum of 416 units (104 hours) per IPP year for Dietary therapy, occupational therapy, and physical therapy. Are there 115restrictions on the number of hours allowed through EPSDT, and if so, is it more or less restrictive than the Waiver allowances? Will it be more or less difficult for families to get needed services for their children? What will Medicaid do to ensure a smooth transition? The Council asks these questions because, while we realize the intent of EPSDT is to make sure the needs of the child are met, we often hear of the difficulties families have in receiving those	Change: Added language regarding EPSDT There is no cap on therapies under EPSDT. Therapy services that are determined medically necessary are only limited by the amount ordered

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		services, often times as a result of paperwork not being filled out exactly as required by the program.	by the referring physician recommends.
115	4/7/21	513.14 Environmental Accessibility Adaptations – The Council is pleased to see Environmental Accessibility Adaptations (EAA) have been added to the Participant-Directed Option, but will continue to register a complaint that the combined maximum of $1,000 per IPP year to cover, home and vehicle adaptations and Participant-Directed Goods and Services is too low. We recognize a Member will not necessarily need an adaptation to both home and vehicle in an IPP year, but might, depending on the circumstances. Adaptations are generally quite expensive and $1,000 will often not cover the cost of an adaptation to a home or vehicle alone. Participant-Directed Goods and Services (PDGS) should not be included in this combined maximum. PDGS is only available as a participant-directed service but has been included in the combined limitations/caps for the traditional options of EAA.	No change: The IDD Waiver is an optional program, designed to provide supplemental services to meet members' needs. It is not all inclusive, and may not always cover everything a member or the member's family wants the member to have.
116	4/7/21	513.14.1 and 513.14.3 Environmental Accessibility Adaptations Home – The Council still disagrees with the limitation which disallows the purchase of adaptations that are solely ADA compliant. As we commented in 2017: "Now that, more than 25 years after the passage of the Americans with Disabilities Act (ADA), industry has responded with a variety of appliances, adaptive equipment, and technology, the DHHR plans to deny individuals with developmental disabilities access to them. Assistance is already very limited by combining three services in the $1,000 cap [EAA Home, EAA Vehicle, and Participant-Directed Goods and Services (PDGS)]. Nevertheless, some assistance towards the purchase of items that can be very expensive is better than none. To insist that, to be covered, an item that is already designed to be accessible to people with disabilities must be further, individually, modified is difficult to understand. We do not believe this means they should be excluded from payment assistance."	Change: Changed to "Appliances compliant with the American disabilities Act (ADA) are sufficient to meet this requirement.

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117	4/7/21	513.15 Day Services – Most of the day services listed in this section require training of staff to be provided by a Behavior Support Professional (BSP) or a Registered Nurse (RN). These services include some that are employment related. Please explain what specific training BSPs and/or RNs receive that qualifies them to train staff to provide employment related services to Members.	No change: This is not a change in the policy manual, however, the trainings provided by BSPs and RNs are specific to their specialties. BSPs train staff on required work-related goals, and RNs train staff on medical issues.
118	4/7/21	513.15.1 Facility-Based Day Habilitation (Traditional Option) – The Council expresses its concern once again about the removal of the limit of time a Member can participate in Facility-Based Day Habilitation (FBDH) and the site of service being listed as a licensed IDD Facility-Based Day Program facility. Although the Manual mentions a Member may access community services and activities from the licensed site, the requirement still exists that the Member must go to a segregated facility first. This actually lessens the likelihood the Member will go on to a community-based setting. This is an example of a policy that should be changed to meet the intent of a State Transition Plan for Home and Community-Based Services. The Council realizes that FBDH facilities were not open for much of the past year due to the pandemic, but we would be interested to see any data prior to last year that showed the percentage of Members who attended a day habilitation program who arrived at the facility and then left to receive services in the community. If BMS is not collecting this data, it should be to assure HCBS funding is being used appropriately. The Council's position, stated in the 2017 comments, is that there is no habilitative or therapeutic justification for providing self-care, social skills training, independent living skills training and other services in a congregate setting. Regardless of any flexibility provided to states, the Council asserts that	No change: Data was compiled and presented to the QIA Council two years ago.

