i	Date Received	Status	Comment	BMS Response
1	11/16/2017	No Change	My daughter has been in the Waiver program for 16 years and it has been so beneficial for her independence and learning life skills for her safety. She is in an ISS home of her own and needs 24/7 care for her to live there and for her safety. Any cuts to her budget will affect both her safety and ability to live there. Please do not cut budget on successful programs such as my daughters. Her safety and care are most important and any cuts to her budget would result in an unsafe situation. Thank you for all the support this program offers.	Our goal in implementing the new methodology is not to decrease spending, but to put in place a system that is more understandable and predictable, based on historic spending patterns. For example, an individual living in a 1-person ISS will have an annual budget between $176,731 - $201,402, depending on their individual circumstances. Individuals living in an ISS or group home typically have had higher spending levels compared to members who live with their families, which the new methodology takes into account. Under the new budget methodology, BMS estimates that over 65% of waiver members will receive a budget higher than the amount they spent on services during their 2016 IPP year, and over 87% of waiver members will receive a budget within 10% of their 2016 IPP year spend. Further, if the waiver member believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
2	11/16/2017	No Change	After reading the new way of calculating budgets, my understanding is that calculations will be made by adds-ons addition to base range which is dictated by an individual 's age and living situation. My frustration is with the stop-loss/stop-gain policy. My son has just turned 18 which allows a PCS cap of 8 hours per day. This however would not be reflected in his 2017 budget spend(budget year start September 1,2016-September 1,2017) therefore the 120% of his last year budget would not allow the whole 8 hour cap. So in fact he and any other participant that would fall into this category would be penalized simply because the year of their birth. This seems very unfair. There should be an allowance for circumstances such as this. I have read over documents provided and can not find anything that would address an issue such as this.	The Stop-Loss will not apply to people who move from one set of limits to another because they turn 18, and we have changed the manual to make this clear. The Exceptions Process is outlined in Section 513.25.4.2.
3	11/16/2017	No Change	My concern is that there are no concessions in the budget for increasing supported employment. If a member has a job, there could possibly be some concessions for employment. This is a more expensive service and can easily consume a small budget. Many members take extreme pride in their employment and depend on the funds for their basic needs. They receive smaller SSI checks and no food stamps. Would there be a way to include additional funds for this service? Possibly factor out a section for how much they currently work and at least allow them to keep 80% of their work schedule?	We agree that Supported Employment is an important service for many people, and the budget ranges will allow people to purchase sufficient Supported Employment, along with other direct care. The unit limits for Supported Employment in Section 513.15.4, *Supported Employment (Traditional Option)* have not been changed: The units of Supported Employment available to a person in the current manual equal 2080 hours per IPP year which equates to 40 hours of Supported Employment per week. This is enough hours for a member to have a full-time job.
4	11/16/2017	No Change	This is *expletive*. one year it's cuts the next it's taxed and now the powers that be are robbing waiver to fund methadone clinics and giving addicts the money designated for waiver recipients. Our children didn't make a choice to be this way but the addicts did. We need it back to the 2015 waiver program. Or tax us and return to the old waiver manual. but please quit taking from special needs and waiver patients just because you can.	Our goal in implementing the new methodology is not to decrease spending, but to put in place a system that is more understandable and predictable, based on historic spending patterns.
5	11/16/2017	No Change	To whom it may concern, I am writing this in regards to the new changes that is trying to be passed. My son is 13 years old and requires a lot of assists daily, from brushing his teeth, toileting, bathing, eating, dressing, medications. That is just a short list of some of his needs. With him being a school aged child two years ago he took a cut to his budget with a cap. I never said anything than, but children require as much help if not more than adults. Now we are looking at these new budgets we are hardly making it as it is, yes my son is in school but he has a lot of doctors appointments, a lot of days sick, no job is gonna work around my son's disability. I went to school got a career but I am not able to work at my career do to my son's disability, he can't get his social security because I have a home and car financed in my name.Why don't you all step back and look at Dhhr look at the people getting assistance that can work, let's make cuts to them, not these children with disabilities.	Our goal in implementing the new methodology is not to decrease spending, but to put in place a system that is more understandable and predictable, based on historic spending patterns. Individuals living in an ISS or group home typically have had higher spending levels compared to members who live with their families, which the new methodology takes into account. Under the new budget methodology, BMS estimates that over 65% of waiver members will receive a budget higher than the amount they spent on services during their 2016 IPP year, and over 87% of waiver members will receive a budget that is either higher than their 2016 IPP year spend or no more than 10% below their 2016 IPP year spend. Further, if the waiver member believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
6	11/17/2017	No Change	As a parent of a very low functioning Autistic son, I am hoping that future cuts in his services will not happen. We do not have adequate staff to provide the 24 hr. care as it is now, lower budgets and cuts in services will devastate families providing the level of care that they need. It is impossible for me to work outside the home, on about 4 hours or less of sleep. Please consider what the cuts will do to the care and well-being of already vulnerable people in this state. Look at ways to improve the services and care they need, not how to hurt them, they did not choose to be handicapped.	There are no changes in the service limitations or caps being proposed at this time. Our goal in implementing the new methodology is not to decrease spending, but to put in place a system that is more understandable and predictable, based on historic spending patterns. Waiver members living in an ISS or group home typically have had higher spending levels compared to members who live with their families, which the new methodology takes into account. Under the new budget methodology, BMS estimates that over 65% of waiver members will receive a budget higher than the amount they spent on services during their 2016 IPP year, and over 87% of waiver members will receive a budget that is either higher than their 2016 IPP year spend or no more than 10% below their 2016 IPP year spend. Further, if the waiver member believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
7	11/17/2017	No Change	I believe that with this new budget process, the artificial caps on PCS hours, respite hours, and EAA dollars should be removed and the budget itself and the IPP should control the services that can be purchased.	Our goal in implementing the new methodology is not to decrease spending, but to put in place a system that is more understandable and predictable, based on historic spending patterns. Waiver members living in an ISS or group home typically have had higher spending levels compared to members who live with their families, which the new methodology takes into account. Under the new budget methodology, BMS estimates that over 65% of waiver members will receive a budget higher than the amount they spent on services during their 2016 IPP year, and over 87% of waiver members will receive a budget that is either higher than their 2016 IPP year spend or no more than 10% below their 2016 IPP year spend. Further, if the waiver member believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
8	11/17/2017	No Change	I have major concerns regarding the new proposed methodology for participants in the Waiver program. The impact that it will have on existing services for my participant will have a very negative impact on her physical, emotional, safety, health and community involvement. Her quality of life and overall well-being will never be the same and her not being able to maintain her independent living situation is at risk. Please reconsider the proposed methodology and the huge negative impact that it will have on so, so many participants. Thank you.	There are no changes in the service limitations or caps being proposed at this time. Our goal in implementing the new methodology is not to decrease spending, but to put in place a system that is more understandable and predictable, based on historic spending patterns. Waiver members living in an ISS or group home typically have had higher spending levels compared to members who live with their families, which the new methodology takes into account. Under the new budget methodology, BMS estimates that over 65% of waiver members will receive a budget higher than the amount they spent on services during their 2016 IPP year, and over 87% of waiver members will receive a budget that is either higher than their 2016 IPP year spend or no more than 10% below their 2016 IPP year spend. Further, if the waiver member believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
9	11/19/2017	No Change	We shouldn't be cutting anything from the waiver program. The new changes will be making it more difficult for those with disabilities	There are no changes in the service limitations or caps being proposed at this time. Our goal in implementing the new methodology is not to decrease spending, but to put in place a system that is more understandable and predictable, based on historic spending patterns. Waiver members living in an ISS or group home typically have had higher spending levels compared to members who live with their families, which the new methodology takes into account. Under the new budget methodology, BMS estimates that over 65% of waiver members will receive a budget higher than the amount they spent on services during their 2016 IPP year, and over 87% of waiver members will receive a budget that is either higher than their 2016 IPP year spend or no more than 10% below their 2016 IPP year spend. Further, if the waiver member believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.

10	11/19/2017	No Change	Dear DHHR, Thank you for coming up with the new methodology for determining budgets. But my main concern is that families doing in home supports gets so little to budget with and while I know we are not using this to support our family but we do so much more than babysit our children. We do programs from Sun up to Sun down and purchasing goals and respite. My concern is for my family is that will not be enough in her budget to meet her needs and respite needs. I do believe that we should be equal to and have just as much as group home and institutional settings. We all need to take equally from the pool to make sure my child's budget is met as well as others. Please reconsider the budget amounts because they way it is figured out now we did the math and she will have such a short wind fall and will have to give up many services we are just a family with a 18 year old who has many behaviors and needs many supports but we want to always keep her in home. waiver was designed to keep our families intact and we has always prided itself on helping families with disabilities and keeping families intact. Thank you and pleas consider this comment and please make sure our family's budget is met I fear for my child won't get the services or supports she needs. We already took bad set back when the last manual came out I don't think we can take another one.	Waiver members living in an ISS or group home typically have had higher spending levels compared to members who live with their families, which is why the new budget methodology generally provides more funding for individuals living on their own. However, if waiver members (including members living with their family) believe services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
11	11/21/2017	No Change	DHHR, by the information presented our disabled individual will be losing from $20,000 to $25,000 more in budget under this new plan. The last go round we were forced to take in a roommate. They told us either we take in a roommate or we have to be prepared to pay for or we would have to cover 12 hrs. care. We did this for a bit, but in order to survive my spouse and I have to work. I also have an elderly mother that requires assistance and we are getting up in age. So the last budget after taking in a roommate covers 12 hrs 1:1 and 12 hr 2:1, but half the time there is not enough staffing. Now by this new proposal I am not sure where the additional $20,000 to $25,000 is supposed to come from. Although we may be able to do some care for our disabled individual, the roommate has no family and gets into some responsibility for his care issues that we may be liable for any accidents etc. We can't afford to pay $20,000 to $25,000 and they can't afford not to have 24 hr. care. Neither can either of them work due to their disabilities. I am not sure what in the world those that make these plans are thinking. Shouldn't we continue to take care of the elderly and disabled in a home environment as long as we can. It is cheaper than paying for them to be in a facility. Neither one of the individuals residing in this home would last in a facility, so is that the ultimate goal just to get them off the list. I pray that someone wakes up and realizes that it is cheaper to keep and care for the elderly and the disabled at home. They are happier and better cared for. We were upset and spent months from the last budget cut leading to the mandating of a roommate. At that time we were told ALL IDDW individuals would HAVE to take in a roommate. We were told we had til February to get one, then for a Christmas present we were advised that effective Jan 4 the budget would no longer cover for our individual 24 hr. care. We spent months before we finally found a good compatible roommate. Yet I look around and talk to other who are still residing on their own and have not been mandated to take a roommate and other that went from having a roommate to no roommate. We do not have the desire to make this family home a group home and I do not feel it should be mandated that any individual be mandated to take in more roommates just to get their needs met. Stop and take a good look at what you are proposing... maybe even try it yourself!!! The plan is NOT a good one. I pray you wake up and realize what you are doing to our disabled and elderly. You may be there someday and/or one of your loved ones may be. How would you like them treated?	Our goal in implementing the new methodology is not to decrease spending, but to put in place a system that is more understandable and predictable, based on historic spending patterns. Waiver members living in an ISS or group home typically have had higher spending levels compared to members who live with their families, which the new methodology takes into account. Under the new budget methodology, BMS estimates that over 65% of waiver members will receive a budget higher than the amount they spent on services during their 2016 IPP year, and over 87% of waiver members will receive a budget that is either higher than their 2016 IPP year spend or no more than 10% below their 2016 IPP year spend. Further, if the waiver member believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
12	11/22/2017	No Change	My name is XXX and the mother of XX who is currently receiving benefits from Chapter 513 IDDW. XX has a care giver, XY, who has been such a rewarding and special person in my daughter, XX's life. She helps XX with community activities and development in her home. I retired from a State Agency in October 2015 and went back to work part-time Aug. 22, 2016, to help XX and I meet our financial needs. PLEASE do not cut the benefits she receives from Chapter 513 IDDW. I may have to look for more work if our financial situation gets worse or becomes a burden to pay our bills.	There are no changes in the service limitations or caps being proposed at this time. Our goal in implementing the new methodology is not to decrease spending, but to put in place a system that is more understandable and predictable, based on historic spending patterns. Waiver members living in an ISS or group home typically have had higher spending levels compared to members who live with their families, which the new methodology takes into account. Under the new budget methodology, BMS estimates that over 65% of waiver members will receive a budget higher than the amount they spent on services during their 2016 IPP year, and over 87% of waiver members will receive a budget that is either higher than their 2016 IPP year spend or no more than 10% below their 2016 IPP year spend. Further, if the waiver member believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
13	11/23/2017	No Change	Being directy affected by these constant cuts of services, I often wonder of the people who are on the brink? These arer the people that will have to place adults and children in State run facilities, return to work to buy medicines and food for themselves. This will raise the total care costs by over 200% per individual, and will cause way more harm than good. You may want to cut some of these higher positions in government to help with cost overruns.	There are no changes in the service limitations or caps being proposed at this time. Our goal in implementing the new methodology is not to decrease spending, but to put in place a system that is more understandable and predictable, based on historic spending patterns. Waiver members living in an ISS or group home typically have had higher spending levels compared to members who live with their families, which the new methodology takes into account. Under the new budget methodology, BMS estimates that over 65% of waiver members will receive a budget higher than the amount they spent on services during their 2016 IPP year, and over 87% of waiver members will receive a budget that is either higher than their 2016 IPP year spend or no more than 10% below their 2016 IPP year spend. Further, if the waiver member believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
14	11/30/2017	Change	I recommend posting the actual email address, as the link does not directly open an email to send, but rather prompts a new email account to be created.	When notified of the issue, BMS posted the actual email address for comments and extended the public comment period by one week.
		No Change	I've seen where the Personal Options model is not successful in ISS settings, and I recommend Personal Options no longer be an option for ISS settings. Personal Options should only be available for In-Home settings.	BMS will consider changes to this policy in a future policy update.
		No Change	If someone under Personal Options chooses to switch back to the Traditional Model, there should be a "default" agency (such as the previous service provider or the SC agency, assuming the SC agency provides direct care services) required to provide the staffing services if no other agency will accept the referral to switch back to the Traditional Model.	BMS will consider changes to this policy in a future policy update.
15	12/3/2017	No Change	I would like to know how you came up with the base budget numbers. What makes a person livng on a 1x1 situation have more need then my son who lives in my home? I do not agree with your methodology when it cuts almost 20,000 from my son's budget. I believe that their needs to be changes made before it is put into effect. I'd start with the base numbers being made more fairly even, then look at other things that the child needs. How about someone that doesn't need 24/7 care would need less money then someone who does? Or how many disabilities the client has? There are many other ways that you can rework this methodology before release. I humbly ask you to please reconsider.	Waiver members living in an ISS or group home typically have had higher spending levels compared to members who live with their families, which is why the new budget methodology generally provides more funding for individuals living on their own. However, if waiver members (including members living with their family) believe services in excess of the budget are necessary, they may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.

16	12/5/2017	No Change	To whom it may concern, I have been looking over the revisions, and have attended the training session on the revision. I think I have my mind around most of this. One point that concerns me is, for the lack of a better phrase, the "If you don't use it you loose it". The thing that stands out to me is there seems to be no provision allowed in the Stop Loss/Stop Gain for times that monies my not be spent for reason outside the clients control. Examples of what I am thinking are times when a client may be hospitalized. During these times agency's staff cannot bill at all. That is monies that won't be able to be spent, therefore will be left in the budget. Another example would be when an agency is short staffed an there is no one to be with a client for things like supported employment or other community services. Again, no billing leaves money on the table to be cut the following year. These are just a couple examples of which I am sure there are others, that are completely out of the clients control. How is it right to penalize their budgets for such reasons? Will there be considerations written in for these types of situations? How will will we know?	When circumstances occur beyond the person's control (hospitalizations, etc.) and monies are not spent that were allocated, then that will be considered during the Exceptions Process. If the waiver member believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
17	12/8/2017	No Change	Section 513.2 If all agency staff leave while the freedom of choice form is discussed, you will need to put procedures in place for member's with communication difficulties who do not have guardians or whose guardians do not attend.	In this situation, the team should address how informed consent can be obtained for invididuals who cannot commnicate their wishes/choices.
		Change	There is a statement "The reporting periods will be based on the quarter during which the provider's on site review takes place on a defined cycle and will be communicated to provider via email." This statement also appears in the current manual, but all agencies currently submit all the staff who worked during the previous year by the a date in January of the following year. Unless you are planning to change the method, you should probably modify this to the current methods.	The policy manual has been changed to include this language in Section 513.2.3.6: IDDW agencies are required to submit evidence to the UMC every year to document continuing compliance with all certification requirements as specified in this manual. This evidence report must include a signed attestation from an appropriate official of the provider agency (e.g. Executive Director, Board Chair, etc.). The report may be sent from a provider's HR system, as an excel spreadsheet or other report that includes all applicable fields and documents the employee's training dates. This form must be submitted electronically to the UMC. This self-review tool allows providers to incorporate into their Quality Assurance and Improvement processes a method to ensure quality services occur and CMS Quality Assurances are met. Each provider will be required to submit a self review annually. The exact due date will be communicated to the provider at least two months prior to the due date.
		Change	Section 513.4 The previous requirement of 48 hours to get an incident in IMS was difficult for multi-county locations, where it may take a day or two to get an incident to the office to be entered into IMS. There are various issues that can hold up incident reports being entered. A 24 hour time frame probably would not be an issue if when you have all your members clustered in a small area, but for areas where there is travel difficulties, it would be almost impossible. Will the new IMS allow us to edit incidents so that we can put a general idea of what the incident is and amend it once the incident report is received?	This statement has been added to the policy manual in Section 513.4: All incidents must be entered into the WV IMS within 24 hours of the provider becoming aware of the occurrence. If the provider becomes aware of the incident on a weekend or holiday, it is acceptable to enter the incident the following business day. NOTE: The incident is able to be edited for up to two weeks following the first entry. This is sufficient time for the IDDW provider to amend the original entry once the incident report or more information is received.
		No Change	Section 513.17.4.1 If this is an unlicensed site, and the member has chosen where they want to live, why do all the members in the home have to receive services from the same residential provider?	When more than one residential provider serves the same site, then by default, that means each person residing in that site is receiving the highest level of services (1:1), which may not be what is needed and would result in higher cost. It is impossible for a lower ratio of staff to person to be utilized when more than one agency is providing the residential service. People may reside together and have different service coordinators, different day services providers, different Behavior Support Professionals, but must have the same residential provider.
		Change	If an LPN is performing a duty that is within their scope of practice, they should be able to bill the LPN code for that service.	This change has been delayed until July 1, 2018 or the individual's next anchor date, whichever is later. When this becomes effective, if the duty is also something that can be performed by an AMAP, then it must be performed using the least costly method. Waiver nursing (LPN and RN) does not include services delegated in accordance with and can be performed by individuals who are AMAPS as defined in W. Va. CSR § 64-60-1 et se4q.; or for visits performed for the sole purpose of meeting the supervisory requirements for LPNs or AMAPs at the direction of an RN. Agencies can still utilize LPNs to pass medications, but must not bill the LPN rate unless it is medication that ONLY an LPN can pass.
		No Change	There is a basic problem with the starting point of the budget development. If you base the budget on paid claims, the budget becomes artificially deflated because of the previous budget cuts that have occurred. Those previous budget cuts limited or eliminated services that could have been provided (or were provided without any reimbursement).	DHHR believes the 2016 IPP year is a sound and reasonable year on which to base the new budgets.
18	12/11/2017	No Change	The changes made to this program will have a negative impact on my son. The money taken from his budget will keep him from the programs and services he needs. He will not be in his least restrictive environment. This will not only effect our family but all those in the program. These individuals need all the assistance they can get,,,,not another cut and set back!!!!	Our goal in implementing the new methodology is not to decrease spending, but to put in place a system that is more understandable and predictable, based on historic spending patterns. Waiver members living in an ISS or group home typically have had higher spending levels compared to members who live with their families, which the new methodology takes into account. Under the new budget methodology, BMS estimates that over 65% of waiver members will receive a budget higher than the amount they spent on services during their 2016 IPP year, and over 87% of waiver members will receive a budget that is either higher than their 2016 IPP year spend or no more than 10% below their 2016 IPP year spend. Further, if the waiver member believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
19	12/11/2017	Change	Program Description Policy Verbiage: There is one Participant-Directed Financial Management Services available to assist persons with self-directing these services: Personal Options Model. Comment: Language is confusing. Suggested Language, if applicable: Personal Options is BMS' one Participant-Directed Financial Management Services Model available to assist persons with self-directing their services.	This section has been changed.
		Change	513.2 PROVIDER ENROLLMENT AND RESPONSIBILITIES - Conflicts of Interest (2nd Paragraph) |To ensure complete impartiality, the Service Coordinator and other agency personnel, with the exception of the legal representative of the member being assessed or the Specialized FamilyCare Provider, will be excused when the Freedom of Choice form is completed during the annual functional assessment. | Comment: "person" being assessed, Family Care should be two words	This has been corrected in the policy manual
		Duplicate	513.2.3.6 Self-Reviews | IDDW agencies are required to submit evidence to the UMC every year to document continuing compliance with all certification requirements as specified in this manual. | Comment: with 513.2.3.6 Self-Reviews | The report may sent from a provider's HR system, an excel spreadsheet or other report that includes all applicable fields and documents the employee's training dates. | Comment: "The report may be sent."	The policy manual has been changed to include this language: IDDW agencies are required to submit evidence to the UMC every year to document continuing compliance with all certification requirements as specified in this manual. This evidence report must include a signed attestation from an appropriate official of the provider agency (e.g. Executive Director, Board Chair, etc.). The report may sent from a provider's HR system, an excel spreadsheet or other report that includes all applicable fields and documents the employee's training dates. This form must be submitted electronically to the UMC and must be an electronically searchable document, in other words, it cannot be in pdf format. This self-review tool allows providers to incorporate into their Quality Assurance and Improvement processes a method to ensure quality services occur and CMS Quality Assurances are met. Each provider will be required to submit a self review annually. The exact due date will be communicated to the provider at least two months prior to the due date.

