COMMENT LOG

Chapter 502 Children with Serious Emotional Disorder Waiver (CSEDW)

Public Comment Period: August 22, 2024, to September 22, 2024

Comment Number	Date Received	Comment	Action
1	9/16/2024	Consideration for a different term here? Adolescent is typically defined as to the age of 19, this program is for adults eligible to age 20.	**No change:** The West Virginia Bureau for Medical Services (BMS) chooses to use adolescent as the term to describe older individuals on the waiver as the American Academy of Pediatrics considers late adolescence to go through age 20.
2	9/16/2024	This should be changed to the highest level of intensity of service delivery in the home and community setting.	**No change:** Per the Centers for Medicare & Medicaid Services (CMS), home and community-based services (HCBS) provided by the Children with Serious Emotional Disorders Waiver (CSEDW) are for individuals who qualify for hospital or institutional level of care.
3	9/16/2024	Is 400 Statewide transition planning no longer required?	**Change:** This training is required and will be added to the policy manual.
4	9/16/2024	Is this the PCTIC training that was developed through Origins and grant funded through WVU Health Affairs?	**Change:** This training is offered through BMS's learning management system (LMS). The training will be relabeled as Trauma Informed Care Training.
5	9/16/2024	This was previously not required until the master POC. Is it now being expected to be completed at the initial?	**No change:** The goal of the CSEDW is to provide intensive support to individuals for 6 – 12 months. To achieve more appropriate and timely discharge to alternative supports, planning for transitioning out of the waiver will begin at the first meeting. The transition plan does not need to be comprehensive at the first meeting, as it can be further developed in the future, but a broad plan must be discussed.
6	9/16/2024	What is the consequence if not? We have part-time staff who cannot hold a caseload of 10 due to the demand of their full-time work.	**No change:** Expectations for caseload capacity are based upon full-time wraparound facilitators. If there is a part-time member of your staff who is unable to have this caseload, please discuss this directly with a supervisor and/or the managed care organization (MCO) care manager.
7	9/16/2024	Previously we were allowed to reassign these to a WF credentialed supervisor throughout the duration of hold. Is this no longer allowed?	**No change:** The wraparound facilitator is expected to maintain the child's/adolescent's case within their caseload while the child/adolescent is on hold, to promote consistency within the program.

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8	9/16/2024	Previously there was a mandated 72 hour contact, is that not still the case? Or is it just contact prior to the 7 day meeting?	**No change:** Contact with the family is required within 72 hours of the assignment date. Further clarification within the manual will be provided to reflect this.
9	9/16/2024	Is this saying there must be one additional supportive service outside of Wraparound Facilitation for CSEDW? Members cannot only have Wraparound Facilitation?	**No change:** Wraparound facilitation is designed to be an integral part of a comprehensive service package, not a standalone service. Therefore, children/adolescents enrolled in the CSEDW are required to receive at least one other billable service in addition to wraparound facilitation.
10	9/16/2024	This should be to notify the Wraparound Facilitator and Aetna CM	**No change:** The current process is to notify the wraparound facilitator and one other member of the child and family team (CFT) when a child/adolescent is admitted to a psychiatric residential treatment facility (PRTF). The wraparound facilitator is then responsible for notifying the managed care organization (MCO) care manager.
11	9/16/2024	Is this expected to be completed at the redetermination meeting?	**No change:** Yes, an updated freedom of choice (FOC) form should be completed at the redetermination meeting.
12	9/16/2024	Will the CANS expectation be to completed at the redetermination meeting? Or is the most recent CANS presented sufficient?	**No change:** The child and adolescent needs and strengths assessment (CANS) must be completed at the redetermination meeting. The most recent CANS is not sufficient.
13	9/16/2024	Who at the ASO is this being submitted to? The SSF who completed the redetermination or someone else?	**No change:** The documentation is being submitted to the Service Support Facilitator (SSF) who completed the redetermination.
14	9/16/2024	In which domains? How many of the “no evidence of needs” selections would consider them ineligible for CSEDW	**No change:** The decision for discharge from CSEDW remains a collaborative process involving the CFT, considering various factors, including CANS domains with “no evidence of needs” and the child’s/ adolescent’s need for intensive services. The Child and Adolescent Functional Assessment Scale (CAFAS) score of less than 90 continues to be the definitive criterion for discharge because the member is no longer eligible for the waiver.