		facility-based day (and other) services isolate people from the broader community. People who are unlikely to work should have access to meaningful community based non-work services that support community inclusion and integration. Such activities may support career exploration later. The provision of Day Habilitation services in typical community settings, rather than in facilities where people are segregated and/or congregated, more closely aligns with the intent of home and community-based services. The Council understands many families face a conundrum because they rely upon this service to give their family member a place to go during the day. The Council does not advocate they be left with no options. The Council believes the DHHR needs to be doing more to encourage and assist waiver service providers in the development of meaningful alternatives to segregated, congregated programs.	
119	4/7/21	513.15.2 Pre-Vocational (Traditional Option) – The Council continues to object to the removal of "and community settings" from the site of service. The CMCS Informational Bulletin provides this core service definition: "Services that provide learning and work experiences, including volunteer work, where the individual can develop general non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings." WV uses its own definition of the service, yet it is hard to imagine how one would "achieve a path to integrated community-based employment for which an individual is compensated at or above the minimum wage…" by spending one's time in a facility based day program. If provider agencies can "employ" the person using pre-vocational services as the method, how will it be determined when the person should be supported to move on to actual competitive integrated employment in the community? There do not appear to be any safeguards from keeping a person "stuck" in pre-	No change at this time.

		vocational services in a licensed IDD Facility-Based Day Program while being paid by the provider to perform some sort of work for the agency. Evidence based practice has clearly found that "work readiness" types of activities that take place in facility-based settings are not effective in leading to integrated employment for people with significant IDD (Marc Gold and Associates, Griffin-Hammis Associates, APSE, ICI, and others). Skills and behaviors needed by a person as a prerequisite for employment should be learned in natural settings. For example, volunteering in a community setting that aligns with a person's interests. The removal of community settings and the possibility of associated volunteer activities would be detrimental to this type of learning. The Council is also interested in knowing whether there is a division of staff and space for Day Habilitation and Job Development services, since both can be offered in the same setting. Is it possible to identify which service each person receives at any given time? If an individual is receiving training in the concepts listed as being pre-vocational services, which of those concepts qualifies as a service for which the individual would be paid to learn? This is another example of a policy that should be changed to meet the intent of a State Transition Plan for Home and Community-Based Services.	
120	4/7/21	The Council's comments regarding 513.15.3 and 513.15.4 have not changed from the ones made relative to the 2017 Manual. We continue to stand by those comments. Legislation is set to pass during this session after which West Virginia will join over 30 other states in becoming an Employment First state. It is important that the Department's policies reflect and support the philosophy of Employment First.	No change at this time. If/when the House bill for Employment First passes, then the program will consider revising the application/manual.

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121	4/7/21	513.15.3 Job Development (Traditional Option) – The current policy manual leaves out, and the draft manual does not include a critical planning service prior to job development - customized career planning that includes the Discovery process. Kentucky's Supports for Community Living (SCL) Waiver, for example, specifies that "job development must begin with Discovery (Person-Centered Job Selection), where the job/goal features of desired employment are selected based on spending time with the person in non-standardized non-testing situations to learn his or her gifts, talents, and support needs." The Council continues to be concerned about the lack of and types of training being required for staff who provide employment related services. Behavior Support Professionals (BSP) and/or Registered Nurses (RN) do not necessarily have expertise in pre-vocational services, job development, or supported employment. Why would these types of professionals be required to provide training or supervise services? As we have commented before, employment related staff must have specialized training, preferably certification, to provide such services. Any paraprofessional staff should be in a different category than staff who provide typical direct care services. Employment is not the same as personal care and should not be treated as such. It is recommended that the IDD Waiver program include minimum training requirements on customized employment. The Certified Employment Support Professional (CESP) curriculum is an example of a nationally recognized training. The Council recommends training on Social Security Work benefits be provided as an IDD Waiver service, or an assurance be made that another agency (e.g. DRS) will provide the counseling. Staff should be trained to provide general information to members and families about how SS work incentives can help people reach their employment goals and become more economically self-sufficient.	No change: BMS will explore adding this to a future amendment to the application.