		Duplicate	Currently, all self-reviews are due at the same time (early in the calendar year). Are you changing this to a cyclic due date per provider? We ask that you consider leaving it as-is. | Suggested Language: All agency self-reviews will be due as defined by BMS. The UMC will communicate the due date in advance, and self-reviews will typically be due within the first two weeks of the calendar year.	The policy manual has been changed to include this language: IDDW agencies are required to submit evidence to the UMC every year to document continuing compliance with all certification requirements as specified in this manual. This evidence report must include a signed attestation from an appropriate official of the provider agency (e.g. Executive Director, Board Chair, etc.). The report may sent from a provider's HR system, an excel spreadsheet or other report that includes all applicable fields and documents the employee's training dates. This form must be submitted electronically to the UMC and must be an electronically searchable document, in other words, it cannot be in pdf format. This self-review tool allows providers to incorporate into their Quality Assurance and Improvement processes a method to ensure quality services occur and CMS Quality Assurances are met. Each provider will be required to submit a self review annually. The exact due date will be communicated to the provider at least two months prior to the due date.
		Change	513.5 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS - Specific Requirements | All IDDW Program forms as applicable to the policy requirement or service code requirement. | Comment: Not a complete sentence, when most other bullets are.	The first two bullets in Section 513.5 under Specific Requirements have been combined into one bullet to read: • Each IDDW provider is required to maintain all required IDDW documentation on behalf of the State of West Virginia and for state and federal monitors, including all IDDW Program forms as applicable to the policy requirement or service code requirement.
		Change	513.5 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS - Specific Requirements | Agencies that wish to computerize any of the forms may do so, however once the automated IPP becomes available through CareConnection® it must be utilized by all agencies. | Comment: CareConnection© has a copyright symbol, not a registered trademark.	Throughout the manual the phrase CareConnection© has been changed to UMC web portal.
		Change	Typically, BMS refers to a vendor's system generically, and not by name.	Throughout the manual the phrase CareConnection© has been changed to UMC web portal.
		Change	513.5 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS - Specific Requirements | The original physical copy of the annual assessment completed by the person, his/her guardian and/or his/her IDT. Once the annual assessment is completed, and the person or his/her guardian has signed the document attesting to its accuracy and completeness, it will be the duty of the Service Provider to ensure that the document is not altered, copied, or distributed in any manner. However, the Service Provider must make the original physical copy annual assessment available to the person, his/her guardian and his/her IDT at the Service Provider's offices, upon request, to review only. | Comment: 1. The first in the paragraph is an incomplete sentence. 2. This bullet is not clear. BMS wants them to maintain the ICAP but not wanting to say "ICAP" in case the assessment to which BMS is referring changes in the future. "Annual Assessment" has always referred to all assessments completed, ICAP, ECA, ABAS-2, Structured Interview, etc. Providers will only actually be keeping the ICAP (it's the only one the UMC will bring a hard copy of). 3. What about providers who maintain completely electronic member records? Will they have to start a physical record to keep the ICAP? What are BMS's expectations in this situation?	This bullet has been changed to: The original physical copy of the ICAP assessment completed by the person, his/her legal representative and his/her IDT. Once the ICAP assessment is completed, and the person or his/her legal representative has signed the document attesting to its accuracy and completeness, it will be the duty of the Service Coordination provider agency to ensure that the document is not altered, copied or distributed in any manner. However, the Service Provider must make the original physical copy of the ICAP assessment available to the person, his/her legal representative and his/her IDT at the Service Coordinator's office, upon request, to review only. The Service Coordinator provider agency may store the document electronically but must be able to make the document available to review upon the request of the person or their legal representative.
		Change	513.8 INDIVIDUAL PROGRAM PLAN (IPP) | The content of the IPP must be guided by the person's assessed needs, wishes, desires, and goals but the requested services cannot exceed the person's individualized budget. If the member and/or the team believes that the member requires services in excess of the individualized budget, the team may list those additional services in the separate section of the IPP set aside for this purpose. However, in order for the member to begin receiving any services under the IPP, the service coordinator must submit a list of services that can be purchased within the member's individualized budget | Comment: Change "member" to "person."	Throughout the manual, the word member has in most places been changed to person.
		Change	513.8 INDIVIDUAL PROGRAM PLAN (IPP) | Comment: 1. This section states ALL IPPs must be uploaded to CC however there is confusion since memo from 05/11/16 states only IPPs with changes need uploaded. 2. Does BMS want to add the current requirement that IPPs include the names of certain staff persons (such as the Respite provider, etc.) on the IPP? 3. It is currently required that the tentative schedule include both paid and unpaid supports. Does BMS want to include this clarification in the manual? 4. Pertaining to the requirement to upload the IPP in the UMC's web portal, BMS may wish to clarify current procedures by stating "If a finalized IPP needs any changes, the team must complete an addendum IPP to reflect those changes before service requests can be considered."	Language was added to clarify that all IPPS should be uploaded into the UMC web portal, that names of all known Respite workers be added, that tentative schedules should include both paid and unpaid supports and that an addendum IPP be uploaded once services are finalized. 1. It is a current requirement in the policy manual (section 513.8) that "All IPPs must be uploaded into the UMC web portal and disseminated to all team members within 14 days.....". 2. A bullet has been added to read: The names of individuals providing PCS Family, In-Home Respite and Out-of-Home Respite (both Traditional and Personal Options) 3. A bullet has been added to read: Tentative Weekly Schedule (including both paid and unpaid supports and any other programs provding any type of serivce, i.e. Personal Care, Private Duty Nursing, etc.) 4. This sentence was also added to this section: IF a finalized IPP needs any changes, the team must complete an addendum IPP to reflect those changes before service requests will be considered.
		Change	513.9 DESCRIPTION OF SERVICE OPTIONS | ...information into the CareConnection® within two business days of receipt… | Comment: CareConnection© has a copyright.	The term CareConnection© has been replaced with UMC web portal.
		Change	513.9.2 Participant-Directed Service Option | Both Family Person-Centered Support: Personal Options and Transportation Miles: Personal Option monies | Comment: "Personal"	This has been corrected in the policy manual
		Change	513.9.2 Participant-Directed Service Option | Family Person-Centered Supports: Personal Options or to Transpiration Miles: Personal Options, nor may any… | Comment: "Transportation Miles."	This has been corrected in the policy manual
		Change	513.14.1 Environmental Accessibility Adaptations Home (Traditional Option) | Appliances of any kind (kitchen, bathroom, etc.) are not allowed unless the appliance is specifically adapted/modified to meet the member's need. Just being Americans with Disabilities Act (ADA) compliant is not sufficient to meet this requirement. | Comment: 1. "appliance" 2. Suggested language change: "Appliances of any kind (kitchen, bathroom, etc.) are not allowed unless the appliance is specifically adapted/modified to meet the member's need. Appliances compliant with the Americans with Disabilities Act (ADA) is not sufficient to meet this requirement."	1. This typograhical error has been corrected in the policy manual. 2. This language has been added to the manual: Appliances of any kind (kitchen, bathroom, etc.) are not allowed unless the appliance is specifically adapted/modified to meet the person's need. Appliances compliant with the American Disabilities Act (ADA) is not sufficient to meet this requirement
		Change	513.15.1 Facility-Based Day Habilitation (Traditional Option | This service will only be available for three years following the implementation date of this manual and upon purchase of this service in the UMC portal for the individual receiving services. | Comment: Is this statement still applicable since CMS has issued clarification about timeline?	This has been corrected in all places in the manual to remove the three year restriction.
		Duplicate	513.16.1 Goods and Services (Participant-Directed Option, Personal Options Model) | Comment: 1. "appliance" 2. Suggested language change: "Appliances of any kind (kitchen, bathroom, etc.) are not allowed unless the appliance is specifically adapted/modified to meet the member's need. Appliances compliant with the Americans with Disabilities Act (ADA) is not sufficient to meet this requirement."	1. This typograhical error has been corrected in the policy manual. 2. This language has been added to the manual: Appliances of any kind (kitchen, bathroom, etc.) are not allowed unless the appliance is specifically adapted/modified to meet the person's need. Appliances compliant with the American Disabilities Act (ADA) is not sufficient to meet this requirement
		Change	513.25.4.2 Service Authorization Process | Once the person's budget has been calculated, the member will receive a notice each year that sets forth the member's individualized budget for the IPP year and an explanation for how the individualized budget was calculated. | Comment: Change "member" to "person."	Throughout the manual, the word member has in most places been changed to person.

		Change	513.25.4.2 Service Authorization Process | The UMC, the person, the legal representative, the service coordinator, and any other members of the IDT that wish to be present will attend the annual assessment. The UMC will work with the person and his or her team to complete three forms: the Inventory for Client and Agency Planning (ICAP), the Adaptive Behavior Assessment System II (ABAS II) and the Structured Interview.	The abbreviations of the assessments have been spelled out in the policy manual.
		Change	513.25.4.2 Service Authorization Process | IPP that is within budget and otherwise compliant with DHHR policies (e.g., all services are within the service-specific caps), DHHR will approve the IPP and authorize services consistent with the IPP. | Comment: Should this say "DHHR or their designated UMC"	This change has been made in the policy manual.
		No Change	2. Is it BMS's intent to change from 60 days to 14 days to report an issue?	Yes. Fourteen days is sufficient for the person or the legal representative to notify the UMC if they believe that a technical error was made in the person's assessment (e.g., a typographical error on the assessment); or there has been a change in circumstances since the assessment that is documented pursuant to a Critical Juncture Meeting under Section 513.8.1.4.
		Change	3. The UMC will now know if the provider submits a redetermination request in the web portal – "attach documents" function issues no notification to the UMC. They're going to have to call or email UMC to notify of a request.	In Section 513.25.4.2 the sentence has been changed to this: Within 14 days of receiving a budget, if the person or their legal representative believes that a technical error was made (e.g., a typographical error on the assessment); or there has been a change in circumstances since the assessment that is documented pursuant to a Critical Juncture Meeting under Section 513.8.1.4, then the person or their legal represtative will direct the Service Coordinator to notify the UMC.
		No Change	513.25.4.2 Service Authorization Process | If the UMC determines there was a technical error in the assessment or in applying the budget methodology, or if a Critical Juncture Meeting is warranted the UMC may re-calculate the budget. If the UMC finds in a redetermination that a documented change pursuant to a Critical Juncture Meeting under Section 513.8.1.4 of this manual has occurred, and that, as a result, the person's budget should be increased, the UMC should as soon as possible send this finding to BMS with a recommendation for the budget increase. BMS will make the final determination as to whether the person's individualized budget should be increased. | Comment: 1. How does the Critical Juncture process tie in here? The UMC has not historically recalculated a budget because a person's needs change mid-service year - that's the whole point of a critical juncture (a critical juncture - as defined for many years - could mean they switched day hab setting, for example). 2. Would the UMC only notify BMS if there was a CJ and not when there was a technical error or error in applying the budget methodology?	If a person has a change in need that necessitates an increase in their services, then the Service Coordinator should convene a Critical Juncture meeting and document the change and need for additional services which would result in a request to the UMC. 2. The UMC should notify BMS if there is a need for an increase in the budget due to a documented need.
		Change	513.25.4.2 Service Authorization Process | ...a person will have the ability to appeal the denial of a request for an exception through a Medicaid Fair Hearing… | Comment: This reads like BMS might deny requests for exception. Should probably be reworded to: "will have the ability to appeal the denial of an exception through...."	This sentence has been changed to: As stated in the Letter of Denial, a person will have the ability to appeal the decision made through the Exceptions Process by requesting a Medicaid Fair Hearing.
20	11/12/2017	No change	The following are our comments for the changes in the IDD Waiver to the current manual:1. I do not agree with the caps still being in place. It undermines the entire IDT process.	There are no changes in the service limitations or caps being proposed in this manual change.
		No Change	2. I do not agree with services being based on where the member lives, not their need.	Waiver members living in an ISS or group home typically have had higher spending levels compared to members who live with their families, which is why the new budget methodology generally provides more funding for individuals living on their own. However, if waiver members (including members living with their family) believe services in excess of the budget are necessary, they may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
		No change	3. More efforts are being made to build high level administration instead of direct care to the member, (Kepro, DHHR, etc.)	Our goal in implementing the new methodology is not to decrease spending, but to put in place a system that is more understandable and predictable.
		No Change	4. Some school based members are on home bound instruction due to their level of care and should be given special exception for respite and direct care services.	The IDDW program cannot substitute for free and appropriate education services available to all children eligible for public education. In addition to waiver services, medically fragile children qualify for-Private Duty Nursing and/or Personal Care Services through the Medicaid State Plan Services, if they meet the medical criteria for such services.
		No Change	5. Second level negotiations should include non-DHHR employees who can give non-biased opinion.	If the person or their legal representative disagrees with the decision, they will have the ability to appeal the decision made through the Exceptions Process by requesting a Medicaid Fair Hearing. The hearing officer will apply the same standard applied by BMS's exceptions process panel, i.e., whether the person has met his or her burden of showing that services in excess of the individualized budget are necessary to avoid a risk of institutionalization.
		No Change	6. No exception to the IPP budget is mentioned. Are there exceptions and what are they?	If the person receiving Waiver services believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
		No Change	7. Under section 513.5, why can't the guardians have a copy of the annual assessment once it has been completed? This document affects the annual budget but more over affects their lives.	The service coordinator will keep the ICAP assessment in the person's clinical chart and the legal representative may review it at any time. Kepro and the company that owns the ICAP has prohibited BMS from sharing it, citing copyright infringement laws.
		No Change	8. Under Section 513.8, the caps prevent utilizing the budget to the fullest extent. Some members do not have natural supports and most of the members have very little unpaid supports.	Our goal in implementing the new methodology is not to decrease spending, but to put in place a system that is more understandable and predictable, based on historic spending patterns. Waiver members living in an ISS or group home typically have had higher spending levels compared to members who live with their families, which the new methodology takes into account. Under the new budget methodology, BMS estimates that over 65% of waiver members will receive a budget higher than the amount they spent on services during their 2016 IPP year, and over 87% of waiver members will receive a budget that is either higher than their 2016 IPP year spend or no more than 10% below their 2016 IPP year spend. Further, if the waiver member believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
		No Change	9. Under section 513.14.1, only items that are not covered are listed. What items are covered? I believe you will find that the more necessary assessed items that are needed to a member are not covered than ARE covered. Also, contractors who provide the adaptions and modifications do not want to wait for their money.	BMS will consider addressing this in a future update. Contractors are paid in a timely manner if all documentation is attached to the request.
		No Change	10. Under 513.17.4.1, where is the Freedom of Choice when a member cannot make the choice of who provides their services just because of where they live?	When more than one residential provider serves the same site, then by default, that means each person residing in that site is receiving the highest level of services (1:1), which may not be what is needed and would result in higher cost. It is impossible for a lower ratio of staff to person to be utilized when more than one agency is providing the residential service. People may reside together and have different service coordinators, different day services providers, different Behavior Support Professionals, but must have the same residential provider.
		No Change	11. Under 513.18.1.2, while a member is in school or facility based program is the time the primary caregiver is making appointments, getting supplies, placing equipment orders, working (or trying to) etc., so this is not respite. It is demeaning to caregivers to make that statement.	The time the primary caregivers takes away from the stress of caregiving is considered a form of unpaid respite for that primary caregiver because the caregiver is not responsible for the person during that time.
		No Change	12. Under 513.25.4.2, a clear and concise process to define and link to the Fair Hearing process is needed. A law degree would be needed to navigate this maze.	The person's service coordinator will receive training in the new budget methodology and will be available to provide assistance and support. People, families and legal representatives will also receive training in the new budget methodology. All trainings will be placed on the BMS website for future reference.
		No Change	13. With the stop/gain in place, there is the potential for a zero dollar budget in everyone's budget. Even with add-ons, the members budgets are going to be decreased because of where they live and who with.	No member will receive a "zero dollar budget" under the new methodology. Our goal in implementing the new methodology is not to decrease spending, but to put in place a system that is more understandable and predictable, based on historic spending patterns. For example, an individual living in a 1-person ISS will have an annual budget between $176,731 - $201,402, depending on their individual circumstances. Individuals living in an ISS or group home typically have had higher spending levels compared to members who live with their families, which the new methodology takes into account. Under the new budget methodology, BMS estimates that over 65% of waiver members will receive a budget higher than the amount they spent on services during their 2016 IPP year, and over 87% of waiver members will receive a budget within 10% of their 2016 IPP year spend. Further, if the waiver member believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.