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122	4/7/21	513.15.4 Supported Employment (Traditional Option) – The Council is pleased to see the restriction in site of service, which no longer allows the service to be provided in any setting owned or leased by the IDDW Provider agency, although the concerns stated above related to payment for pre-vocational services that benefit the provider are heightened because of this change. While some components of Supported Employment Services, such as those provided to individuals who wish to be self-employed, may not be provided in integrated community work settings, this section could be strengthened by a statement that makes clear all other employment must be in integrated community work settings. The Council suggests the term "integrated settings" be more fully described as typical workplaces in the community where most co-workers do not have disabilities. It should also be made clear that supported employment services are predicated on the belief that persons with I/DD, including those with complex support needs, can work in the general workforce when provided with the opportunity, training, and support.	Change: Changed to "This service must be provided in an integrated community work setting unless the member is self employed, and may not be provided in any setting owned or leased by an IDDW provider agency. An integrated setting requires that most of the member's co-workers in the setting do not have disabilities."
123	4/7/21	513.18 – Respite – In a recent survey by the Council, respite care was the service most mentioned as needed and unable to be obtained. Respondents say there are not enough hours allowed to meet their needs and/or they are not able to find respite providers. Respondents have delayed needed surgery because of a lack of respite. Several respondents mention the cut in allowable hours has made their lives harder and has also made finding a respite care provider harder because people do not want to work the small number of hours allowed. The Council believes there is no useful purpose in the Department using a policy Manual to inform families as to what they believe are the various forms of respite they receive (other than the formal Waiver service). It is an opinion, not a policy, and does not belong here. It is inappropriate and offensive to assume	Change: Removed other forms of respite from language. Adjusting the limit on Respite will be considered for a future amendment.

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		what is or is not a form of respite for a family providing care to an individual who qualifies for this program. This was added to the Manual when respite hours were cut drastically, apparently as an attempt to justify the cut. It should be removed. Why is there a requirement for documentation if a BSP is involved in training plans for the Personal Options models of Respite but not for the Traditional models?	Change: Added the requirement to the traditional option.
124	4/7/21	513.19 Case Management – The first item in Limitations/Caps states the amount of service is limited by the member's individualized budget, but case management is a mandatory service and the PMPM rate has been established by the Department. The Council understands conflict-free case management (CFCM) has been required by CMS and can no longer be ignored by WV, however, we have some concerns about the plans for implementation. Although the per Member per month (PMPM) rate for Members living with family is less than for Members living in other settings ($200 rather than $250), some Members may be hurt by having this amount deducted from their budget, whether or not they need or use $200 worth of service.	Duplicate (comment 44) No change: If the member's agreed upon services do not fit within the individualized budget, they may access the Exceptions process and the CM can explain the need on the form.
125	4/7/21	The Council has advocated a flat rate for these services for at least two decades, but there are no controls in place to encourage good case management. These are some concerns we have and some we have heard from providers:	No change:

			BMS and Kepro will be monitoring to ensure quality case management is being provided.
126	4/7/21	• Many providers say the rates are not high enough to provide the service. Apparently, rates were determined using billing history from previous years, but those rates were not covering the cost of providing the service and CFCM agencies will not be providing other services to help make up the difference. Based on the job requirements, case managers are required to fill the role of social worker, accountant, and advocate. The Department should consider looking at the prevailing wages in these careers to set a fair rate.	No change: Thank you for the feedback, and we will consider the comment, however, rates are not included in new policy.
127	4/7/21	• The service includes a two-page list of activities a case manager must perform and another page of limitations and caps, some of which appear to be in conflict. For example, in listed activities, case managers are required to upload certain documents into the Utilization Management Contractor's (UMC) web portal, along with any additional documentation BMS or the UMC may request, but in limitations/caps a case manager cannot bill for Utilization Management activities	No change: Though the PMPM rate is tied to the monthly home visit, case managers are still required to complete the activities listed and document them on the CM log.
128	4/7/21	• Some provider agencies have, in the past, acted as representative payee for Members they serve. Case management agencies are now prohibited from performing this service for Members for whom they provide case management. We are not aware of how many agencies may have decided to become strictly case management agencies now. Were they aware of this restriction prior to making this decision? If they were representative payees for Members who will continue to receive case management services from them, how long will Members have to find new representative payees?	No change: This is a requirement by CMS in CFCM. The early workgroups on CFCM were aware of this requirement.
129	4/7/21	• In a power point presentation on the Bureau's CFCM webpage, it states case managers should engage in high quality, person-centered planning (PCP) that keeps the full focus on the person, and that PCP depends heavily on quality case management. They go on to state caseload sizes that match scope of responsibility and account for the level of support individuals will need are a	No change: Agencies providing case management services must be licensed or if providing CM only, certified through KEPRO.

		requisite for good case management. The Council believes the Department should do more to encourage true PCP and to ensure case managers and others are trained in the use of PCP. The Council also disagrees with the lack of any requirements for caseload size. Since the rate of pay is considered low by many providers and apparently little oversight is planned, it seems likely agencies will be inclined to take on larger caseloads in order to be able to afford to provide the service. Members will suffer because of this.	Duplicate (regarding removal of case load limit, comment 71)
130	4/7/21	• The Policy Manual does not speak to the possibility of exceptions to CFCM. It is our understanding that exceptions could be made for remote, rural areas or for cultural/linguistic reasons. If the Department has such a policy, it should be spelled out in this manual. More than a link to the WV Department of Arts, Culture, and History showing ethnic regions should be provided to explain what the Department interprets as "culture."	No Change: Cultural exemptions are limited to linguistic barriers only at this time.
131	4/7/21	And finally, concerning policy. Where does one look to find IDDW policy that is not spoken to in this Policy Manual? For instance, some forms associated with this program indicate there is policy associated with a question, but that information does not appear in this Policy Manual. Is there another Policy Manual associated with this program, and where might one expect to find, for example, the remainder of the policy on EAA – Vehicle?	No change: There is only one IDDW policy manual. However, BMS and the utilization management contractor host monthly policy clarification calls to address questions pertaining to the manual. A comprehensive list of clarifications can be found on the BMS IDD Waiver website.
132	4/8/21	513.19.1 Addition of CFCM as required by CMS 4th bullet from the bottom on page 119 – "Case Management cannot be billed for training agency staff" – we've clarified that in some cases the CM may be the most appropriate person to train on items such as health and safety and emergency care/crisis plan training if there is not a BSP or RN on the IDT. This is reflected in FAQ 118. I think amending this bullet may be in order.	No change: This statement was already removed due to the PMPM rate now being tied to the monthly Home Visit.
133	4/8/21	513.2.5, 513.2.6, 513.12.7, 513.12.8 and the equivalent traditional option services Addition of dietary, occupational, physical, and speech therapies	Duplicate:

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		(Participant-Directed Option, Personal Options Model) Note – this is an existing traditional service but adding to Personal Options services to ensure members' access upon implementation of CFCM Providers have been informed over the past couple of years that members under the age of 21 cannot access these therapy services through the waiver program (per CMS), rather they should pursue them through the state plan/EPSDT program. I don't see anything in the draft policy manual that reflects this. We've received feedback that services are very difficult to access in this manner due to a lack of response. I believe it is vitally important to have this noted in the policy manual rather than addressing via policy clarification in order to avoid having opposing directives in writing.	Current authorizations and service providers for therapy services for children will remain in place until the services can be smoothly transitioned to EPSDT providers.
134	4/8/21	513.2.5, 513.2.6, 513.12.7, 513.12.8 and the equivalent traditional option servicesAddition of dietary, occupational, physical, and speech therapies (Participant-Directed Option, Personal Options Model) Note – this is an existing traditional service but adding to Personal Options services to ensure members' access upon implementation of CFCM -Continue to authorize therapies for children under 21 until a transition plan has been implemented. CFCM got pushed back multiple times – and having a plan in place focusing on cross systems education, support, and training will prevent kids from having a lapse in therapies. Most regions don't have enough school therapists to pick up the slack until EPSDT can take over. -Physicians, therapists, and IDDWaiver providers routinely report they have no idea what the EPSDT program is – there needs to be some sort of liaison or training specialist doing training much like we do when new manuals come out (anyone registered as a Medicaid provider should receive the training) -Whomever does the claims (not sure if it's Gainwell or somewhere else) needs to be involved in the trainings so providers know how to bill and they can discuss how payments work. I had one mom from the Northern Panhandle get signed up, but then the therapist didn't get paid for over a year. -Our medical department needs involved so providers understand how to get authorizations	Duplicate (Comment 133)

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		-There are supposed to be regional representatives for the program to provide training, education, and assistance with getting authorizations. I have only ever heard from one – and he quit about a year ago – so those individuals need put in place. -The forms need updated/made more available – it's a whole song and dance to even get to them on the website – maybe a link to BMS website and/or include electronic forms with the trainings -The program needs restructured – there are reviews which must take place annually that is lengthy and difficult to do – maybe look at affidavits the physicians can sign saying the member's situation hasn't changed (at least for therapies? Not sure this would apply to other things the program covers like dental, medical, etc). -Maybe look at July 1, 2022 as date for trainings/program revisions/hiring people for the program to be completed. -Trainings/working out the bugs take place through December 2022 -Roll out transition by anchor beginning 1/1/2023	
135	4/8/21	sec. 513.3.12 / p 28 CM Agency Staff Qualifications If the 14 hours of CFCM training are required, this should be addressed here. I know that it's on the CFCM section on the website, but that could be missed if not also included here.	No change: By not specifying the number of hours in policy, it allows flexibility to increase or decrease the hours as needed without having to update the policy manual.
136	4/8/21	sec. 513.19.1 / p 118 Documentation This section should specifically address the home visit (DD3) only as this is the documentation required for the billing of the CFCM code. The progress log, as detailed here, implies all of the same requirements of a progress note. It's old language and doesn't apply.	No change: Though the PMPM rate is tied to the monthly home visit, the case management (progress) log is still a requirement for case manager to complete.

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137	4/8/21	sec. 513.19.1 / p 118 Limitations/Caps The language in the first two bullets imply that more Case Management can be needed and purchased. It's old language.	Change: Language revised.
138	4/8/21	sec. 513.19.1 / p 119 Limitations/Caps All of these bullets after the first two apply old language about what the CM cannot bill; however, the CM isn't billing except for the Home Visit. This is old language and is confusing. Although I think that the CM must have strong time management skills, there may be times when they have to wait at a doctor's office - but again, they are not "billing" for this service so I don't think it applies here.	Duplicate (comment 12)
139	4/8/21	sec. 513.19.1/p 119 Limitations/Caps 5th Bullet: Can this be expanded? It includes that the CM cannot compile reports for Social Security. I'd like to see the language include that the CM cannot secure or set up utilities for a member in the IDDW program.	No change: The CM can assist with accessing utilities if necessary.
140	4/8/21	sec. 513.13.1/p 69 Electronic Monitoring 11th Bullet: Can this be clarified to state that it is the Electronic Monitoring provider agency's HRC approval that is the requirement?	Change: Changed language to IDDW "residential service provider."
141	4/8/21	sec. 513.13.1/p 69 Electronic Monitoring 13th and 14th Bullet: The CM is being required to conduct a programmatic review, drill including testing and response time and reports to the IDT any problems. This is an onerous responsibility on the CM who is present in the home once/month. I realize this has been part of this manual, but hasn't been used yet (at least not that I'm aware of). This seems to be something that should be a mandate on the provider agency to ensure the functionality of the system. The CM can inquire about it at the Home Visit and at IPP meetings. But to have the CM being the one responsible to review, drill and report problems seems inadequate. And there is nowhere in the CM qualifications or trainings that this is addressed.	Change: Changed language to reflect that the residential agency should be responsible for testing the system.
142	4/8/21	sec.513.19.1 Change from SC to CM Please ensure that the IPP and changes to this manual are reflected well in the review tool. There have been changes in the past that weren't reflected on the review tool which caused problems with reviews (conflicting or contradictory standards and expectations)	No change