21	12/14/2017	No Change	1. My main concern is about the new methodology of determining individual budgets. I understand that there is a limited amount of money and there needs to be ways to address spending. However, my son requires 24 hour one to one care. He cannot have a roommate because of his OCD behaviors (that will not specifically elaborate on), but would not allow another individual with special needs to have any level of privacy, access to possessions, in addition to physical and emotional wellbeing concerns. So, 24 hour care costs at $20 per hour = $175, 200. Even with "add owns" I am concerned that his basic needs for BSP will exceed the budget range.	BMS recognizes that individuals living alone typically have had higher spending levels compared to people who live with roommates, and the new methodology takes this into account. For example, an individual living in a 1-person ISS will have an annual budget between $176,731 - $201,402, depending on their individual circumstances. In addition, if the person receiving IDDW services believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process.
		No Change	2. I have consulted with nationally known behaviorist, Dr. James Ball, on several occasions, and he admits that my son's behaviors are extreme in intensity and duration, dangerous and developed very late in his life, which is unusual even for autism. With BSP services the behaviors may lessen and particular behaviors may almost disappear, yet a new behavior will develop and present problems. My son will always need intense BSP services. I wish I had a specific way to suggest how to address this unique budget issue. My main concern is that there may need to be a "panel" or some other way to address possible budget increases for individual needs that are challenging and unusual. On the positive side, I do believe that a budget range and the "add-ons" is a more transparent way to determine budgets based on the individual's living setting. I think before it was more of a "mystery" and parents were left wondering. This at least gives a baseline for people to see how the budgets are determined.	BMS agrees that a panel is helpful to address individual circumstances that might not be sufficiently served by the funding provided by the budget. Under the new system, if a person receiving IDDW services believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process; these Exceptions Process requests will be evaluated by a three-person panel. If the person receiving IDDW services does not agree with the decision of the Exceptions Panel, then the person still has the option of filing for a Medicaid Fair Hearing and the case will be heard by an impartial hearing officer employed by the Board of Review. Although the Board of Review is an arm of DHHR, this entity functions totally independent of the Bureau for Medical Services.
		No Change	3. I would like to see cost savings in other areas. I will mention it here again (even though I have written legislators on 2 different occasions with no responses) that my son requires incontinent supplies. I could buy them at Walmart for approximately $90 per month, yet the delivery service currently used by Medicaid costs $180 per month. I would like to be issued some kind of a card (only good for pullups) that I could use. This would result in a savings of $1080 per year. My son is not the only client who needs these. If only 1,000 people on Waiver needed incontinent supplies this would amount to over $1 million dollars in savings per year. This would be where I would start to find a cost savings. The Waiver program is a blessing and a safety net for our most vulnerable citizens. Thank you for the opportunity to comment and for all the hard work everyone does to help our family members with challenging special needs to be included in the community and cared for.	3. This suggestion is outside the purview of the IDDW program, but your comment has been shared with the Durable Medical Equipment Unit.
22	12/15/2017	No Change	Section 513.3.17: We have a lot of staff that live in Ohio and Ohio does not require inspection stickers on vehicles so what would be required? Also If staff are only transporting in a company van (and the company carries the insurance on the van) is a valid driver's license all that is needed?	Policy states that any staff person who provides transportation services must abide by local, state, and federal laws regarding vehicle licensing, registration and inspection. If a staff person is only transporting in a company van, then the valid driver's license must be on file in their personnel record.
		Duplicate	Section 513.4: Some consideration in meeting the 24 hour requirement over weekends and holidays is requested, as not all agency staff have access to the WV IMS. This could require certain employees consistently working weekends and holidays.	This statement has been added to the policy manual: All incidents must be entered into the WV IMS within 24 hours of the provider becoming aware of the occurrence. If the provider becomes aware of the incident on a weekend or holiday, it is acceptable to enter the incident the following business day. NOTE: The incident is able to be edited for up to two weeks following the first entry. This is sufficient time for the IDDW provider to amend the original entry once the incident report or more information is received.
		Duplicate	Section 513.5: Several guardians reside out of state and do not participate in the annual assessments---How will their signatures be obtained or do they now have to attend all annual assessments? Will final assessment results be available at the end of the annual assessment for signatures to be obtained attesting to its accuracy and completeness? How would the Service Provider maintain the original/signed copy when the only form of medical records is electronic? Several individuals have dual agencies who need to access the annual assessment information to complete additional assessments to develop programing. How are these professionals to access these results without being provided a copy?	This statement has been added to the policy manual: If the person has a legal representative that is not in attendance, the legal representative must sign the Freedom of Choice within 10 days.
		No Change	Section 513.15.4: Can this change be reconsidered? It restricts individuals who are not able to obtain employment in the community. Their supportive employment opportunities will be eliminated with this change.	Supported Employment has always had the site of service as being the local public community, this is not a change. It is a clarification because some IDDW providers were providing this service on their site which is not the local public community.
		Change	Section 513.20.1: OHFLAC does not allow AMAPs to administer medications in Day Treatment sites. Can an LPN bill the LPN code when doing a med pass at a Day Treatment program?	Clarification was received from OHFLAC that both LPNs and AMAPs can med pass at a licensed Facility Based Day Habilitation site. The policy manual has been changed to continue to allow an LPN to bill for a med pass at a licensed Facility Based Day Habilit
		No Change	513.25.4.2: Must legal representatives now attend all annual assessments? If they do not attend, do they forgo their right to question the accuracy of the answers? Can other team members question the accuracy of the answers? What will the person or their legal representative review during the assessment to verify the answers were recorded accurately?	In the current manual, it is the responsibility of the legal representatives to attend annual assessments (Section 513.25.2); this has not a proposed change. The person or their legal representative will have the opportunity to sit next to the KEPRO staff inputting the answers into the computer while someone else scores the hard copy of the ICAP. The member or the legal representative may review the paper copy upon request to the service coordinator who can also allow the person or the legal representative to review the cumulative scores entered into the UMC web portal.
		No Change	513.25.4: Budget Methodology: Will this notice be uploaded to CareConnection?	Yes, this is the annual budget letter that is sent to the person/legal representative and uploaded into the UMC web portal for Service Coordinator's review and use.
		Change	513.25.4: Exceptions Process: Will there be revisions to the current DD5 form to accommodate this change? (i.e. a new section reflecting all the additional services the consumer or his/her legal representative believes the person needs)?	A new IPP form will be available by May 1, 2018, however, each agency may use their own form as long as it contains all required components.
		No Change	513.25.4: Can Service Coordinators still complete the exceptions process request form and submit the supporting documentation to BMS?	The Service Coordinator may assist the person or their legal representative in completing the form and submitting the supporting documentation.
23	12/15/2017	Change	Section 513.15.1/p65: this service will only be available for three years following the implementation date of this manual and upon purchase of this service in the UMC portal for the individual receiving services- this service cannot be limited to 3 years for some consumers.	This has been corrected in the policy manual.
		Change	513.20.1/p106: this service can only be used for activities that require a nurse to complete according to the WV Nurse Practice Act, however, any medication administration and performance of health care maintenance tasks as described in W. Va. CSR §64-60-1 et seq. should be provided by a trained Approved Medication Assistive Personnel. There is a push from the State to use AMAPs and there will be psychiatrists who will not give orders for the use of AMAPs. Because a physician's order is required, the push to use AMAPs may violate AMAP rule 7.1.c.4.d. It will also present financial strain to agencies for AMAPs to be reimbursed the same as non-AMAP staff due the required level of training.	This change has been delayed until July 1, 2018 or the person's next anchor date, whichever is later. If the duty is also something that can be performed by an AMAP, then it must be performed using the least costly method. Waiver nursing (LPN and RN) does not include services delegated in accordance with and can be performed by individuals who are AMAPS as defined in W. Va. CSR § 64-60-1 et se4q.; or for visits performed for the sole purpose of meeting the supervisory requirements for LPNs or AMAPs at the direction of an RN. Agencies can still utilize LPNs to pass medications, but must not bill the LPN rate unless it is medication that ONLY an LPN can pass.
		Duplicate	513.2.3/p19: The 100% personnel file review should be a representative sample just as it is for the KEPRO reviewers.	KEPRO uses the self-review that is submitted to pull a representative sample which is 10% of all employees or a minimum of 2 files personnel files for the on-site review.
24	12/15/2017	Change	§513.25.4.2 Service Authorization Process, subpart Redetermination Requests**.** DRWV has noted that individuals who disagree with assessed budgets are required to submit a redetermination request within fourteen (14) days of receiving a budget. The UMC then reviews the request to determine if an error was made, however no timeline is prescribed by the current process for the UMC to return their assessment to the beneficiary. Failure to provide a timeframe may result in undue delay in receiving appropriate services. Failure to require a timeframe may also negatively infringe upon a beneficiary's right to a Medicaid Fair Hearing and a final determination within a reasonable amount of time. DRWV proposes that the UMC be required to make a determination within twenty (20) days of receipt of the Redetermination Request.	This suggestion has been added to the policy manual but noted that a decision will be made within 20 business days after the UMC has received a redetermination request.

		Change	513.25.4.2 Service Authorization Process, subpart Exceptions Process. Once a redetermination request has closed, a beneficiary may pursue the exceptions process. However, again there is no prescribed timeframe for submitting a request for services in excess of the budget. Further, once a request is made to BMS for review via the exceptions process, BMS is under no prescribed timeframe to render a decision. This may cause undue delay in accessing necessary services and may also negatively infringe upon a beneficiary's right to a Medicaid Fair Hearing and a final determination within a reasonable amount of time. DRWV proposes that BMS be required to provide a decision within twenty (20) days of receipt of a request for Exceptions Process Review.	This suggestion has been added to the policy manual but noted that a decision will be made within 20 business days after the Exceptions Panel has received submission explaining the basis for the exceptions request with any/all supporting documentation.
		No Change	§513.25.4.2 Service Authorization Process, subpart Budget Methodology. While DRWV understands the need for a clear metric to establish beneficiary budgets and does not disagree with the "Stop/Gain" ratio, DRWV is concerned that capping the "Stop/Loss" ratio at 80% of a beneficiary's actual spend could result in the Exceptions Process being overwhelmed or in beneficiaries not being able to access services that they need to remain safe in the community.	Based on DHHR's actuaries' analysis, only a small percentage of people in the waiver will have budgets that are equal to or less than 80% of their 2016 IPP year spend. Further, DHHR is preparing for a large number of requests for exception requests, particularly in the first year of the new system; we do not believe the Exceptions process will be overwhelmed. As you note, the Exceptions Process will create an avenue for people requesting services in excess of their budget, including people impacted by the Stop Loss.
25	12/18/2017	Duplicate	513.25.4.2 States that if the DD2 is not completed at the functional assessment, it is the responsibility of the service coordinator to obtain the signature of the legal representative prior to or at the annual	This statement has been added to the policy manual: If the person has a legal representative that is not in attendance, the legal representative must sign the Freedom of Choice within 10 days.
		Change	513.3.17 Proof of insurance, inspection and registration should not be required if staff are not using their personal vehicle, and only provide transportation in an agency vehicle.	This has been changed to read: In addition to meeting all requirements for IDDW Staff in Sections 513.2 - 513.2.1, the provider is required to maintain documentation that agency staff providing transportation services have a valid driver's license. If a personal vehicle is used, the provider must maintain documentation of proof of current vehicle insurance, inspection, and registration. Staff must also abide by local, state, and federal laws regarding vehicle licensing, registration, and inspections.
		Duplicate	513.4 24 hours needs to be clarified as to if this is a straight 24 hours or 24 business hours. There are incidents that occur on the weekend when the staff that enters incidents into IMS are not working, limiting the ability to enter incidents within 24 hours.	This statement has been added to the policy manual: All incidents must be entered into the WV IMS within 24 hours of the provide becoming aware of the occurrence. If the provider becomes aware of the incident on a weekend or holiday, it is acceptable to enter the incident the following business day. NOTE: The incident is able to be edited for up to two weeks following the first entry. This is sufficient time for the IDDW provider to amend the original entry once the incident report or more information is received.
		No Change	513.5 The change to the manual should address the following concerns: 1. Is this a copy of the entire questionnaire, or just the results? 2. How many years of assessments need to be kept on file? 3. Does the assessment need to be kept in paper format only? Can the assessment be stored in an electronic format if it is made a read only document by IT? If previous year's assessments need to be kept on file, can they be stored in an electronic format? 4. Do these assessments need to be kept in a separate file?	1. The entire ICAP booklet will be kept on file in the person's file within the Service Coordinator's IDDW provider office. 2. All records and documents must be maintained by the IDDW provider for at least five years or in the event there is a dispute concerning a service provided, until the dispute is ended (Section 513.5). 3. It is acceptable to keep in electronic format as long as it can be made available upon request. 4. No, the assessment needs to be kept in the person's file.
		Duplicate	513.8 An updated DD5 with the format on how to include the new information for an over the budget request needs to be sent to providers.	A new IPP form will be available by May 1, 2018 however agencies may develop their own forms as long as all required components are present.
		Duplicate	The exceptions process needs to be quick and efficient with results from BMS so a member does not have to wait months into the service year to get an answer to the request.	This suggestion has been added to the policy manual but noted that a decision will be made within 20 business days after the Exceptions Panel has received submission explaining the basis for the exceptions request with any/all supporting documentation.
		No Change	513.14.1 Who determines if appliances have adaptations that are sufficiently adapted/modified to meet the member's need?	As stated, a kitchen or bathroom appliance that is ADA compatible is not sufficient to meet the need for this service. For example, almost all toilets on the market are now ADA compatible. Every parent or landlord must have a working toilets as part of providing a safe and healthy environment. It is not the responsibility of the IDDW program to provide basic household appliances necessary and used by every member of the family.
		Change	513.15.2 What specific tasks would be considered a benefit to the provider? Does this only apply to people receiving pre-voc? What about someone that has a goal of learning to take out the trash, or clean up after them self?	This statement has been added to the policy manual: Tasks of a benefit to a provider are those tasks, performed by a person receiving IDDW services, for which the provider would otherwise have to pay an employee to complete. A person taking out trash generated by the whole room or setting (not just the person's personal trash) would be an example of a task benefiting the provider. A person being trained to clean up after him/her self would not fall in this category.
		No Change	513.25.4.2 A return to a per diem or global authorizations should be considered. With the new budget methodology, many people will have reduced budgets. Base budgets do not provide adequate service provision with the staffing ratios that would need to be purchased, in order to ensure the health, safety, and needs of the members being served. Personal need an choice are eliminated from the budget methodology. Reduced staff will not be adequately able to monitor the health and safety of members. This could result in more staff burnout, and higher rates of abuse and neglect incidents. Reduced budgets do not support the new regulations for integration with the Transition Plan. Individuals will be less able to get out into their communities and will be restricted to staying home more often. This will also negatively impact individual choice, if one or two individuals in a home want to go on an outing and the other individual does not. In that situation someone will not get to choose. The new budget methodology does not address an individual with multiple medical needs that would require a higher staffing ratio than will be able to be purchased in a 1:3 ISS. The higher medical needs of someone that requires a lot of LPN services is not supported with the new budget methodology. The add on amounts will not be sufficient enough to address a person's need. The high add on for externalized problem behavior is $4287 which is only 214 hours for the year, or approximately 18 hours of 1:1 services. The stop gain/loss rule is going to create a downward spiral to individual budgets. Therapies will be cut from services in order to provide 24/7 care. This is taking away needed services that benefit individuals. We had had many members benefit from the ongoing physical therapy services that they received, increasing their mobility and independence greatly with the utilization of this service. Under this methodology, all individuals in the home wood have to match the lowest budget of the member's in the home in order to keep staffing ratios within each person's budget. This will be challenging to do if all individuals in a home have different anchor dates, and if a roommates budget significantly decreases during the middle of the others budget year.	Our goal in implementing the new methodology is not to decrease spending, but to put in place a system that is more understandable and predictable, based on historic spending patterns. For example, an individual living in a 1-person ISS will have an annual budget between $176,731 - $201,402, depending on their individual circumstances. Individuals living in an ISS or group home typically have had higher spending levels compared to members who live with their families, which the new methodology takes into account. Under the new budget methodology, BMS estimates that over 65% of waiver members will receive a budget higher than the amount they spent on services during their 2016 IPP year, and over 87% of waiver members will receive a budget within 10% of their 2016 IPP year spend. Further, if the waiver member believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process. The Stop Loss/Stop Gain will not create a "downward spiral" of budgets. It will only impact a small percentage of people in the waiver, and BMS believes it is important to ensure that no people receive more than a 20 percent decrease in budget through the transition to the new system.
		No Change	513.20.1 State AMAP training and testing conflicts with the waiver manual revisions	We are unaware of any conflicts but have consulted OHFLAC on these changes.
		No Change	Provision of AMAP services need to have a higher rate of reimbursement in order to find and retain qualified staff.	The State is considering possible rate changes in the future.
		Change	RN's have many concerns about AMAP's being under their license, and if errors will come back on their license, putting them at risk of losing their nursing license. RN's also have concerns that it will fall on their license if a fully trained AMAP was found to be pocketing medications intended for the member. Also, the RN has concerns that an AMAP will not notice medical concerns that an LPN might notice. RN's are unable to ensure the health and well-being of the individual with staff that are not trained to notice early signs of a health issue	BMS has consulted OHFLAC and the Board of Nursing and is unaware of any precedence that has put the license at risk. RNs can determine if they want to approve a staff as an AMAP. This change has been delayed until July 1, 2018 or the individual's next anchor date, whichever is later.

		Change	Some of our guardians and natural families have expressed concerns over AMAPs. There is no exception to the AMAP rule if the guardian refuses AMAP care, or if the physician states that the member is not a good candidate for services by an AMAP and does not write an order for AMAP to be provided	This change has been delayed until July 1, 2018 or the individual's next anchor date, whichever is later. When this becomes effective, if the duty is also something that can be performed by an AMAP, then it must be performed using the least costly method. Waiver nursing (LPN and RN) does not include services delegated in accordance with and can be performed by individuals who are AMAPS as defined in W. Va. CSR § 64-60-1 et se4q.; or for visits performed for the sole purpose of meeting the supervisory requirements for LPNs or AMAPs at the direction of an RN. Agencies can still utilize LPNs to pass medications, but must not bill the LPN rate unless it is medication that ONLY an LPN can pass.
		No Change	There needs to be reimbursement for RN services, including the time RN's spend training AMAPs, supervising AMAPs, and time spent conferring with AMAPs via telephone when on call.	This is considered an administrative service and is not reimbursable through the IDDW.
		No Change	AMAPs need to bill for the time that they are preparing for the med pass, as well as the time that they are actively with the client dispensing meds.	The AMAP rate is inclusive of this. It is recommended, but not required, that agencies utilize pharmacies that pre-package medication.
		Change	There needs to be a transition period for switching all medication administration over to AMAPs, in order to give agencies time to select appropriate staff, complete all background checks and qualifications, complete AMAP training, and staff to pass the AMAP test. This cannot be accomplished quickly.	This change has been delayed until July 1, 2018 or the individual's next anchor date, whichever is later. When this becomes effective, if the duty is also something that can be performed by an AMAP, then it must be performed using the least costly method. Waiver nursing (LPN and RN) does not include services delegated in accordance with and can be performed by individuals who are AMAPS as defined in W. Va. CSR § 64-60-1 et se4q.; or for visits performed for the sole purpose of meeting the supervisory requirements for LPNs or AMAPs at the direction of an RN. Agencies can still utilize LPNs to pass medications, but must not bill the LPN rate unless it is medication that ONLY an LPN can pass.
		Change	AMAP medication administration would call for a 1:1 service. If the AMAP is the staff working in the home, with a 1:3 ratio, staff's ability to monitor other individuals in the home would be greatly impaired while completing medication administration.	This change has been delayed until July 1, 2018 or the individual's next anchor date, whichever is later. When this becomes effective, if the duty is also something that can be performed by an AMAP, then it must be performed using the least costly method. Waiver nursing (LPN and RN) does not include services delegated in accordance with and can be performed by individuals who are AMAPS as defined in W. Va. CSR § 64-60-1 et se4q.; or for visits performed for the sole purpose of meeting the supervisory requirements for LPNs or AMAPs at the direction of an RN. Agencies can still utilize LPNs to pass medications, but must not bill the LPN rate unless it is medication that ONLY an LPN can pass. Most agencies use bubble-pack medication or arrange medication administration around shift changes.
		No Change	The services an AMAP can provide within the scope of their training need to be clearly stated. The services that only an LPN or only an RN need to be clearly stated. Clarify what is meant by the statement of "monitoring of medication" Non-Client direct services that can be reimbursed through the nursing code need to be clearly stated. Clarify what is an insulin pen.	The services an AMAP can provide within the scope of their training can be found on the OHFLAC website: http://ohflac.wvdhhr.org/Programs/AM.html. The services an RN/LPN can provide within the scope of their training is can be found on the WV Board of Nursing website: http://wvrnboard.wv.gov/Pages/default.aspx.
26	12/18/2017	No Change	513.2 If the purpose of this addition is actually to enhance the focus on the members served, why would these trainings not be added to the requirements for Qualified Support Workers? In many instances, it is the less monitored staff who do not support and emphasize the objectives listed in these recommended additions to training. This recommendation further reflects the difference in the types of supports expected to be provided the IDDW members by staff type, rather than the IDDW ensuring all members are provided supports focused on person-centered philosophies and best practices.	These requirements are listed in the section with all the other staff qualifications.
		No Change	513.3.7 Would like to provide a couple emergency examples of consideration. First, due to a mechanical failure, a staff had to seek out warrantied repairs, the dealership provided a temporary vehicle but would not release the registration to the staff for documentation. We could only document the available items, but the car met all safety requirements. Second, a staff member's car broke down, they got a rental, but forgot to get a copy of the registration. Once again, the vehicle met safety requirements but staff was unable to provide the "required" proof of safety. In acknowledgement of emergencies and special circumstances, while attempting not to interrupt IPP outlined supports, there may need to be an option to document special occurrences, which although would be few, would permit a staff to provide the support outlined and be compensated for such diligence in helping provide transportation in emergency or unexpected circumstances.	Agencies should make every effort to obtain documentation or suitable alternative (statement from dealership/rental agency, photo of document) and document attempts.
		No Change	513.5 Could the department clarify for IDDW members in the manual that within HIPPA, the law specifically says that its provisions for patients' access to their records (cited above, CGS § 20-7c(a)-(d)) do not apply to "any information relative to any psychiatric or psychological problems or conditions." (CGS § 20-7c(e)).	This comment cites Connecticut Law. West Virginia and federal law and regulations are applicable to the IDDW program, not Connecticut Law. Also, BMS does not think it is necessary to discuss specific HIPAA provisions applicable to providers , as providers know, or should know, they are subject to all applicable provisions of HIPAA.
		Change	513.8 The content of the IPP must be guided by the person's assessed needs, wishes, desires, and goals but the requested services cannot exceed the person's individualized budget. If the member and/or the team believes that the member requires services in excess of the individualized budget, the team may list those additional services in the separate section of the IPP set aside for this purpose. However, in order for the member to begin receiving any services under the IPP, the service coordinator must submit a list of services that can be purchased within the member's individualized budget, making sure all direct care service needs are purchased first Only services that can be purchased within the budget may be authorized and all other service needs must be covered by natural or unpaid supports or from programs other than the IDDW, 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 person has had a documented change in need since the annual functional assessment was conducted, then a Critical Juncture should occur immediately to discuss the need for additional services. Comment: 3rd sentence suggestion: However, in order for the member to begin … purchased within the member's [initial] individualized budget …. 4th sentence suggestion: Only services that can be purchased with in the [initially] approved budget may be authorized …. [If excess services are approved through the process identified in Section 513.25.4.2, they may be moved from the set aside section of the IPP and added as a pre-approved addendum.]	An IPP form will be available on May 1, 2018 that has an additional section for services that the member is requesting but not yet able to purchase.
		No Change	513.15.4 I believe the state should take the initiative to validate an opportunity for behavioral health centers to engage in business activity and ventures to assist with the operations of supports for individuals with disabilities and their communities at large. The state should generate a methodology which would permit a behavioral health center to initiate business ventures which would be integrated, except for the fact that a licensed entity operates the business – and therefore, even if it meets all other litmus tests for being integrated, cannot be considered an integrated work site due to the licensing tag. To support mission, many IDDW providers will begin, if not currently moving toward, developing business models and ventures which would not only promote integrated work sites, but have the knowledge and experience to better ensure success. A move like this would promote and instill a better direction for Employment First philosophies.	Behavioral Health Centers may engage in business activity and ventures to assist with the operations of supports for individuals with disabilities and their communities at large now.

		Change	513.20.1 What exception will be acknowledged if, or when, a physician refuses to provide the order for use of AMAP personnel or orders the use of an LPN or RN to complete the medical treatment required by the IDDW member. OHFLAC will require a behavioral health center to follow the physician order. Does this mean that BMS has the authority to not pay for the recommended medical treatment ordered by a physician? Will the intent of this section, to assist in lowering medical costs, be used to dictate reimbursable support services which may not be validated by the primary physician and IDT.	This change has been delayed until July 1, 2018 or the individual's next anchor date, whichever is later. When this becomes effective, if the duty is also something that can be performed by an AMAP, then it must be performed using the least costly method. Waiver nursing (LPN and RN) does not include services delegated in accordance with and can be performed by individuals who are AMAPS as defined in W. Va. CSR § 64-60-1 et se4q.; or for visits performed for the sole purpose of meeting the supervisory requirements for LPNs or AMAPs at the direction of an RN. Agencies can still utilize LPNs to pass medications, but must not bill the LPN rate unless it is medication that ONLY an LPN can pass.
		Duplicate	513.2 Page 118. The last sentence of the 1st paragraph requiring the SC to get the signature on the Freedom of Choice form seems to defeat the purpose of the proposed change in 513.2 requiring all IDDW providers to leave the meeting during the completion of the Freedom of Choice form.	This statement has been added to the policy manual: If the person has a legal representative that is not in attendance, the legal representative must sign the Freedom of Choice within 10 days.
		Change	Page 118. In the 3rd paragraph, the first sentence, for person-centered philosophy promotion, it should read, "The UMC, the person, the legal representative, the service coordinator and any other members of the IDT that [the IDDW member] wishes to be present ….	This has been changed in the manual to read: The UMC, the person, the legal representative, the service coordinator and any other members of the IDT that the member wishes to be present will attend the annual assessment.
		No Change	Page 119. Regarding the first paragraph. If the individual/legal guardian refuse to sign the acknowledgement, due to conflict or concern with the UMC representative, does the UMC still act as the entity to resolve the issue?	Yes, the UMC is still the entitiy assigned to resolve this issue.
		Change	Page 120. Spacing error in last paragraph, next to last sentence. This policy will continue to apply year to year … evidenced by a decrease [ ] in the individual's ….	This spacing error has been corrected in the policy manual.
		Change	Could an outline of timelines be included in this section? Either a chart or a summary outline of the length of time involved with each process and the time expected for "exception" approval of authorizations. It would be nice if a weekly review were completed and approved "exception" reviews would receive authorization approvals the first day of the next week.	An outline of timelines will be added to the website as soon as possible.
		Duplicate	Could BMS consider this language addition below to align with the ICAP publisher's test disclosure statement? However, the Service Provider must make the original physical copy annual assessment available to the person, his/her guardian and his/her IDT at the Service Provider's offices, upon request, to review only, and no notes, copies, photographing or other duplication efforts will be permitted.	This bullet has been changed to: The original physical copy of the ICAP assessment completed by the person, his/her legal representative and his/her IDT. Once the ICAP assessment is completed, and the person or his/her legal representative has signed the document attesting to its accuracy and completeness, it will be the duty of the Service Coordination provider agency to ensure that the document is not altered, copied or distributed in any manner. However, the Service Provider must make the original physical copy of the ICAP assessment available to the person, his/her legal representative and his/her IDT at the Service Coordinator's office, upon request, to review only. The Service Coordinator provider agency may store the document electronically but must be able to make the document available to review upon the request of the person or their legal representative.
27	12/19/2017	No Change	513.8 IPP What if the individualized budget is not enough for direct care services need while the team files for exception?	We do not expect this to occur, in part because we are now requiring a decision on an exceptions request to be made within 20 business days, unless an individual is changing from a natural family setting to an ISS or Group Home setting. That is why permission must be received before changing settings.
		No Change	523.9.2 Participant Directed Service Option. If participants or representative are to be able to self direct their services they should be allowed to use their budget for the needs of the member. Families have not been able to fid qualified workers to provide services. Adult members have no natural supports. Rural area, low pay and severe nature of the disability play a factor in finding staff. That what attracted families to self directed model in the first place.	By the very definition of Respite, it may not be used to pay parents/Specialized Family Care providers to provide this service to themselves. If additional Transportation is needed, then Non-Emergency Transportation is available if the person is being transported to or from a Medicaid approved services. The person or legal representative exercises self-direction by choosing qualified workers of their choice, training the workers, deciding the rate of pay and schedule of each worker and separating the worker from employment.
		No Change	Day Services. Program is moving backwards and is a segregated institutional setting. I have visited Day Program with my daughter. Upon visiting she had a meltdown due to the environment (noise, Personal space, sensory overload). Congregating individuals together is not a thriving environment.	All Day Services are optional for adults. It is not a requirement that an adult access any Day Services.
		No Change	513.16.1 Goods and Services. If Participant are self direct model their services should be allowed to be used any way they see fit. To many restrictions.	Not all items requested are approvable items, thus BMS has tried to define those to avoid confusion and disappointment.
		No Change	513.17.1.2 Family Person Centered Support (Personal Options) Comment If Participants or representative are able to self direct services they should be allowed to use budget for their needs. That is what attracted families to self direct in the first place. All self direction has been removed.	The person or legal representative exercises self-direction by choosing qualified workers of their choice, training the workers, deciding the rate of pay and schedule of each worker and separating the worker from employment.
		No Change	513.18.1.2 Respite Personal Options Model. Members who struggle to keep staff should be allowed to transfer amount to another self directed service.	People are permitted to use the funding in their budget for any waiver service, subject to BMS policies and limits, most of which have not changed in this new service authorization system. This includes transferring funds originally allocated in the IPP to one service for use for another service, after the appropriate change has been made in the IPP, subject to BMS policies and limits. However, parents/Specialized Caregivers cannot be paid for Respite; by the very nature of the definition, Respite may not be used to pay parents/Specialized Family Care providers to provide this service to themselves. We have also clarified our policy around Transportation, to limit the extent to which budget funds can be used for Transportation. However, members are still able to purchase up 9600 units of Transportation annually, which BMS believes should suffice. If additional Transportation is needed, then Non-Emergency Transportation is available if the person is being transported to or from a Medicaid approved services. The person or legal representative exercises self-direction by choosing qualified workers of their choice, training the workers, deciding the rate of pay and schedule of each worker and separating the worker from employment.
		No Change	Panel deciding request for additional services. Can DHHR and its contractor provide an impartial evaluation and decision of services needed? All three panel members should be independent (not employed by DHHR or its Contractor) At least one person providing Person Center Support should be on panel. The only criteria being applied to render decisions will be the provision of just enough services to prevent institutionalization. Who can determine such risk? Medicaid Fair Hearing Can hearing officers employed by DHHR be impartial? In the past very few have restored services even with legal council. Should have a Administrative Law Judge to cases.	BMS believes these decisions on exceptions requests should be made, in the first instance, by BMS and its contractors. BMS is responsible for the IDDW and is best positioned to make these complex decisions. However, if the person receiving IDDW services does not agree with decision of the Exceptions Panel, then the person still has the option of filing for a Medicaid Fair Hearing and the case will be heard by an impartial hearing officer employed by the Board of Review. Although the Board of Review is an arm of DHHR, this entity functions totally independent of the Bureau for Medical Services.
		No Change	Supporting for profit agencies over Participant Directed Model. Taking all liberties away from the self directed model. Comment Thank you for consideration of my suggestion for services for this very vital program to keep our most vulnerable citizens at home and in their community.	The person or legal representative exercises self-direction by choosing qualified workers of their choice, training the workers, deciding the rate of pay and schedule of each worker and separating the worker from employment.
28		Change	The West Virginia Developmental Disabilities Council offers he following comments on Chapter 513, the Intellectual and Developmental Disabilities Waiver Program Manual. ~ **Pg. 8 - Program Description and 513.1 Bureau for Medical Services (BMS) Contractual Relationships -** Website addresses have been shortened/changed to links, rather than spelled out. Not everyone is accessing the Manual directly from a computer; spelling out website addresses allows individuals to type the address into a search engine. This is not consistent throughout the Manual since, for example, website addresses continue to be spelled out on pages 10-12.	This has been changed in the policy manual and a reference section has been added.
		No Change	~**Pg. 11 – 513.2 Provider Enrollment and Responsibilities** – The Council is pleased to see the requirements for Direct-Care Ethics training spelled out. It is important that anyone who provides direct services be knowledgeable of and adhere to "Direct-Care Ethics." Are the related trainings also covered in the certification of professional staff?	Not at this time, but will be considered in the next policy revision.

		No Change	~**Pg. 12 – 513.2 Provider Enrollment and Responsibilities, Conflicts of Interest** – The Council has no opinion on this change. While we agree it would be good to have the Member make this choice without any agency personnel in the room, we do not necessarily agree that this will "ensure complete impartiality."	BMS welcomes any suggestions you have for future revisions to this section. This was a suggestions made by the IDDW Quality Improvement Advisory Council and we have attempted to incorporate it at this time.
		Duplicate	~**Pg. 26 – 513.4 Reporting Requirements** – The Council favors the shortened timeframe for entering incidents into WV IMS from 48 hours to 24 hours.	This statement has been added to the policy manual: All incidents must be entered into the WV IMS within 24 hours of the provide becoming aware of the occurrence. If the provider becomes aware of the incident on a weekend or holiday, it is acceptable to enter the incident the following business day. NOTE: The incident is able to be edited for up to two weeks following the first entry. This is sufficient time for the IDDW provider to amend the original entry once the incident report or more information is received.
		Duplicate	~Pg. 28 – 513.5 Documentation and Record Retention Requirements, Specific Requirements – The Council questions why this requirement was added. Why would a Member not be allowed to have a copy of any assessment that has been completed on them?	Kepro has informed BMS that the owner of the ICAP will not allow copies of the ICAP to be distributed because of copyright issues. BMS is exploring available options.
		No Change	~Pg. 37 – 513.8 Individual Program Plan (IPP) – The Council has no opinion on this change, but has one question of clarification and one other comment. All direct care service needs must be purchased first prior to purchasing additional services (except for service coordination, we assume), and if the individualized budget does not meet other identified needs, the Member may file for an exception. Question of Clarification: What would be the process to follow if the individualized budget did not include enough funding for the direct care service needs themselves? Or if there was not enough for service coordination after the purchase of all direct care service needs?	There is an allowance for circumstances like this. Please review Section 513.25.4.2 which outlines the Exceptions Process.
		No Change	Comment: The Council agrees that all IPP meetings should be scheduled at a time and location that takes into consideration the schedule and availability of the person who receives services and the other members of the team. We hear from parents that most meetings take place during work hours and/or at the offices of service agencies, which leads us to believe meetings are really scheduled at the convenience of everyone other than the person who receives services (and their family members, if applicable).	The current policy manual states that "All IPP meetings should be scheduled at a time and location that takes into consideration the schedule and availability of the person receiving services and the other members of the team" (Section 513.8)
		No Change	~Pg. 45 – 513.9.2 Participant-Directed Service Option – If waiver participants are to be able to self-direct their services they should be allowed to manipulate their portion of the budget in any way they see fit so long as needs are being met.	The Participant-Directed Service Option allows the person or legal representative to exercise self-direction by choosing qualified workers of their choice, training the workers, deciding the rate of pay and schedule of each worker and separating the worker from employment.
		No Change	~Pg. 63 – 513.14.1 Environmental Accessibility Adaptations Home (Traditional Option) – The Council vehemently disagrees with the addition of one more limitation/cap to items that can be purchased through the EAA service. 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. It is fully understood that ADA compliant items are typically also able to be used by the general population. We do not believe this means they should be excluded from payment assistance. For example, if a Waiver participant who uses a wheelchair is being taught to cook they need to be able to reach the mechanisms on a stove that control the heat. An ADA accessible stove would allow for that. Why should the person be denied the opportunity to learn to cook for themselves just because other family members would also be using the stove? Should they have to move to a more restrictive setting to learn to cook? Might they not someday end up in a more restrictive setting because they lack independent living skills? And if the same individual could be more independent in the bathroom with a higher toilet or an accessible tub, should they be denied the opportunity to gain independence because other family members might be using the same toilet and tub? Living at home with family is not institutional living, and individuals who are able to live at home should not be discriminated against in such a manner.	As stated above, a kitchen or bathroom appliance that is ADA compatible is not sufficient to meet the need for this service. For example, almost all toilets on the market are now ADA compatible. Every parent or landlord must have a working toilet as part of providing a safe and healthy environment. It is not the responsibility of the IDDW program to provide basic household appliances necessary and used by every member of the family.
		No Change	~Pg. 65 – 513.14.2 Environmental Accessibility Adaptations Vehicle (Traditional Option) – The addition of "such as running boards" is an unnecessary qualifier to the current limitation of, "This service may not be used for adaptations or improvements to the vehicle that are of general utility (such as running boards), and are not of direct medical or remedial benefit to the individual." While it could be argued that running boards might allow someone who otherwise would not be able to do so to step up into a vehicle, this adds to the appearance that, with each re-write of the Manual, one can expect to see other items that Members have requested added to this category (as well as in EAA Home and Participant Directed Goods and Services) for which the BMS will not help purchase.	It was necessary to define this further at this time.
		No Change	~ Pp. 65-72 – 513.15 Day Services – In general, the Council is surprised and disappointed to see the changes that have been made in this section. They indicate backwards movement for individuals who receive Waiver services. The Centers for Medicare and Medicaid Services (CMS) finally began moving into the future with the announcement in 2015 that services called Home and Community Based Services (HCBS), that are funded through the Medicaid Waivers, would not be provided in segregated, congregated, institutional-type settings and gave states until 2020 to transition to true home and community based services. Each state is required to develop a working plan for this transition. WV does not yet have final approval on its transition plan and is now moving backwards on its implementation.	As stated, Day Services are an optional service for adults and no adult has to access these services. The change in this section was made in response to complaints from many families about the limitation on the availability of Day Services. WV does have initial approval on their state-wide transition plan and it is posted on the website along with the approval letter from CMS to remove the three year restriction for an person to receive Facility Based Day Habilitation: http://dhhr.wv.gov/bms/Programs/WaiverPrograms/WVSWTP/Pages/default.aspx
		No Change	The WV DD Council, along with other State Agency and community members, is working to move WV forward towards becoming an Employment First state. Competitive integrated employment (CIE) in locations where the employee interacts with other persons who do not have disabilities (similar to how other people in the community typically interact), and for which an individual is compensated at or above the minimum wage, is the first option considered for how working aged people with developmental disabilities spend their days in states that follow Employment First principles. As recent as the end of August, CMS representatives, including the Director of Long Term Services and Supports, at the national Home and Community Based Services Conference continued to reiterate that, while they are not telling states they cannot offer congregated and segregated services, they cannot be paid for with HCBS funding. We believe the HCBS settings requirements are still in effect and challenge the BMS to share with us information from CMS to the contrary.	Services described in 513.15 are based on those in the CMS approved State Transition Plan for the Integrated Services Rule for Home and Community Based Services. None of these services are segregated. The state plan includes how any service settings that are not integrated were identified. These were inspected and have come into compliance. They will continue to be inspected annually and, if deficiencies are found, a follow up review will assure continued compliance. All settings are in communities with community/setting interfaces occurring on a regular basis. CMS has approved the State Transition Plan, including the state's setting requirements for HCBS, these requirements are, de facto, still in effect.