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143	4/8/21	sec. 513.4 Removal of case management case load When appendix K is no longer suspended and travel to and from member homes and day programs are required, there will be a limit based on the availability of days to conduct such visits - meaning a reasonable max. Could the state/CMS see the requirement for monthly home visits be bi-monthly and/or allow continuation of phone contacts instead?	No change: This will be considered with a future amendment to the application.
144	4/8/21	For documentation purposes, we have received many complaints about the requirement from CMS imposing CFCM as it's outlined once Appendix K is no longer suspended. The request is that existing IDDW members be allowed an option of grandfathering in if their choice is to remain with their CM provider agency who may also be their IDDW service provider agency. It could be for members who have been on the IDDW program prior to 2015, or something of that nature.	No change: This is a federal mandate. BMS has asked CMS if there can be exceptions such as grandfathering, and the answer was no.
145		I'm emailing today regarding the proposal to take away the option to purchase therapy services for children under the age of 21. I currently have 2 boys on the IDD waiver program and they both receive OT services through Waiver. I have had one son on the waitlist for over 4 years and the other son on the waitlist for over 2 years for therapy services. I call frequently to see when an evaluation can be scheduled but am told that due to their "chronic" condition of Autism, they put other patients ahead of them. OT over the past several months has been so very beneficial to both of my boys. Both receive OT in school but it's 30 minutes a month and for the past several months it has been done remotely, which has not been effective for either of them. Their current therapist comes every week for an hour to an hour and a half each. The time is structured and utilized very well to help them meet their needs. The nearest therapy facility would be Milestones which is 1 hour and 40 minutes from my house. My husband and I both work full time jobs and it would be impossible for us to take them there weekly and get the same type of therapy that my boys are currently receiving. Also, the therapist coming into the home has been so beneficial. She has been able to see the dynamics of how the family works and all the relationships within	Duplicate (comment 79)

		the home. She has been able to see their strengths and weaknesses within the home and community. Taking the boys to a facility would really limit what the therapist does because it would not be based on in-the-moment observations. These types of observations are key because it's real life, it's not a structured clinical setting. Life is unpredictable and our therapist has been able to help work with the boys to teach them skills to help maneuver and adapt in life.	
146	4/9/21	pg 13 CFCM annual training For the initial training we have to do the components but annually are we required to do the components or can the CM Supervisor/Trainer train from the manual?	No change: The initial training only needs completed once. Annually, training may be conducted from the manual.
147	4/9/21	Financial eligibility We get "dinged" when members are not on Waiver within 7 days of referral yet we can't do anything until they are financially eligible. This sometimes can take months if left up to the parents for various reasons, yet the CM agency is responsible. Wouldn't it make more sense for Kepro to ensure financial eligibility. That would also reduce the amount of unpaid work the CM has to do before members are on the program. Unrealistic expectation.	No change: An Initial IPP meeting, for new program members, must take place within 7 calendar days of: - Acceptance of referral in CareConnection© - Member being marked "active" in CareConnection© The 7 calendar day time period begins with whichever date comes later. Example: Active in CC on 6/1/2020, referral accepted 6/5/2020. The Initial IPP meeting must be conducted by 6/12/2020. Following this timeline will ensure agencies are not "dinged' by the UMC.
148	4/9/21	pg 85 Typo on the top line. It should say EAA but says EEA	Change: Changed "EEA" to "EAA"