		No Change	The Workforce Innovation and Opportunity Act (WIOA), CMS Home and Community Based Services Rule, and the *Olmstead* decision support and define integrated settings, support competitive integrated employment, and seek to reduce the use of segregated work services and settings. The Council's Employment First Workgroup studied high performing states and found that the phase out, reduction, or closure of facility based programs is a key state program element needed to support Employment First practices. The I/DD Waiver services in each of those high performing states have been critical to increasing employment of people with significant IDD and assisting people in transitioning out of segregated facilities. Two nearby examples are the IDD Waivers in Delaware and Maryland. Delaware's IDD Waiver includes "Employment Navigators" who have specialized training and coordinate employment planning for program members based on the requirement that "competitive and integrated employment, including self-employment, shall be considered the first option when serving persons with disabilities who are of working age." Maryland's IDD Waiver provides "expanded day habilitation" services that include Employment Discovery and Customization.	BMS will consider "expanded day habilitation" services that include Employment Discovery and Customization in a future update.
			513.15.1 Facility-Based Day Habilitation (Traditional Option) – The change log indicates the three-year limit for this service is being removed, but it has not been removed from the Manual. The Council objects to the removal of the three-year limit for this service unless the BMS removes the licensed site as an allowable location. The *Informational Bulletin* from the Center for Medicaid, CHIP and Survey & Certification (CMCS) dated September 16, 2011, gives the following instruction: "Day habilitation may be furnished in a variety of settings in the community other than the person's private residence. Day habilitation services are not limited to fixed-site facilities." It also states, "Day habilitation services may also be used to provide supported retirement activities. As some people get older they may no longer desire to work and may need supports to assist them in meaningful retirement activities in their communities." The Council's position 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 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.	There is no link between a three year time limit for Facility-Based Day Habilitation and whether a setting is licensed. The three year time limit was arbitrary and limited a person's choice and treatments based on the person's need. The BMS does not in any way prohibit day habilitation services being provided in a variety of settings in the community, but these services must be an adjunct to services provided within settings/fixed-site facilities. The BMS will continue to identify the need for choice of settings and programs including facility based DH. Families people receiving services will continue to have options for services, including FBDH, as these services may be provided in compliance with the Integrated Services Rule.
		No Change	513.15.1 Facility-Based Day Habilitation (Traditional Option) – The change log indicates the three-year limit for this service is being removed, but it has not been removed from the Manual. The Council objects to the removal of the three-year limit for this service unless the BMS removes the licensed site as an allowable location. The *Informational Bulletin* from the Center for Medicaid, CHIP and Survey & Certification (CMCS) dated September 16, 2011, gives the following instruction: "Day habilitation may be furnished in a variety of settings in the community other than the person's private residence. Day habilitation services are not limited to fixed-site facilities." It also states, "Day habilitation services may also be used to provide supported retirement activities. As some people get older they may no longer desire to work and may need supports to assist them in meaningful retirement activities in their communities." The Council's position 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 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 have faced a conundrum since the State Transition Plan was first released because they rely upon this service to give their family member a place to go during the day. Many agencies also rely upon it for that reason. The Council does not advocate they be left with no options. The Council believes the DHHR needs to be doing more to educate families on the changes brought about by the CMS rule, and more importantly, encouraging and assisting waiver service providers in the development of meaningful alternatives to segregated, congregated programs. Whether the DHHR/BMS believes the rule is no longer in effect or in some manner will not be enforced does not change the fact that it is the right direction in which to move. It is time to move beyond following a model that was developed during the time of widespread institutionalization of people with intellectual and other developmental disabilities.	In order to provide people with the greatest choice of settings, the BMS has made provision for the continuation of settings where the training is Facility Based. The elimination of Facility Based training would limit a person's choice. Training should occur where it is most beneficial to the person, and where the person chooses to receive the training. This training must occur in a setting that is integrated through compliance with the Integrated Settings Rule.
		No Change	513.15.2 Pre-Vocational (Traditional Option) – The Council objects to the removal of "and community settings" from the site of service. The previously mentioned 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 there is no timeframe for this service, and if, as suggested by the addition of "Persons may receive minimum wage. If the IDDW provider benefits from the person's labor, then the person must be paid," 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-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.	The BMS agrees that people should not be left without options. The elimination of all Facility Based Day Habilitation services certainly would act to reduce options for people substantively. BMS would only require that a setting be closed if the provider failed to meet the criteria for integration and choice as delineated in the State Transition Plan and the Integrated Settings Rule. It is expected that, as with all services provided to people receiving IDDW services, that IDT (including the person) will determine when or if the person wishes to receive Supported Employment Services. The treatment and the ISP developmental process are the safeguards which prohibit a person being "stuck" with any services the person and team do not find necessary.
		No Change	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 volunteer activities would be detrimental to this type of learning.	The Pre-vocational services listed in 513.15.2 are general skills identified as needed for successful transition to any Supported Employment job setting. These may be taught in a Facility based setting, giving the person time to acquire the skills that employers expect him/her to have when hired. These skills, when acquired, enhance the employability of the person. Tasks of a benefit to a provider are those tasks, performed by a person, for which the provider would otherwise have to pay an employee to complete. A person taking out trash generated by the whole room or setting (not just the person's personal trash) would be an example of a task benefiting the provider. A person being training to clear up after him/herself would not fall in this category.

		No Change	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. Will it be possible to distinguish the difference between what each person is receiving? Finally, 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? How does this differ from Supported Employment.	Facility Based Day Habilitation, Job Development and Pre-Vocational services may all be offered in the same setting. The assignment of staff and placement of the training activities are based on the needs of each member as delineated in the IPP. Staff must in all cases meet the training requirements for each service they provide.
		No Change	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." Customized career planning is needed so that staff and the member are seeking and negotiating for the right job for the focus person.	Customized planning is a part of the evaluation process and IPP development process. This is revisited at least annually. BMS will provide training to providers on member career planning and possible assessment instruments. At this time, Customized Employment as a specific service code is not an option in the current IDDW in WV, but will be considered in future updates.
		No Change	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.	Staff receive training to meet the needs of the person and the implementation of Supported Employment Plans of Instruction available in an local public community setting not owned or leased by the IDDW provider. Facility Based Day Habilitation and Pre-Vocational services may be offered in the same setting which is a licensed site. The treatment team would identify which objectives/goals/activities fell under FBDH or Pre-Voc. The IPP would distinguish which service the person was receiving. A 'concept/goal' may be trained through an activity (i.e. trash pickup) for which the person should be paid. When the activity benefits the provider, the person should be paid. Pre-Vocational differs from Supported Employment in that the entity providing the payment is the provider of services. In Supported Employment the entity providing the payment is not the provider. Pre-Vocational differs from Supported Employment in that the setting is the provider of services. In Supported Employment the setting is not the provider. Supported Employment does not take place at an IDDW licensed facility/center/site.
		Change	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.	This language has been added /changed in Site of Service in the policy manual: This service may be provided in an integrated community work setting and may not be provided in any setting owned or leased by an the IDDW Provider agency. Most of the member's co-workers in the setting do not have disabilities.
		No Change	~Pg. 74 - 513.16.1 Goods and Services (Participant-Directed Option, Personal Options Model) - If waiver participants are to be able to self-direct their services they should be allowed to manipulate their portion of the budget in any way they see fit so long as needs are being met. Also, please see comments related to accessibility given in 513.14.1 Environmental Accessibility Adaptations Home (Traditional Option).	The person or legal representative exercises self-direction by choosing qualified workers of their choice, training the workers, deciding the rate of pay and schedule of each worker and separating the worker from employment.
		No Change	~Pg. 80 – 513.17.1.2 Family Person-Centered Support (Personal Options Model) - If waiver participants are to be able to self-direct their services they should be allowed to manipulate their portion of the budget in any way they see fit so long as needs are being met.	The person or legal representative exercises self-direction by choosing qualified workers of their choice, training the workers, deciding the rate of pay and schedule of each worker and separating the worker from employment.
		No Change	~Pg. 95 – 513.18.1.2 In-Home Respite (Personal Options Model) – The current Manual already includes two statements apparently meant to make families aware that they receive respite in ways other than through this Medicaid Waiver funded service. The addition of extra examples of what the BMS believes families should consider as respite serves no useful purpose.	The time the primary caregivers takes away from the stress of caregiving is a considered a form of unpaid respite for that primary caregiver because the caregiver is not responsible for the person during that time.
		No Change	The above comment applies to all other forms of respite mentioned in section 513.18 in which those same statements have been added. Earlier comments (Section 513.9.2) pertaining to which services can have their equivalent monetary value transferred to another self-directed service also applies here.	The time the primary caregivers takes away from the stress of caregiving is a considered a form of unpaid respite for that primary caregiver because the caregiver is not responsible for the person during that time.
		No Change	~Pg. 113 - 513.21.2 Transportation Miles (Participant-Directed Option, Personal Options Model) - The Council's comments from Section 513.9.2 also apply here.	The person or legal representative exercises self-direction by choosing qualified workers of their choice, training the workers, deciding the rate of pay and schedule of each worker and separating the worker from employment.
		Duplicate	~Pp. 118-123 – 513.25.4.2 Service Authorization Process – The Council takes issue with this new statement: "The UMC, the person, the legal representative, the service coordinator, and any other members of the IDT that wish to be present will attend the annual assessment." We would agree to a change to the statement that said "…and any other members of the IDT that the person wishes to have present will attend the annual assessment." Inviting everyone to attend an assessment of an individual that is sometimes very hard on the individual and/or their families, since the focus is on what the person is not able to do, is insensitive and extra people should be left to the discretion of the individual. It would also potentially make scheduling the assessment more difficult.	This has been changed in the manual to read: The UMC, the person, the legal representative, the service coordinator and any other members of the IDT that the IDDW wishes to be present…..
		Change	What is the process by which the UMC "shall resolve the issue" when there is disagreement on the assessment? The individual must notify the UMC within five days of the assessment date. What will be the timeframe in which the UMC shall resolve the issue?	This language has been added: The person and/or his legal representative shall sign an acknowledgment that they participated in the assessment, and were given the opportunity to review and concur with the answers recorded during the assessment. If the person or his legal representative declines to sign the acknowledgment for any reason (e.g., he or she does not believe the answers were recorded accurately), the person or their legal representative shall notify the UMC through their service coordinator within 5 days of the assessment date, and the UMC shall resolve the issue by conferring with the person and/or the legal representative to come to an agreement on the answers on the assessment. If the person or their legal representative still disputes the answers on the assessment, then the issue can be appealed through a Medicaid Fair Hearing. The Assessment Data Modification Request (WV-BMS-IDD-13) form must be fully completed must cite the items in question.
		Change	In the section, Budget Methodology (pg. 120), a statement is made which references Section 513.25.4.2, which is the section in which the statement is located and therefore unnecessary.	This sentence has been changed to read: A person may request services that cost up to the top of their individualized budget range, but may not use services costing above their individualized budget range, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in this section.
		No Change	The Council appreciates the transparency of the base budgets and possible add-on amounts! In Table 2 (pg. 120), categories are listed from lowest to highest except for those listed in Externalized Problem Behavior. We suggest these two be reversed for clarity and continuity.	We appreciate the Council's support for the new budget methodology. This is the way the table has appeared during all of our trainings, handouts, and postings on the website and it would be confusing if it was changed now.
		No Change	In the first full paragraph following Table 2, the Council believes there is a mistake in wording. While we believe the intent was to say that no person enrolled in the program as of March 30, 2018 will have their budget cut more than 20%, the wording appears to indicate no person will receive less than a 20% cut. The clarifying sentence which follows this statement indicates a person will receive at least 80% of their old budget, or the new calculated amount, whichever is higher.	Your understanding of the intent is correct: No one will receive less than 80% of their actual spend from the previous year, unless they request less or move to a less expensive setting. We think this is clear from the current text in the manual.

		No Change	The second paragraph, on Pg. 121, is a section that could benefit from having some specific examples listed. To the best of the Council's knowledge, the only "other" Medicaid services to be accessed outside the Waiver are medical care (which people would already be accessing) and possibly personal care services for those who qualify. Private insurance companies do not typically offer home and community based services; they offer coverage for health care and sometimes limited therapy services, which should already be billed prior to Medicaid. Specifically, what services does the BMS envision individuals accessing through these other means?	The examples you cite are frequently used in addition to state plan Medicaid Private Duty Nursing.
		Duplicate	Redetermination Requests (pg. 121) – This section does not provide any measurable timelines for the UMC to notify the BMS of the need for an increased budget due to a documented changed in an individual's status and it does not provide a measurable timeframe within which the BMS will make a final determination on increasing the budget. The Council suggests "as soon as possible" be replaced with a specific timeframe and that a specific timeframe be added as to when the BMS will render its decision.	This suggestion has been added to the policy manual but noted that a decision will be made within 20 business days after the Exceptions Panel has received submission explaining the basis for the exceptions request with any/all supporting documentation.
		No Change	Exceptions Process (pg. 122) – The Council does not have a recommendation as to who or what entity it should be, but believes it would be better if at least one of the three individuals on a panel to determine exceptions was not employed by, or paid through, DHHR or its contractors.	BMS believes these decisions on exceptions requests should be made, in the first instance, by BMS and its contractors. BMS is responsible for the IDDW and is best positioned to make these complex decisions. However, if the person receiving IDDW services does not agree with decision of the Exceptions Panel, then the person still has the option of filing for a Medicaid Fair Hearing and the case will be heard by an impartial hearing officer employed by the Board of Review. Although the Board of Review is an arm of DHHR, this entity functions totally independent of the Bureau for Medical Services.
		No Change	The Council takes exception to the clear statement being made that the only criterion being applied to render decisions in this program will be the provision of just enough services to "prevent a risk of institutionalization." Who can determine such a risk?	The legal representative or the team members will determine this based on their knowledge of the person and the support needed to keep them from being institutionalized. The Exceptions Panel will then determine whether the person has shown that this standard is met.
		No Change	A program designed to provide home and community based services in lieu of institutionalization of an individual should support people to live full and rich lives in their communities. We agree with the statement in the program description, which states: "The IDDW Program is a program that reimburses for services to instruct, train, support, supervise, and assist individuals who have intellectual and/or developmental disabilities in achieving the highest level of independence and self-sufficiency possible." The Council remains concerned about those families who can no longer access enough hours of service to be employed full-time outside the home. Children with significant medical issues that cause them to be unable to attend school cannot access enough hours of service to allow both parents, or single parents, to work. Forcing families to use the limited respite care now available to cover the loss of hours allowed for personal care services (PCS) does not leave any respite hours available for a true respite. Despite the earlier spelling out of events the BMS believes qualifies as respite, those things do not provide the type of respite that allows caregivers to reconnect with other family members, friends, or community members. They do not allow family members living in the same household the opportunity to go out to dinner and a movie, to attend a sporting event, or any number of other opportunities families who are not providing care to an impaired family member do not have to think twice about being able to do. It appears that the DHHR would find it more desirable to cover more costly services, provided in 24 hour per day group settings, rather than support parents in their desire to keep their family intact and healthy. The WV Developmental Disabilities Council thanks the Bureau for Medical Services for the opportunity to express its concerns regarding this very important program.	For children under the age of 18, there is possible average of 52.5 hours of paid supports available on the average weekly – 35 hours of some type of Person-Centered Support and 17.5 hours of Respite. In addition, medically fragile children may qualify for Medicaid private duty nursing under the state plan. For Adults over the age of 18, there is a possible average of 93.5 hours of paid supports available on the average weekly – 56 hours of some type of Person-Centered Supports, 17.5 hours of Respite and up to 20 more hours of Day services. Both scenarios would be sufficient for a parent to work a full-time job outside the home. In addition, a person might qualify for state plan Personal Care Services if they are at the maximum of the services available on the IDDW.
		Change	Section 513.2- The member/legal representative should be able to choose whether they want the SC to leave or remain in the room during the completion of the FOC. I applaud the effort to ensure that Waiver participants and their families have true choice in provider agencies; however, given that when the legal representative doesn't attend the functional assessment the SC facilitates the completion of the Freedom of Choice form this will not be an effective way to promote choice for a many Waiver recipients.	This statement has been added to the policy manual: If the person has a legal representative that is not in attendance, the legal representative must sign the Freedom of Choice within 10 days.
29	12/21/2017	Duplicate	Section 513.2.3.6- Thank you for the opportunity to use different formats for submission of the 100% review of staff's training documents. I am not sure if this is an option during the middle of a Waiver manual, but I continue to believe that a 100% survey of staff credentials is overly burdensome on the provider and the state. This process could continue to ensure that files are complete and accurate by having a smaller sample. The reviewers would then ensure that they see a percentage of the sample submitted. If discrepancies are noted that could cause a larger percentage of records to be reviewed. If the review was a sample, another potential cost saving tool would be to have the chart review occur via a desk audit. Agencies could submit the employee file information requested electronically to show verification. If discrepancies were noted then a face to face review would be warranted. Perhaps in the future required documentation could be uploaded into the WV cares system within some required timeframe to ensure that staff are indeed qualitied to provide services. Section 513.4 Thank you for this change.	KEPRO uses the self-review that is submitted to pull a representative sample which is 10% of all employees or a minimum of 2 personnel files for the on-site review.
		No Change	513.5- I do not understand why the Waiver participant, or their representative, would not be allowed to have a copy of the annual assessment if requested. Whether the document is hand written, or computer generated, a copy could not alter the content if the original was available in the file and on care connection.	Kepro has informed BMS that the owner of the ICAP will not allow copies of the ICAP to be distributed because of copyright issues. BMS is exploring available options.
		No Change	513.8- Although I agree that direct supports are the most valued and important service I am concerned that in all situations the team must address direct supports prior to professional services. SC is a mandatory service and I believe that it should be treated as such within the budget process. In my experience, it tends to be easier to find natural support for direct service than for professional services. Teams should maintain as many choices as possible about how they utilize the budget.	Only approximately 5% (231) of the individuals currently accessing the IDDW will receive a budget that does not cover all the services they had last year. These individuals should access the Exceptions Process to explain to the Exceptions Process the need for the additional services. Further, if the person receiving IDDW services believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
		No Change	513.18.1.2/513.18.2.1/513.18.2.2- The manual already states on page 90 that "Anytime the primary caregiver can get a break from providing care, then this is a form of respite." The term may be confusing for some. Respite is defined as a "break from providing care" but many care providers do not feel that they get a "break" during the non-paid respite services because they are ordering disability related supplies, filling out disability related paperwork, setting up disability related appointments, etc. etc. etc. I would recommend either leaving out this additional information since it has already been stated or indicating that it is anytime that the caregiver is not providing "direct care".	BMS feels this is clearly stated but will consider further explanation in future policy updates.

		Change	513.20.1- I understand that funds for this program and many others are an issue, but I have grave concerns about mandating the use of AMAP staff. The agency at which I work utilizes AMAPS in combination with LPN services to ensure that Waiver participants get their medications as outlined by the physician and the treatment team. Using AMAPS has been a positive in many ways. It allows increased flexibility for the Waiver participant and has saved money for other needs within the budget. It is also risky and quite costly. 1. It is risky to the license of the RN providing oversight. An RN should be able to determine if they approve a staff person to be an RN. Agencies may be unable to give this choice based on this change. Using AMAPS is also risky regarding potential for adverse events. AMAPS are less skilled and trained than LPN/RN staff. I find that medication errors or issues are often discovered by a LPN/RN who is passing meds. I believe that using a combination of AMAP and LPN/RN for medication pass has lessened this risk. Mandating the use of AMAP staff by not allowing nursing billing for medication pass will initially save cost for the Waiver program. I am not sure that is true in the long term. Increased Adverse advents increases RN time. Simply having AMAPS increases RN time as RNs must then Verifying and documenting physician orders instead of the LPN providing this service. AMAPS also have less decision making ability which could cause an increase in RN time. 2. Using AMAPs is also incredibly costly to the agency. On top of the already required orientation (ours takes 40 hours) the AMAP class is a 40 hour class and a test. That is a ton of paid time that is not reimbursable. AMAPS require a high school diploma or GED and agency staff do not so this causes potential conflict in hiring. If all staff are not AMAPS then some AMAP staff have to travel to pass medications. For example, staff may start shift at 6am to pass multiple medications before they go on shift at 8am. Those 2 hours of time and travel have no reimbursement for the agency. The last rate increase for providers occurred in 2011. Since that time the cost of everything, including staff wages, has increased. Staff who are asked to do more work tend to expect more money. These issues will cause huge financial burdens for agencies. I think that allowing teams to determine how to use the budget, including LPN medication pass services is best. If the determination is to continue toward AMAPS then please consider adding an AMAP code that pays higher than the $5.01 for the medication pass time.	This change has been delayed until July 1, 2018 or the individual's next anchor date, whichever is later. Once effective, agencies can still utilize LPNs to pass medications, but must not bill the LPN rate unless it is medication that ONLY an LPN can pass. 1. BMS has consulted OHFLAC and the Board of Nursing and is unaware of any precedence that has put the license at risk. RNs can determine if they want to approve a staff as an AMAP. All states use a form of AMAPs to pass medications. 2. BMS found that most of the IDDW providers currently use AMAPs to pass medication. The agencies say that the cost is well worth it and they view it as an administrative cost and report they are making a profit. This information is listed on the WV HealthCare Authority website in Table 27 of the most recent annual report: http://hca.wv.gov/data/Reports/Documents/AnnualRP2016/Table_27.pdf AMAPs are not incredibly costly to the agency. The cost of an AMAP is 1/2 to 1/3 that of an LPN or RN.
		No Change	513.24.4.2- Although I appreciate that the new budget methodology allows participants to know what to expect in their budget I think that such drastic changes will be detrimental to the program. Waiver is designed to allow the participant to have the "highest level of independence and self sufficiency possible. I believe that the budget constraints for Waiver have caused the state to unintentionally set up a system that discourages habilitation and discourages change for the individual. Participants cannot afford to make strides toward improvement because improvement in ICAP or ABAS scores causes a potential decrease in budget. Participants cannot afford to explore creative ways to promote growth and independence because every dollar spent on change of behavior or change of medical status means a loss in the next budget. Participants cannot afford to be creative in accessing natural support to make their budgets go further without being placed in a different living category. I believe that discussion needs to occur with families and other stakeholders about how to promote cost savings while meeting individual needs. Family homes and natural supports are ultimately a way to save money for the program, but limits are encouraging families to explore 24-hour placements for the participant. I also believe that once budgets are set that team should be able to determine how to use those services without caps on specific services. For most teams, providing a cap number and then allowing choice within that number would promote choice and allow teams to work the way the participant needs them to work. Regarding the use of "actual spend" to determine assigned budget based on the stop gain or loss I have concerns about the time period being used and providing choice. Medicaid allows 1 year from service to bill. If services are not billed then it will appear that actual money is spent than truly was. I am unsure what time period that the actuaries reviewed and if back billing could have affected their numbers. The choice issue involves the ability to choose between self-directed and traditional services. The base budget for an adult living in a natural family is approximately half of what it would take for that person that have the maximum allowable direct 1:1 services from an agency, a little travel and a little SC. This will detrimental for the people who live in natural family homes and use their Waiver services to maintain employment or for people who have families who are unable to provide direct care or self direct. This scenario may not mean the difference between living at home or living in an institution, but it will likely mean the difference between being a valued employee and sitting and sitting life wasting. Families will be left little choice, but to self direct or	Our goal in implementing the new methodology is not to decrease spending, but to put in place a system that is more understandable and predictable, based on historic spending patterns. For example, an individual living in a 1-person ISS will have an annual budget between $176,731 - $201,402, depending on their individual circumstances. Individuals living in an ISS or group home typically have had higher spending levels compared to members who live with their families, which the new methodology takes into account. Under the new budget methodology, BMS estimates that over 65% of waiver members will receive a budget higher than the amount they spent on services during their 2016 IPP year, and over 87% of waiver members will receive a budget within 10% of their 2016 IPP year spend. Further, if the waiver member believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
		No Change	In order for the panel to be non-biased it should include at least one individual who is not directly paid via DHHR. This could be a family member, a member of the advocacy group, an employee of the DD council or some other entity. Several of the people that we serve who live in 24 hour sites transitioned there from institutions and have no family to help support. They will most likely be outliers who must go through the exceptions process. The process costs money. It costs the state time, but it also costs the budget time in the form of SC services. I understand that the case would have to be reviewed once to ensure that the information provided is accurate, but if people are known outliers and nothing has changed in their situations it would be more financially feasible to have an exception last longer than one budget year. Overall comment: It would be wonderful if at some future point care connection attachments could sort or file by year. The list of attachments is getting very long for some people.	Under the new methodology, BMS expands the panel of people reviewing requests for services in excess of the budget to three members, in part to facilitate a thorough review of each request (under the current second level negotiation process, requests are reviewed by one person). BMS believes these decisions on exceptions requests should be made, in the first instance, by BMS and its contractors. BMS is responsible for the IDDW and is best positioned to make these complex decisions. However, if the person receiving IDDW services does not agree with decision of the Exceptions Panel, then the person still has the option of filing for a Medicaid Fair Hearing and the case will be heard by an impartial hearing officer employed by the Board of Review. Although the Board of Review is an arm of DHHR, this entity functions totally independent of the Bureau for Medical Services. Regarding your comment about Care Connection, BMS agrees and will pass this section along to the software developers.

30	12/22/2017	Duplicate	513.2 "to ensure complete impartiality" only the KEPRO SSF and the client/guardian will be permitted in the room when the SSF reviews the Freedom of Choice form. Although this contradicts with the section in the manual concerning the expectations of the SC to assume responsibility for this form when the guardian isn't present during the KEPRO assessment.	This statement has been added to the policy manual: If the person has a legal representative that is not in attendance, the legal representative must sign the Freedom of Choice within 10 days.
		Duplicate	513.4 This change to upload incidents within 24 hours instead of 48 hours is onerous. We have staff who are responsible to immediately engage, investigate, and/or take action concerning incidents, but those are not necessarily the same staff who upload the data into WVIMS.	This statement has been added to the policy manual: All incidents must be entered into the WV IMS within 24 hours of the provider becoming aware of the occurrence. If the provider becomes aware of the incident on a weekend or holiday, it is acceptable to enter the incident the following business day. NOTE: The incident is able to be edited for up to two weeks following the first entry. This is sufficient time for the IDDW provider to amend the original entry once the incident report or more information is received.
		Duplicate	513.5 "it will be the duty of service provider to ensure that the document is not altered, copied, or distributed in any manner." but the SC must make the original physical copy available to the person, etc. .." Does this mean that it cannot be electronically stored? The manual section does not explain this, nor does it specify which service provider, although the assumption is that this means the SC service provider. Please clarify how this will work when there are multiple service providers.	The original physical copy of the ICAP assessment completed by the person, his/her guardian and/or his/her IDT. Once the ICAP assessment is completed, and the person or his/her guardian has signed the document attesting to its accuracy and completeness, it will be the duty of the Service Coordinator Provider agency to ensure that the document is not altered, copied, or distributed in any manner. However, the Service Coordinator Provider must make the original physical copy of the ICAP assessment available to the person, his/her guardian and his/her IDT at the Service Coordinator Provider's offices, upon request, to review only. Service Coordinator Providers may store the document electronically but must be able to make the document available for review upon the request of the person or their legal representative.
		No Change	513.25.4.2 In a 2 person ISS, residents are limited to the least amount available. The person with the higher budget may not get to utilize the whole assigned budget and would be limited by the lowest budget in the home. When one person has 1:1, both have and when one person has 1:2, both have 1:2.	Persons living in 2 person ISS are not limited to the least amount available. Each person starts with a base budget, then add-ons are added on if applicable, then the stop gain/stop loss rule is applied using the person's last year's spend.
31	12/22/2017	Duplicate	513.25.4.2 States that if the DD2 is not completed at the functional assessment, it is the responsibility of the service coordinator to obtain the signature of the legal representative prior to or at the annual IPP. This contradicts section 513.2, which states that the service coordinator and other agency personnel, with the exception of the legal representative of the member being assessed or the SFCP, will be excused when the Freedom of Choice form is completed during the annual functional assessment.	This statement has been added to the policy manual: If the person has a legal representative that is not in attendance, the legal representative must sign the Freedom of Choice within 10 days.
		Duplicate	513.2 to ensure complete impartiality only the KEPRO SSF and the client/guardian will be permitted in the room when the SSF reviews the Freedom of Choice form. Although this contradicts with the section in the manual concerning the expectations of the SC to assume responsibility for this form when the guardian isn't present during the KEPRO assessment.	This statement has been added to the policy manual: If the person has a legal representative that is not in attendance, the legal representative must sign the Freedom of Choice within 10 days.
		Duplicate	513.4 24 hours needs to be clarified as to if this is a straight 24 hours or 24 business hours. There are incidents that occur on the weekend when the staff that enters incidents into IMS are not working, limiting the ability to enter incidents within 24 hours. This change to upload incidents within 24 hours instead of 48 hours is onerous. We have staff who are responsible to immediately engage, investigate, and/or take action concerning incidents, but those are not necessarily the same staff who upload the data into WVIMS. And the staff who enter are not working beyond 40 hours per week. Some consideration in meeting the 24 hour requirement over weekends and holidays is requested, as not all agency staff have access to the WV IMS. This could require certain employees consistently working weekends and holidays.	This statement has been added to the policy manual: All incidents must be entered into the WV IMS within 24 hours of the provide becoming aware of the occurrence. If the provider becomes aware of the incident on a weekend or holiday, it is acceptable to enter the incident the following business day. NOTE: The incident is able to be edited for up to two weeks following the first entry. This is sufficient time for the IDDW provider to amend the original entry once the incident report or more information is received.
		Duplicate	530.20.1 OHFLAC does not allow AMAPs to administer medications in Day Treatment sites. Can an LPN bill the LPN code when doing a med pass at a Day Treatment program?	Clarification was received from OHFLAC that both LPNs and AMAPs can med pass at a licensed Facility Based Day Habilitation site. The policy manual has been changed to continue to allow an LPN to bill for a med pass at a licensed Facility Based Day Habilitation site.

		Duplicate	513.25.4.2 A return to a per diem or global authorizations should be considered. With the new budget methodology, many people will have reduced budgets. Base budgets do not provide adequate service provision with the staffing ratios that would need to be purchased, in order to ensure the health, safety, and needs of the members being served. Personal need and choice are eliminated from the budget methodology. Reduced staff will not be adequately able to monitor the health and safety of members. This could result in more staff burnout, and higher rates of abuse and neglect incidents. Reduced budgets do not support the new regulations for integration with the Transition Plan. Individuals will be less able to get out into their communities and will be restricted to staying home more often. This will also negatively impact individual choice, if one or two individuals in a home want to go on an outing and the other individual does not. In that situation, someone will not get to choose. The add on amounts will not be sufficient enough to address a person's need. The high add on for externalized problem behavior is $4287 which is only 214 hours for the year, or approximately 18 hours a month of 1:1 services. The stop gain/loss rule is going to create a downward spiral to individual budgets. Therapies will be cut from services in order to provide 24/7 care. This is taking away needed services that benefit individuals. We have had many members benefit from the ongoing physical therapy services that they received, increasing their mobility and independence greatly with the utilization of this service. Under this methodology, all individuals in the home would have to match the lowest budget of the member's in the home in order to keep staffing ratios within each person's budget. This will be challenging to do if all individuals in a home have different anchor dates, and if a roommates budget significantly decreases during the middle of the others budget year.	Our goal in implementing the new methodology is not to decrease spending, but to put in place a system that is more understandable and predictable, based on historic spending patterns. For example, an individual living in a 1-person ISS will have an annual budget between $176,731 - $201,402, depending on their individual circumstances. Individuals living in an ISS or group home typically have had higher spending levels compared to members who live with their families, which the new methodology takes into account. Under the new budget methodology, BMS estimates that over 65% of waiver members will receive a budget higher than the amount they spent on services during their 2016 IPP year, and over 87% of waiver members will receive a budget within 10% of their 2016 IPP year spend. Further, if the waiver member believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
		Duplicate	513.25.4.2: Must legal representatives now attend all annual assessments? If they do not attend, do they forgo their right to question the accuracy of the answers? Can other team members question the accuracy of the answers? What will the person or their legal representative review during the assessment to verify the answers were recorded accurately?	In the current manual, it is the responsibility of the legal representatives to attend annual assessments (Section 513.25.2), this has not a proposed change. The person or their legal representative will have the opportunity to sit next to the KEPRO staff inputting the answers into the computer while someone else scores the hard copy of the ICAP. The member or the legal representative may review the paper copy upon request to the service coordinator who can also allow the person or the legal representative to review the cumulative scores entered into the UMC web portal.
		Duplicate	513.25.4.2 PAGES 118-125: Will this notice be uploaded to CareConnection?	Yes, this is the annual budget letter that is sent to the person/legal representative and uploaded into the UMC web portal for Service Coordinator's review and use.
		Duplicate	What if the technical error is detected by the Service Coordinator or any other team member? May they report the error to the UMC, or must it come directly from the consumer or the legal representative? Will there be revisions to the current DD5 form to accommodate this change? (i.e. a new section reflecting all the additional services the consumer or his/her legal representative believes the person needs)?	The Service Coordinator, with permission from the person or their legal representative, may report the error to the UMC. Yes, a revision will be made to the DD5 to accommodate this change. The new form will be available by May 1, 2018.
		Duplicate	Can Service Coordinators still complete the exceptions process request form and submit the supporting documentation to BMS?	The Service Coordinator may assist the person or their legal representative in completing the form and submitting the supporting documentation.
		Change	513.3.7 Proof of insurance, inspection and registration should not be required if staff are not using their personal vehicle, and only provide transportation in an agency vehicle.	This has been changed to differentiate between the use of personal and agency vehicles.
32	12/22/2017	No Change	I have a 25yr old daughter who lives at home, needs total care, attends Day-Hab and loves her life with her family and friends at the day program. I will only address home based care because that's what I know. I can't begin to tell you how upset I am with the new way of determining budgets. You say this new system will be more accurate, but you also said the old system was accurate while all of us affected by it told you it was not. You now admit the old way was not accurate or transparent, but you want us to trust you on this. You're wrong!! There is nothing transparent about your Low-End/High-End totals. You say these totals were made by actuaries and have a 95% accuracy. That really all depends on what their goal was. If the goal was to cut the budget significantly and then categorize people to fairly share the cuts, then I guess it is accurate. But if the goal was (as it legally should be) to try to assess individual needs and meet them as close as possible, you failed once again. There is such a wide range of needs among this population and to say that 95% of those living at home fall within $38,283 and $44,321 is ludicrous. There are those that are mobile and can do very well with supervision and then there are those that need 24hr nursing and there is only $6038 range. You know as well as I do those totals are not going to take some families very far. But you say there are add-ons. Well the worst raw scores would only add $10,768 more dollars unless there are behavior problems, but they must be very serious and that is not the norm. This is going to be disastrous for families. So, the families should get unpaid help. This is not always possible, and an individual has a right to stay in the home if they want to. Well you say there is the stop-loss rule, so each person will receive no less than 80% of the 2017 budget. Most families took a significant cut to comply with their 2017 budget and now it will be 20% less! So now we have the Exceptions Process where a panel of 3 people from BMS and KEPRO will review for errors and documentation about how the person could be institutionalized if they don't get the excess funds approved. What if the person just wants to stay in their home and live a normal life as much as possible with their family. Isn't that reason enough to increase the budget (I believe Federal law says they have that right). Also, the appeal process is now non-existent because it goes right back to the institutional question and not to the right of the person to live the life they want. Why don't you just be honest and call this what it is; a HUGE cut to waiver disguised as compliance and transparency. I also can't understand why families are targeted so much. According to you we should be able to get unpaid help and ask friends and neighbors if we don't have family available to PLEASE help us. Don't you see how much keeping individuals in their homes is saving you? With all your fancy actuaries why can't they figure that out and give families the help they need to take care of the ones they love! This really is awful and you all should be ashamed of yourselves	Our goal in implementing the new methodology is not to decrease spending, but to put in place a system that is more understandable and predictable, based on historic spending patterns. For example, an individual living in a 1-person ISS will have an annual budget between $176,731 - $201,402, depending on their individual circumstances. Individuals living in an ISS or group home typically have had higher spending levels compared to members who live with their families, which the new methodology takes into account. Under the new budget methodology, BMS estimates that over 65% of waiver members will receive a budget higher than the amount they spent on services during their 2016 IPP year, and over 87% of waiver members will receive a budget within 10% of their 2016 IPP year spend. Further, if the waiver member believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
33	12/22/2017	No Change	BMS has admitted in the first Power Point slide it used to explain the new budget methodology that the algorithm it has been using to determine annual budgets (and will continue to use through June 2018) "was outdated;" "based on claims data from 2010" and "was not transparent." BMS then contends in slides 2-3 of that Power Point presentation that the new methodology will be more transparent and robust because it will utilize 2016 budget data and the services that each IDDW individual actually used in 2016. This is a flawed premise and is based upon a false presumption that whatever services an individual received in 2016 were all that the person needed.	A new waiver application was approved by CMS on July 1, 2015 and the new policy manual which included new services and changes to existing services did not go into effect until 12/1/2015. Individuals were allowed 365 days to transition to the new policy manual as their anchor dates or six month IPPs occurred. Since implementation of the new IDDW policies in 2015, BMS has monitored the number of people in the waiver moving to different settings and the number of people in the waiver moving to institutions, and there has not been a statistically significant increase in those numbers. A person in the IDDW is not required to hire a private attorney to pursue a Medicaid Fair Hearing. In additiona, each denial letter includes a list of entitites that may provide free legal services to eligible individuals. See the list and contact information below: Disability Rights of WV - 1-800-950-5250 Legal Aid of WV - 1-866-255-4370
		No	The new methodology is no more transparent than the flawed algorithm it seeks to replace, contrary to	The budgets are not based on the individual person's spending in 2016; rather, the budgets were calculated looking at aggregate data of all people in the