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149	4/9/21	pg 116 2nd line-Caser Management should be Case Management	Duplicate (comment 10)
150	4/9/21	sec.513.19.1 Change from SC to CM Please ensure that the IPP and changes to this manual are reflected well in the review tool. There have been changes in the past that weren't reflected on the review tool which caused problems with reviews (conflicting or contradictory standards and expectations)	Duplicate (comment 142)
151	4/9/21	sec. 513.4 Removal of case management case load When appendix K is no longer suspended and travel to and from member homes and day programs are required, there will be a limit based on the availability of days to conduct such visits - meaning a reasonable max. Could the state/CMS see the requirement for monthly home visits be bi-monthly and/or allow continuation of phone contacts instead?	Duplicate (comment 143)
152	4/9/21	For documentation purposes, we have received many complaints about the requirement from CMS imposing CFCM as it's outlined once Appendix K is no longer suspended. The request is that existing IDDW members be allowed an option of grandfathering in if their choice is to remain with their CM provider agency who may also be their IDDW service provider agency. It could be for members who have been on the IDDW program prior to 2015, or something of that nature.	Duplicate (comment 144)
153	4/9/21	"513.2.4 Ensure that a member is not discharged unless a viable discharge/transfer plan is in place that effectively transfers all services that the member needs to another provider(s) and is agreed upon by the member and/or their legal representative and the receiving provider(s)." Provider Agency Certification. This needs revised and the state needs to be designated as the provider of last resort. Individual Providers who determine they can no longer serve an individual should not be made to serve someone who they deem to be a safety risk or determined no longer able to provide quality services.	No change: Technically a member remains with their current agency until the member is successfully transitioned to another agency.
154	4/9/21	"513.2.1.8 Failure of the hiring entity to maintain state and federal background check documentation that all direct access personnel are eligible to work, or employing an applicant or engaging an independent contractor who is ineligible	No change: WV Cares can impose financial penalties. Contact WV Cares for more information.

		to work may subject the hiring entity to civil money penalties." Record Retention What are the civil money penalties.	
155	4/9/21	Section 513.2/Page 13 Provider Enrollment and Responsibilities This statement is no longer accurate based on Policy Clarification Calls as it has been indicated that outpatient services can be provided. Please provide clarification.	No change: Did not clarify statement in question.
156	4/9/21	Section 513.4/Page 30 Reporting Requirements If the case manager contacts the agency and/or resource consultant and 1) does not receive a response prior to the home visit or 2) is informed no incidents occurred since the last home visit, and they are informed at the visit an incident actually occurred-- Who reports this incident in the IMS?	Duplicate (comment 59)
157	4/9/21	Section 513.6.4/Page 38 Slot Allocation Referral and Selection Process A case management agency cannot reach capacity when there is no maximum case load	Duplicate (comment 95)
158	4/9/21	Section 513.6.4/Page 38 Slot Allocation Referral and Selection Process refers to a service coordinator instead of case manager	Change: Changed “service coordinator (SC)” to “case manager (CM)”
159	4/9/21	Throughout the Manual There are several places where Service Coordinator (SC) is still being used instead of Case Manager (CM)	Duplicate (various comments)
160	4/9/21	Pages 41, 91 – 102, and 121 Individual Program Plan, Home-Based Agency Person-Centered Support (Traditional Option), Home-Based Agency Person-Centered Support (Personal Options Model), Licensed Group Home Person-Centered Support (Traditional Option), Unlicensed Residential Person-Centered Support (Traditional Option), Unlicensed Residential Person-Centered Support (Personal Options Model) and Skilled Nursing LPN Person Centered Supports has been interchanged with Participate Directed Supports throughout these pages of the Draft Manual. Please clarify as it results in confusion of these services (Home Based Agency PCS (Traditional Option), Home-Base Agency PCS (Personal Option Model, Licensed Group Home PCS (Traditional Option), Unlicensed Residential PCS (Traditional Option) and LPN Services	Duplicate (comment 97)