		Change	assertions by BMS in the training sessions held in early November, unless BMS willingly discloses the data that it provided to the actuarial company that performed the data analysis that serves as the basis for determining the new methodology. Without seeing the data, the IDDW population is unable to verify or confirm either its accuracy or its completeness and the due process violations that resulted in the federal district court issuing a preliminary injunction will still exist and create a basis for the same type of challenge that successfully caused BMS to attempt to come up with a new methodology. The IDDW population also has a due process right to examine the analysis of the actuarial company to verify it accuracy. The actuarial calculations are no less mysterious to the public than the workings of the algorithm that BMS admits was flawed and needed to be abandoned. 2.The amount of services he or she actually utilized in 2016, but essentially ignore the historical needs of the person. Such a process fails to consider the long-established individual needs of the person in favor of a one-year "snapshot" that does not consider factors like: someone being hospitalized and unable to utilize services or losing a respite worker or nurse and having difficulty replacing the person quickly. On paper, it may look like the person did not need the services authorized in 2016 because they were not fully utilized, when the reality may simply be the illness of the IDDW person or loss of his staff or support person was the cause of underutilization. Establishing an "exceptions process" does not solve this problem, but merely creates another layer of bureaucracy and "red tape" and anxiety for this vulnerable population to have to negotiate.	waiver in 2016. The "amount of services he or she actually utilized in 2016" is not relevant to calculating the person's budget, except with respect to the Stop Loss/Stop Gain. The new methodology addresses transparency concerns by clearly basing the budget on an individual's age, residential settings and individual ICAP scores.
		No Change	The amount of services he or she actually utilized in 2016, but essentially ignore the historical needs of the person. Such a process fails to consider the long-established individual needs of the person in favor of a one-year "snapshot" that does not consider factors like: someone being hospitalized and unable to utilize services or losing a respite worker or nurse and having difficulty replacing the person quickly. On paper, it may look like the person did not need the services authorized in 2016 because they were not fully utilized, when the reality may simply be the illness of the IDDW person or loss of his staff or support person was the cause of underutilization. Establishing an "exceptions process" does not solve this problem, but merely creates another layer of bureaucracy and "red tape" and anxiety for this vulnerable population to have to negotiate.	The budgets are not based on the individual person's spending in 2016; rather, the budgets were calculated looking at aggregate data of all people in the waiver in 2016. The "amount of services he or she actually utilized in 2016" is not relevant to calculating the person's budget, except with respect to the Stop Loss/Stop Gain. The Exceptions Process is optional, and it does not create any additional burden for the people who decline to use it. The Exceptions Process provides an avenue for people to receive services in excess of their budget, if the person such services are necessary. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
		No Change	The Stop-Loss/Stop-Gain Calculation is too rigid and does not consider the individual. One size does not fit all when it comes to an IDDW individual, but the rigid application of formulas to determine budgets is an attempt to ignore individual needs and merely control budget outlays. That violates the civil rights of this population group. Adding a mere 20% to someone's budget under the new methodology may still result in a significant shortfall of what services are needed. However, under the proposed policy changes, such a person must first be subjected to the exceptions process and if that fails to result in services the person has traditionally needed, he or she will need to go through a Fair Hearing appeal process that is being revamped in such a way that it will likely be impossible for anyone to prevail. A person will have to prove they are likely to be institutionalized without continuing to receive services they have traditionally been authorized to receive, presumably based upon prior decisions by BMS that they were needed, but which appear now to be considered inconsequential past decisions.	The Stop Loss policy does not "add" 20% to a person's budget. Rather, it caps the decrease in budget a waiver member can receive at 80% of his or her 2016 IPP year spend. In addition, the exceptions process can be used for individuals' whose 2016 year spend, and thus their Stop Loss/Stop Gain, does not reflect the amount of services they have historically received (e.g., because of a hospital stay in 2016).
		No Change	Why are only parts of the ICAP being utilized as possible "add-ons"? Why are only serious maladaptive behaviors considered worthy of "add-ons"? Why are there no "add-ons" for those who have substantially serious, physical, medical issues as opposed to maladaptive behaviors? This is yet another example of how the methodology is flawed and fails to capture the individual differences between the various members of this divergent population group.	BMS used add-ons to ensure members' service needs are met. The add-ons were chosen because it was determined, in an actuarial analysis, that they had a statistically significantly relationship to the amount of waiver services a person uses.
		No Change	There is a serious lack of transparency about how the annual assessment scores will be utilized, if at all, in establishing the baseline budget range for each person. It appears the annual assessment will NOT be utilized at all in this fashion, and that only parts of the assessment (i.e., certain ICAP categories) will be utilized for possible "add-ons."	It is correct that only certain ICAP categories will be utilized for possible "add-ons" to the base budgets, but the annual functional assessments (in their entirety, not just the ICAPs) are used to determine annual medical eligibility for the program. Each person must be found both medically and financially eligible annually to continue to be eligible for this program.
		Duplicate	Section 513.25.4.2 at pp. 118-119 – It is unfair to expect people to agree to the accuracy of the answers that are being entered by the Kepro person into a computer without giving the person a printout of the information at that time and then give the person a chance to compare the answers to the final results that appear in the data the results from the assessment and the structured interview. How can anyone be expected to trust that the answers were entered accurately without being given a printout? Common sense dictates the be done and a copy be provided prior to the assessment ends and people depart.	The person or legal representative is encouraged to sit next to the KEPRO assessor while the paper form and computer forms are completed. The original physical copy of the ICAP assessment completed by the person, his/her legal representative and his/her IDT. Once the ICAP assessment is completed, and the person or his/her legal representative has signed the document attesting to its accuracy and completeness, it will be the duty of the Service Coordination provider agency to ensure that the document is not altered, copied or distributed in any manner. However, the Service Provider must make the original physical copy of the ICAP assessment available to the person, his/her legal representative and his/her IDT at the Service Coordinator's office, upon request, to review only. The Service Coordinator provider agency may store the document electronically but must be able to make the document available to review upon the request of the person or their legal representative.
		No Change	Section 513.25.4.2 at pp. 119 – determining the "base" budget on a person's living setting is completely biased and fails to consider the specific needs of an individual. One person may be in a natural family setting, able to speak, able to walk and feed himself, etc., while another, like my daughter, is almost infantile in her development in the natural family setting, unable to walk, talk, feed herself, toilet herself, etc. How can she start with the same "base" budget as the prior person I described? The "add-ons" simply do not capture these differences because they emphasize maladaptive behaviors and not the physical differences I have described. The methodology is flawed at the outset with such a structure as this and a flawed "base" budget.	The add-ons capture the differences between someone who lives in a natural family home who is able to independently walk, talk, feed and toilet themselves and someone who cannot do any of those things or needs assistance. In addition, if the person believes the budget is insufficient even with the add-ons, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
		No Change	Section 513.25.4.2 at pp. 122-123 – The Exceptions Process utilizes "the risk of institutionalization" as a standard for determining if someone satisfies an exception and is approved for a larger budget. This is harmful on many levels due to the fundamental flaws in the methodology already mentioned. For example, since only 2016 "spend" data is used as a baseline for consideration of the Stop-Loss/Stop-Gain calculation, in cases where someone's "spend" was substantially lower because of personal illness or the loss of a direct support person, respite worker, nurse, etc., such an individual will be punished and likely denied services they certainly need, but were unable to obtain because of unfortunate circumstances like these outside of their control. The fact that a family did not institutionalize their son or daughter when they lost a nurse or respite worker or direct support person appears to assure that they will lose if they pursue the "exception process." The standard for prevailing in the "exception process" is far too narrow, as worded, and actually appears to violate federal law and the civil rights of this population group. It also appears to be an illegal attempt to narrow the scope of review that the Board of Review applies in the Fair Hearing process.	The IDDW program is designed to ensure that a person can continue to live in the home and/or community rather than an institution, and it therefore makes sense for the standard for the Exceptions Process to be "risk of institutionalization." In addition, if the 2016 baseline for the Stop Loss is artificially decreased because of circumstances that occur beyond the person's control (hospitalizations, etc.), then that will be considered during the Exceptions Process.
34	12/22/2017	No Change	Pg. 11 - 513.2 Provider Enrollment and Responsibilities - The Arc of WV is pleased to see detailed specifics for the Direct-Care Ethics requirements for training. We would like to see more oversight on the quality and content of these trainings, however.	The UMC, KEPRO does retrospective reviews annually and inspects a random 10% of all employee files for compliance with qualifications, including Ethics. If a significant portion of the files reviewed do not meet BMS' standards, then the matter will be referred to the BMS Office of Program Integrity for a more thorough review that may result in a higher disallowance to the agency.

		Duplicate	Pg. 28 - 513.5 Documentation and Record Retention Requirements, Specific Requirements - The Arc of WV would like an explanation as to why this requirement was added. It is our opinion that any Member who wishes should be allowed to have a copy of any assessment that has been completed on them.	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.
		Duplicate	Pg. 37 - 513.8 Individual Program Plan (IPP) - The Arc of WV agrees that all IPP meetings should be scheduled at a time and location that takes into consideration the schedule and availability of the person who receives services and the other members of the team.	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.
		Duplicate	Pg. 45 - 513.9.2 Participant-Directed Service Option – The Arc of WV adamantly believes that if waiver participants are to be able to self-direct their services they should be al lowed to customize and manipulate their portion of the budget in any way they see fit so long as needs are being met.	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.
		Duplicate	Pg. 63 - 513.14.1 Environmental Accessibility Adaptations Home (Traditional Option) – The Arc of WV vehemently disagrees with the addition of one more l imitation/cap to items that can be purchased through the EAA service. 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. Pp. 65-72 - 513.15 Day Services – The Arc of WV does not support the changes that have been made in this section as, in our opinion, they represent a backward trend for individuals who receive Waiver services and go against the Centers for Medicare and Medicaid Services (CMS) Home and Community Based Services (HCBS), mandate that services would not be provided in segregated, congregated, institutional-type settings. It was this ruling that gave states until 2020 to transition to true home and community based services. WV does not yet have final approval on its transition plan and is now moving backwards on its implementation.	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.
		Duplicate	CMS representatives continue to reiterate that congregated and segregated services cannot be paid for with HCBS funding. We would like BMS to share with us any information they have from CMS that the HCBS settings.	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.
		Duplicate	513.15.1 Facility-Based Day Habilitation (Traditional Option) - The Arc of WV's position 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 and believes that 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. 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.	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.
		Duplicate	513.15.2 Pre-Vocational (Traditional Option) - The Arc of WV objects to the removal of "and community settings" from the site of service. 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. 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 volunteer activities would be detrimental to this type of learning.	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.
		Duplicate	513.15.3 Job Development (Traditional Option) - The Arc of WV 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? Employment is not the same as personal care and should not be treated as such. The current pol icy manual leaves out, and the draft manual does not include, a critical planning service prior to job development - customized career planning that includes a discovery process that identifies the importance of 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. Customized career planning is needed so that staff and the member are seeking and negotiating for the right job for the focus person.	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.
		Duplicate	513.15.4 Supported Employment (Traditional Option) – We are 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 and believe this section could be strengthened by a statement that makes clear all other employment, aside from self-employment, must be in integrated community work settings. In addition, The Arc would like to see a more detailed description of the phrase "integrated settings" that includes the reference to typical workplaces in the community where most co-workers do not have disabilities.	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.
		Duplicate	Pg. 74 - 513.16.1 Goods and Services (Participant-Directed Option, Personal Options Model) – The Arc of WV adamantly believes that if waiver participants are to be able to self-direct their services they should be allowed to customize and manipulate their portion of the budget in any way they see fit, as long as their needs are being met.	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.
		Duplicate	Pg. 80 - 513.17.1.2 Family Person-Centered Support (Personal Options Model) - The Arc of WV adamantly believes that if waiver participants are to be able to self-direct their services they should be allowed to customize and manipulate their portion of the budget in any way they see fit, as long as their needs are being met.	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.
		Duplicate	Pg. 113 - 513.21.2 Transportation Miles (Participant-Directed Option, Personal Options Model) - The Arc of WV adamantly believes that if waiver participants are to be able to self-direct their services they should be allowed to customize and manipulate their portion of the budget in any way they see fit so long as needs are being met.	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.
		Duplicate	Pg. 113 - 513.21.2 Transportation Miles (Participant-Directed Option, Personal Options Model) - The Arc of WV adamantly believes that if waiver participants are to be able to self-direct their services they should be allowed to customize and manipulate their portion of the budget in any way they see fit so long as needs are being met.	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.

		Duplicate	Pp. 118-123 - 513.25.4.2 Service Authorization Process –The Arc of WV does not agree with the inclusion of the new statement: "The UMC, the person, the legal representative, the service coordinator, and any other members of the IDT that wish to be present will attend the annual assessment." We would agree to a change to the statement that said "…and any other members of the IDT that the person wishes to have present will attend the annual assessment." Inviting everyone to attend an assessment of an individual that is sometimes very hard on the individual and/or their families, since the focus is on what the person is not able to do, is insensitive and extra people should be left to the discretion of the individual. It would also potentially make scheduling the assessment more difficult.	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.
		Duplicate	Pp. 118-123 - 513.25.4.2 Service Authorization Process –The Arc of WV does not agree with the inclusion of the new statement: "The UMC, the person, the legal representative, the service coordinator, and any other members of the IDT that wish to be present will attend the annual assessment." We would agree to a change to the statement that said "…and any other members of the IDT that the person wishes to have present will attend the annual assessment." Inviting everyone to attend an assessment of an individual that is sometimes very hard on the individual and/or their families, since the focus is on what the person is not able to do, is insensitive and extra people should be left to the discretion of the individual. It would also potentially make scheduling the assessment more difficult.	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.
		Duplicate	The Arc of WV would like a detailed explanation of what the process is for the UMC to "resolve the issue" when there is disagreement on the assessment? What will be the timeframe in which the UMC shall resolve the issue after the individual has notified the UMC within five days of the assessment date?	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.
		Duplicate	Redetermination Requests (pg. 121) - This section does not provide any measurable timelines for the UMC to notify the BMS of the need for an increased budget due to a documented changed in an individual 's status and it does not provide a measurable timeframe within which the BMS will make a final determination on increasing the budget. The Arc of WV suggests that it is imperative that a specific timeframe be determined by BMS and then the phrase "as soon as possible" be replaced with that specific timeframe in the manual. It is also our recommendation that a specific timeframe be added as to when the BMS will render its decision.	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.
		Duplicate	Exceptions Process (pg. 122) - The Arc of WV believes that there should be representation through at least one of the three individuals on a panel to determine exceptions, by a person who is/was not employed by, or paid through, DHHR or its contractors.	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.
		Duplicate	The Arc of WV is concerned about the interpretation of the criterion being used to make decisions that basically only addresses whether the prevision of services is just enough to "prevent a risk of institutionalization." We are adamantly opposed to the suggestion that as long as people are living just above the institutionalization threshold then they should be happy with what they get from BMS. We fully believe that individuals with IDD should have access to a program that supports them in living full and rich lives in their communities. That being said, we agree with the statement in the program description, that states: "The IDDW Program is a program that reimburses for services to instruct, train, support, supervise, and assist individuals who have intellectual and/or developmental disabilities in achieving the highest level of independence and self-sufficiency possible ", but believe the criterion needs to support that concept.	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.
		Duplicate	The Arc of WV remains concerned about lack of access to enough hours of service to allow some families to be employed full-time outside the home. Specifically, the families of children with significant medical issues that cause them to be unable to attend school cannot access enough hours of service to allow both parents, or single parents, to work.	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.
		Duplicate	Finally, despite providing details on what the BMS believes qualifies as respite, in most families, those things do not provide the type of respite that allows caregivers to reconnect with other family members, friends, or community members. It appears that the DHHR would find it more desirable to cover more costly services, provided in 24 hour per day group settings, rather than support parents in their desire to keep their family intact and healthy.	This is a Duplicate of a comment/question submitted by the DDC, please see answers to comment #28.
35	12/22/2017	Duplicate	DHHR must reconsider the changes to Skilled Nursing Licensed Practical Nurse (Traditional Option). As drafted, the manual requires that "...any medication administration and performance of health care maintenance tasks as described in W. Va. CSR §64-60-1 et seq. should be provided by a trained Approved Medication Assistive Personnel. If the LPN performs these tasks, then the LPN must drop down and bill the appropriate direct care code for Person-Centered Support or Day Services code." The West Virginia's Nurse Practice Act, as well as W. Va. CSR §64-60-1 et seq., do not require the delegation of medication administration and performance of health care maintenance tasks to AMAP personnel. In fact, delegation is left to discretion of the LPN or RN in accordance with the West Virginia Board of Examiners for Registered Professional Nurses decision model. As drafted, the IDDW manual does not permit the licensed nurse to exercise that decision model. Rather, it financially mandates the RN/LPN use AMAP personnel by prohibiting to pay the nurse's full wage to provide these services. Complex and medically fragile patients who need the skills, assessment, and independent professional judgement of a licensed nurse in the administration of their multiple medications and health care maintenance tasks will now be severely compromised and risking their health and safety by this change. I strongly encourage DHHR to modify this change to permit the flexibility of paying the licensed nurse's full wage rate in those circumstances where using AMAP personnel in the medication administration and performance of health care maintenance tasks are not in the best interest of the IDDW consumer.	This change has been delayed until July 1, 2018 or the individual's next anchor date, whichever is later. When this becomes effective, if the duty is also something that can be performed by an AMAP, then it must be performed using the least costly method. Waiver nursing (LPN and RN) does not include services delegated in accordance with and can be performed by individuals who are AMAPS as defined in W. Va. CSR § 64-60-1 et se4q.; or for visits performed for the sole purpose of meeting the supervisory requirements for LPNs or AMAPs at the direction of an RN. Agencies can still utilize LPNs to pass medications, but must not bill the LPN rate unless it is medication that ONLY an LPN can pass. It is true that the West Virginia Nurse Practice Act, as well as W. Va. CSR §64-60-1 et seq., does not require the delegation of medication administration and performance of health care maintenance tasks to AMAP personnel, but they do allow it.
36	12/22/2017	No Change	Specialized Family Care should not be grouped with Natural Family Care. We should have our own category and a larger Stop/Loss Gain base budget. We do not have the Family Support that they have. The lack of Family Support is why they are placed with us in the first place. We cannot have just anyone come into our homes for respite.	The WV IDDW has categorized Specialized Family Care Providers with natural families since the program began in 1984. It would not be appropriate to categorize these providers in the same category as 24 hours staffed settings (group homes).
		No Change	We must have paid Respite workers. They must be fingerprinted, background check etc. just like me, or an agency worker, or someone contracted by the client. Our clients cannot stay at anyone else's home unless it is a certified Specialized Family Care Home. There are no SFC homes that do Respite in almost all areas, and that is if the client is able to stay outside their home. If our clients budgets are cut to level of the proposed Natural Family base pay, then it will take away money that is needed for Respite, Transportation and PCS and Day Habilitation or Job Services. Most of our clients have taken a large hit in budget reductions now. Anything more would be drastic for them.	All respite workers, in-home or out-of-home, must be fingerprinted through the WV CARES. All out-of-home respite may only take place in certified Specialized Family Care Homes, even for children and adults living with their natural families. The budgets for a child or an adult in a SFCP setting are just like those in a Natural Family setting. All adults are eligible for Day Services, such as Supported Employment or Facility Based Day Habilitation. No budget reductions are proposed for this manual change.

		No Change	Specialized Family Care Clients have to pay $542 a month out of their SSI and SS. Medicaid or Waiver doesn't pay for this. This is to cover their room and board which is food, special diet food, living quarters, clothing, toiletries, furniture etc. This is NOT a benefit that serves us, but is what our clients need to live on at a basic level. The only "pay" the SFC Provider gets is the PCS and it is not enough to pay respite care workers after respite care monies run out. The base budget proposed doesn't even cover the services needed at home. They need care 24/7. We do a service for WV that saves money. A lot of money apparently, after seeing the base budget amounts for Group Homes and ISS homes.	The IDDW program cannot pay for room and board; paying for room and board is prohibited by federal law. The WVDHHR Bureau for Children and Families pays $600.00 per month to the foster family who cares for a child in the custody of WVDHHR. Adults pay $17.50 per day from their monthly SSI or Social Security benefit to the SFCP for this cost.
		Duplicate	There needs to be a medical person not associated with BMS to serve on the panel that will grant services needed over the budget along with a parent or outside person, also not associated with BMS. This makes the process more fair and believable.	BMS believes these decisions on exceptions requests should be made, in the first instance, by BMS and its contractors. BMS is responsible for the IDDW and is best positioned to make these complex decisions. However, if the person receiving IDDW services does not agree with decision of the Exceptions Panel, then the person still has the option of filing for a Medicaid Fair Hearing and the case will be heard by an impartial hearing officer employed by the Board of Review. Although the Board of Review is an arm of DHHR, this entity functions totally independent of the Bureau for Medical Services. In addition, the manual requires that the Exceptions Panel include one person with medical training.
		Change	If it needs to go to a Fair Hearing or the next level, then the panel should consist of people who have not served on the first panel. This would make it more fair and not just a rehash of what the previous panel did.	During a Medicaid Fair Hearing, the impartial hearing officer is the person who makes the decision. No one on the exceptions panel serves as an impartial hearing officer.
		No Change	SFC Providers should be treated with some respect at any public trainings or meetings. We should not be treated as if we are money hungry people. Comments about how the room and board "benefits" us, and how we don't have to pay taxes on our money which also "benefits" us is rude and uncalled for. We do pay SS and Medicare taxes and we only get paid $9.88 an hour for only 4-8 hours of PCS a day, depending on the client and their budget. The rest of the hours we don't get paid. So treat us with some respect! We have earned it.	BMS agrees that Specialized Family Care Providers should be treated with respect and that the focus should be on what the person in placement needs, not how much money the SFCP "gets".
37	12/22/2017	Duplicate	Pg. 26-513.4 Reporting Requirements We do not feel that shortening the amount of time given to enter incidents into IMS from 48 hours to 24 hours is going to make any difference, but it will put an extra hardship on the agencies. Sometimes it is difficult enough to get incidents entered into IMS in the 48-hour timeframe. Shortening the timeframe will only ensure that agencies fail to pass this requirement on review. Having a shorter timeframe to enter incidents into IMS may result in more errors and less detail, not purposefully, but from being rushed to meet the deadline.	This statement has been added to the policy manual: All incidents must be entered into the WV IMS within 24 hours of the provide becoming aware of the occurrence. If the provider becomes aware of the incident on a weekend or holiday, it is acceptable to enter the incident the following business day. NOTE: The incident is able to be edited for up to two weeks following the first entry. This is sufficient time for the IDDW provider to amend the original entry once the incident report or more information is received.
		Duplicate	Pg. 28-513.5 Documentation and Record Retention Requirements, Specific Requirements We understand the requirement for the original assessment document to remain unaltered. However, we do not see how making copies of the original for the member, their legal representative or for use by the IDT would cause any issues, as it is a copy and even if altered would not replace the original. We feel the best way to ensure the document remains unaltered would be to have the Facility Support Facilitator upload the original to care connection.	The original physical copy of the ICAP assessment completed by the person, his/her legal representative and his/her IDT. Once the ICAP assessment is completed, and the person or his/her legal representative has signed the document attesting to its accuracy and completeness, it will be the duty of the Service Coordination provider agency to ensure that the document is not altered, copied or distributed in any manner. However, the Service Provider must make the original physical copy of the ICAP assessment available to the person, his/her legal representative and his/her IDT at the Service Coordinator's office, upon request, to review only. The Service Coordinator provider agency may store the document electronically but must be able to make the document available to review upon the request of the person or their legal representative.
		Duplicate	Pg. 37-513.8 Individual Program Plan We have concerns that members budgets will simply not allow for direct care service needs let alone other services. Under the current Manual and budget methodology many budgets already do not fully meet the needs of the members. If it is required to purchase all direct care staffing first, then Service Coordination should be taken into account and a certain amount added in for this required service. We agree that no member should have to give up any needed direct care service. But how can that be if that member is required to have a Service Coordinator and their budget doesn't cover it and the needed direct care services? Also, if the member requires Behavior Support Professional Services or other professional services then how will they be able to access them with such small budget amounts if we must purchase all direct care services first? How can a member receive the best care and services if we have to limit professional resources for them? This is forcing these members to choose between their direct care needs as oversight while the guardian works and professional services where they receive many resources to help with behaviors, healthcare, and community integration. This is not a fair choice for them to have to make. It is also unfair to put agencies in the position of having to provide a service because of licensing issues, but not be reimbursed for it because the members budget is too low.	BMS believes it is important to prioritize ensuring that the person has sufficient direct care to keep him or her safe and healthy. If the waiver member believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
		Duplicate	Pg. 45-513.9.2 Participant Directed Service Option, Pg. 80 513.17.1.2 Family Person Centered Supports-Personal Options, Pg. 95 513.18.1.2 In-Home Respite-Personal Options, Pg. 113 513.21.2 Transportation Miles-Personal Options How is it person centered to put limits on how the member can self-direct their budget? The self-directed option was provided to allow the member to make more of the decisions on how their money is used for them and their services. Putting limits on how they can do this, limits their choices instead of allowing them to use their services in a manner that they see fit, not the state. By putting such limits on self-directed services then how is this delivery model any different than traditional? What benefit does self-directed have when it is still limiting the scope of the choices the member can make with their budget. No two members have the same amount of natural supports at home or in the community. Putting these limits on this continues to deny the members accessibility to services and risks ensuring they are able to stay in their home and not be institutionalized. These limits seem to have been put in place to penalize the families who are caring for the individual and ensure that these members are not able to access their budgets to their full extent or receive the services they are truly in need of and would be the best option for their care and wellbeing.	There are some limits on the flexibility the person receives if they choose self-direction. However, the person or legal representative exercises self-direction by choosing qualified workers of their choice, training the workers, deciding the rate of pay and schedule of each worker and separating the worker from employment.
		Duplicate	Pg. 63-513.14.1 Environmental Accessibility Adaptions for Home Advocating for members to live in a home setting but not allowing their home to be adapted to meet their needs is not acceptable. It should not matter if this adaptation may be used by others in the home who are not on Waiver. How is it right to discriminate against the community we serve because they live in a home setting which is what the state wants? We should be providing as many resources as possible for Waiver members to be able to access their home and the items in it. A member's independence should not be limited because the adaption "may" be used by someone other than the member.	As stated above, a kitchen or bathroom appliance that is ADA compatible is not sufficient to meet the need for this service. For example, almost all toilets on the market are now ADA compatible. Every parent or landlord must have a working toilet as part of providing a safe and healthy environment. It is not the responsibility of the IDDW program to provide basic household appliances necessary and used by every member of the family.
		Duplicate	Pg. 65-513.14.2 Environmental Accessibility Adaptions for Vehicle This change is just another way of removing person centered from Waiver. No two members are the same and if a required adaptation is required and it is the cheapest and easiest route to go then it should be the IDT's decision on if these items are acceptable for the member. If it is deemed fit by the IDT that the member needs such items that may be deemed "general utility" but the amount is within the $1,000 limit and the member is within budget EAA and Goods and Services should be able to be used how the IDT deems fit. Once again, we are limiting waiver members instead of ensuring they have the access they require.	It was necessary to further the define the approvable items for this service.

		Duplicate	Pg. 65-72-513.15 Day Services, 513.15.1 Facility Based Day Habilitation, 513.15.2 Pre-Vocational, 513.15.3 Job Development, 513.15.4 Supported Employment These changes are beneficial to Waiver members. Setting limits is once again a form of discrimination. Not every member is capable of moving towards working. We agree that employment should be the goal for those that are capable but sadly opportunity is not something there is plenty of in this state. Finding places of employment for those without disabilities is difficult enough but when these places of employment feel that staffing Waiver members or having a job coach on site is not worth the risk of the liability involved what options do our members have? There is a need for more resources for our members who are not capable of working. The community and many local businesses are not providing the needed resources such as changing tables, medical care, and integration and are not able to without assistance from the state. When these time limits were first put in place we as an agency were not given the resources or education to implement. Clients are either being turned away or put on waiting lists through the Department of Rehabilitation Services. We are required to access DRS services prior to Waiver Supported Employment but DRS has not been a beneficial resource. Our question is what are Waiver members expected to do while waiting on these resources in the community. We have members who would be eligible to work and would like to but with the lack of resources is not able to do this in a timely manner and does not do well in a community setting…what are these members to do? What are we as agencies supposed to do but provide them with the best services we can with such limited supports and resources when it comes to employment for our members in our area. Also, how do we take members who are not used to such routines and settings and simply throw them into pre-vocational training? How does the state know how long these transitions should take for each member? We really need better transition plans from home to pre-voc to job development to supported employment to employment before a huge change like this should take place. If the member chooses to work for an IDDW agency in their building for a job that is available this should be their choice. This is once again limiting the choices of the member. Many members enjoy working at the agency as we are willing to provide them with work that they are capable of doing in a setting that is set up with the members in mind. Telling a member, they cannot work somewhere is a form of discrimination because you are telling them they do not get a choice of employment because they have a disability and because they chose to access Waiver services. Other individuals without disabilities are not given these same limits and it would be considered discrimination to do such. This change has also essentially made many members unemployed who were previously employed for many years with various agencies.	The site of service for Supported Employment has always been the local public community and the rate of pay has always been at least minimum wage. By removing the 3 year restriction on Facility Based Day Habilitation and the 2 year restriction on Pre-Vocational Services, the time limits are open ended so that people that choose to access these services may take as long as they need to transition to Supported Employment. We are not telling anyone they cannot work. We encourage everyone to work at their own pace. The only difference is that IDDW agencies can no longer use people to perform tasks of benefit to the IDDW agencies. Tasks of a benefit to a provider are those tasks, performed by a member, for which the provider would otherwise have to pay an employee to complete. A member taking out trash generated by the whole room or setting (not just the member's personal trash) would be an example of a task benefiting the provider. A member being trained to clean up after him/her self would not fall in this category.
		Duplicate	Pg. 74 Goods and Services If it is deemed fit by the IDT that the member needs an item that fits in the $1,000 limit and the member is within budget Goods and Services should be able to be used however the IDT deems fit based off the needs of the member. Having a list of items that are not approvable that contains many items that have been requested and approved in the past is discrimination and has become an unapproved item only because the state doesn't want members to truly have access to this service or the goods/services they need. How is it fair for the state to say they are not willing to cover certain items that someone somewhere deemed an inappropriate use of this service. If this service is already capped at a dollar amount, then that monetary amount should be able to be used by the member however the IDT deems fit. Once again, no two members are the same and treating the IDDW community as if they are all one and the same is the exact opposite of person centered. Also see comments for EAA home & vehicle.	In the next manual revision, BMS will consider listing only items that can be approved instead of listing all the items that cannot be approved. Not all items are approvable items now and the $1000 is not a guarantee that an item will be approved just because the person has chosen to self-direct their services.
		Change	Pg. 118-123 513.24.4.2 Service Authorization Process "The person or their legal representative shall notify the UMC through their service coordinator within 5 days of the assessment date, and the UMC shall resolve the issue. The Assessment Data Modification Request (WV-BMS-IDD-13) form must be fully completed and must cite the items in question." This was changed from 60 days of the assessment date to 5 days…This is an unrealistic time constraint put in place to ensure there is not enough time to dispute inaccuracies in the assessment data. The results are not provided to the family or the agency in under 5 days so how can we compare the hard copy that was completed to the data entered by the UMC to ensure accuracy? Under the current manual, results are usually obtained with only a short period of time to review and dispute with the 60-day deadline how will it be possible in 5 days? "and the UMC shall resolve the issue" how are they going to resolve the issue? There is no mention of the process beyond completing and submitting the DD-13. What timeline will the UMC be held to for resolution of these issues? The families and agencies are given many strict deadlines but the UMC never seems to be held to the same standard.	This time period is in reference to when the person or his legal representative declines to sign the acknowledgement that they participated in the assessment and we given the opportunity to review and concur with the answers recorded during the assessment. This time period has been changed from 5 days to 10 days in the policy manual. The 60 day time limit is the response time to review the budget calculation and seek an exception.
		No Change	Pg. 119 Budget Methodology Under the current manual there has never been much rhyme or reason behind the budget amount given to each individual because based on the needs of the members the current budget amounts have never made sense in a person-centered manner. The budget methodology needed to be changed and the transparency in the new methodology is appreciated, however the starting budget ranges are far to low to meet the needs of the Waiver community. It is sad that the state feels it appropriate to only provide just enough services to keep Waiver members out of institutions and that their goal is not more focused on quality of life, habilitation and integration. If provided with the appropriate amount of monies for services and resources, the waiver community would certainly benefit in more ways than just avoiding institutionalization. These starting budget ranges are grouping people together based on criteria that is not going to help differentiate between actual needs of the individual members. This is not person centered. There are add on's which is a great concept, but the amounts for these add on's and the number of add on's are not enough to meet the needs such as crisis placement, therapies, behavior intervention, ect. This seems to be another tactic by the state to lower costs at the expensive of the Waiver Community. This new budget methodology and add on's even with the stop/loss stop/gain rule will result in budgets much lower than any member has been accustomed to while on the program.	It is important to remember that the base budget is just a starting point. After the add-on amounts and the stop loss/stop gain, BMS estimates that over 65 percent of waiver members will receive a budget higher than the amount they spent on services during their 2016 IPP year, and over 87 percent of people accessing IDDW services will receive a budget that is either higher than their 2016 IPP year spend or no more than 10 percent below 10 percent of their 2016 IPP year spend. Further, if the waiver member believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.

38	12/22/2017	No Change	It says that supported employment cannot be provided in any setting owned or leased by the IDDW provider agency. I don't think this is fair. My uncle has lot of medical problems, and takes several medications that effect him differently everyday. This causes a problem for him when it comes to working. It effects when he can work and for how long. Working for the agency for years my uncle has been able to work what days he can and what time frame he can. By the agency being able to hire him as an employee he has a sense of worth and by receiving a pay check values what he can contribute to society. Where else can he work only when his disability allows and receive a pay check? Please reconsider this. There are not job sites that will hire someone on a work when you can basis. Thank you.	Supported Employment which includes a job coach can only be provided in integrated public settings, however, pre-vocational services may be provided at a site owned or leased by an IDDW provider. A person engaged in pre-vocational activities may receive pay
39	12/22/2017	No Change	It is concerning that people who clearly cannot live without 24 hour assistance are subject to have their budget for services reduced based on a former year's spending, which may include staff shortages (never billed for) beyond a client's control. Common sense would dictate that certain basic levels of care need to be sustained for many in this population. People cannot be justly reduced to a numbers game yet a numbers game seems to be in the Waiver mindset. Also, the quality of individual care would likely rise if direct care workers were paid a fitting wage for offering what is one of the highest services to their fellow man.	The IDDW includes members with different needs, children, adults, some of which live with their family and have natural supports and some of which who live in 24 hour group homes and need paid support 24 hours a day because no natural supports are available. It is important to remember that the base budget is just a starting point. After the add-on amounts and the stop loss/stop gain, BMS estimates that over 65 percent of waiver members will receive a budget higher than the amount they spent on services during their 2016 IPP year, and over 87 percent of people accessing IDDW services will receive a budget that is either higher than their 2016 IPP year spend or no more than 10 percent below 10 percent of 10 percent of their 2016 IPP year spend. Further, if the waiver member believes services in excess of the budget are necessary, he or she may apply for additional services through the Exceptions Process. Decisions on requests through the Exceptions Process are appealable through the Medicaid Fair Hearing process.
40	12/22/2017	Change	May the money left over in the monthly spending plan be carried over into the next month?	No, monies may not be carried over as approved in the application by CMS. This paragraph was added to the policy manual: There are many reasons why a person may not use their entire allocated budget (hospitalization, periodic increase of informal/non-paid supports, etc.). Any unused funds from one month may not be carried over to later months within the person's annual budget period. The Personal Options vendor assigns a Personal Options Resource Consultant to assist and support each self-directing person to develop and monitor monthly spending plans. The Resource Consultants will ensure the person/representative is aware of under-utilization and/or any attempts to over spend the monthly spending plan.
41	12/22/2017	Change	The West Virginia Behavioral Health Provider Association commissioned a report from Health Management Associates to research and analyze the new WV IDDW Individual Budget Authorization and Process.	The Bureau for Medical Services is working with the acturial firm who developed the new methodology and will send a response to the WVBHPA as soon as it is available.