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161	4/9/21	Section 513.17.2.2/Page 94 Home-Based Agency PCS (Personal Options)This service title should not include "Agency" since the service is not provided by an agency as directed through PPL.	Change: Removed entire section.
162	4/9/21	Section 513.19.1/Page 117 Case Management Do all Crisis Plans for every member now have to include a plan for a member to go to a crisis site or state institution? Or should this be a separate activity that the Case Manager is responsible for outside of the Crisis Plan?	Duplicate (comment 99)
163	4/9/21	Section 513.19.1/Page118 Case Management The manual states the case manager is to inform the member of their rights in writing at least annually. If there are multiple agencies working with the member, we assume the Case Manager is responsible only for informing the individual of their rights as relates to the case management agency, and not their rights as relates to other services being provided by other organizations. Is that true?	No change: That's correct. The case manager informing the member of their rights in writing annually pertains to the services provided by the case management agency.
164	4/9/21	Section 513.19.1/Pages 118-119Case Management "With PMPM, why is this list of services that cannot be billed needed? Maybe the Case Management log should include these activities? If not, how will the case manager document "non-billable" activities? "	Duplicate (comment 12)
165	Sent 4/8/21 Received 4/14/21 due to verified technical error	Section 513.2, Provider Enrollment and Responsibilities, Conflicts of Interest, page 13: o DRWV was pleased to see the addition to the manual that identifies agency and agency staff serving as landlords as a conflict of interest. However, DRWV feels that clarification is needed to identify if this applies to all agencies or only those providing case management services.	No change: This applies to any agency with exceptions listed in this section.
166	Sent 4/8/21 Received 4/14/21 due to	• Section 513.2.4, Provider Agency Certification, page 23: o DRWV was pleased with the additional prohibitions to electronic communication. Specifically, "Prohibiting using personally identifiable information in text messages and subject lines of emails" and "Prohibiting the	No change: BMS thanks you for your positive feedback.

	verified technical error	use of personally identifiable information in the body of emails unless the email is sent securely through a Health Insurance Portability and Accountability Act (HIPAA) compliant connection".	
167	Sent 4/8/21 Received 4/14/21 due to verified technical error	• Section 513.4, Reporting Requirements: o DRWV is disappointed that the cap on a Case Manager's caseload has been removed. There is a concern that this change will decrease the quality of individualized services that clients need.	Duplicate (comment 71)
168	Sent 4/8/21 Received 4/14/21 due to verified technical error	• Section 513.19.1, Case Management (Traditional Option), Service Unit, page 118: o DRWV remains concerned that the quality of case management services will decrease for the member by moving to a per member/per month rate. There is a concern that the case management agency will bill the monthly rate without providing the additional individualized services that the member needs.	Duplicate (comment 125)
169	Sent 4/8/21 Received 4/14/21 due to verified technical error	• Section 513.27 Transfer, page 136, "An IDDW provider may not terminate services unless a viable IPP is in place that effectively transfers needed services from one IDDW provider to another provider and is agreed upon by the member and/or their legal representative and the receiving provider.": o Although the policy remains unchanged, DRWV submits this comment to highlight its continuing concern about the Bureau of Medical Services' failure to enforce this policy. Violations of this policy result in the unnecessary institutionalization of members and place members at serious risk of institutionalization. IDDW providers in West Virginia routinely violate this policy when they discharge members from their agencies after the member is involuntarily hospitalized. And BMS permits these violations by allowing providers to discharge members without a transition in place to another agency.	No change: Technically a member remains with their current agency until the member is successfully transitioned to another agency.

		When BMS fails to enforce this policy, members often remain involuntarily hospitalized after they are ready for discharge because there are no community services in place. This violates the integration mandate of Olmstead v. L.C., which requires BMS to administer programs, services, and activities in the most integrated setting appropriate to the needs of the member. To avoid discrimination based on disability, BMS must consistently enforce § 513.27 to ensure that no IDDW provider terminates services without a transition plan that is agreed upon by the member, his/her legal representative, and the receiving provider.	