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15	9/16/2024	How is this being executed? By signing through an electronic platform? Is the ASO responsible for this?	**No change:** This will be documented in the plan of care (POC), which is a fillable PDF that can be signed electronically or printed and signed with ink.
16	9/16/2024	Can consideration for this be made to be emailed to families as well? Deadlines are being missed for appeals and discharge POCs due to the delay with standard mail.	**No change:** As of now, the process will remain in place.
17	9/16/2024	Acentra policy is that this information is to be emailed to the Wraparound Facilitator. This is not being executed consistently	**No change:** This will be discussed directly with the administrative services organization (ASO).
18	9/16/2024	Is the expectation here that a CANS is completed at every significant life event meeting? Sometimes significant life event meetings are held to add a service or adaptive equipment.	**No change:** Yes, the CANS should be completed at every significant life event meeting.
19	9/16/2024	This should be 7 calendar days of Wraparound Facilitation assignment.	**No change:** The CSEDW enrollment assignment date is the same as the Wraparound Facilitation assignment date.
20	9/16/2024	This should be 30 days of the wraparound facilitation assignment date.	**No change:** See previous response to item #19.
21	9/16/2024	Will this be added to the signature page of the POC? The current one does not have it.	**No change:** This will be added to the POC currently in development.
22	9/16/2024	Is it not also based on what the family identifies as their current needs? That does not always align with the referral reason.	**No change:** The CFT, which includes the child/family, service providers, and other relevant stakeholders, is ultimately responsible for developing the POC. This collaborative process helps to ensure that the goals, which are informed by assessments and the child's/family's identified needs and preferences, align with the person-centered planning principles of HCBS waivers.
23	9/16/2024	This should be 30 days from the WF assignment date	**No change:** The suggested language is synonymous with the CSEDW enrollment assignment date and therefore no modification is necessary.
24	9/16/2024	Is this expected to be submitted to the MCO with the POC? Currently it is just being uploaded to our agency files. I think this would be a reach of an ask for a family story required to be submitted with a POC and not finalized if missing.	**No change:** The Family Story is submitted to the MCO along with the master POC.
25	9/16/2024	This was previously 14 so it is changing to 15?	**No change:** The age has remained 15.

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26	9/16/2024	Are the signatures just for the participants? We have been told that it needs to be sent to all team members whether they participated or not.	**No change:** All team members, including those not present, should sign the master POC.
27	9/16/2024	what exactly are discharge reports? This needs clarification.	**No change:** Discharge reports include all documentation pertaining to discharge.
28	9/16/2024	Information regarding a geographical exclusion should be mentioned here.	**No change:** The geographic exclusion criteria is described in Section 502.17.1 Child and Family Team (CFT).
29	9/16/2024	If other service providers are expected to be a part of the CFTs they should be compensated.	**No change:** BMS will continue with its current policies on reimbursement at this time.
30	9/16/2024	What is this? This sounds similar to the crisis plan that we are already completing. Who is writing this and where is it included in the POC.	**No change:** A dedicated section within the POC will be included to describe crisis plans and document any crisis incidents.
31	9/16/2024	Where would this be included? This is not currently included on the signature page of the POC	**No change:** This will be included in the POC.
32	9/16/2024	How are service providers being compensated for this?	**No change:** BMS will continue with its current policies on reimbursement at this time.
33	9/16/2024	Why is this date not aligning with the 14 day submission date?	**No change:** The 10-business-day timeline is intended to account for holidays.
34	9/16/2024	The expectation for all other service providers to log their own documentation for participating in the POC?	**No change:** Yes, documentation of participation in the POC process is expected from all service providers. This aligns with standard clinical record-keeping practices and helps ensure that all decisions and contributions impacting the child's/adolescent's care are accurately recorded.
35	9/16/2024	Why isn't this 10 or 14 days like all other timelines within the policy?	**No change:** The seven-day timeline for obtaining child/adolescent and family/legal guardian feedback is to prioritize their input and helps to ensure their voices are heard early in the POC development process, before incorporating feedback from other service providers.
36	9/16/2024	Is this determined of the accepted versus finalized POC by the MCO?	**No change:** Yes, the MCO care manager will review the POC.
37	9/16/2024	CFT and POC, these should be the same throughout. It would make sense to use POC.	**No change:** The CFT refers to the child and family team and CFT meetings. The POC refers to the Plan of Care document.

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38	9/16/2024	How are we supposed to gather enough information to complete a Master POC within 7 days to align with NWI expectations?	**No change:** The policy language articulates that the initial POC can serve as the master POC under certain circumstances, such as when the provider has a prior relationship with the child/adolescent. It is not mandatory for the initial POC to become the master POC.
39	9/16/2024	Is this occurring at home visits with the family or is this a formal POC every month?	**No change:** The meeting is a formal CFT meeting every month that is separate from home visits.
40	9/16/2024	Is the originating agency required to send these documents to the receiving agency?	**No change:** Yes, the expectation is the originating agency is required to send documents to the receiving agency. If the receiving agency does not receive the documents from the originating agency, they may reach out to the MCO for assistance.
41	9/16/2024	Is the discharge meeting not held first and then the discharge form completed?	**No change:** The discharge plan will be discussed and developed in meetings, with a best practice recommendation for a final discharge meeting to occur upon completion of the discharge form.
42	9/16/2024	So can a family choose 100% telehealth only and override CMS mandate?	**No change:** A family cannot choose 100% telehealth. Telehealth can be used for up to 50% of total services the child/adolescent receives per calendar year of enrollment. A backup plan must be discussed for the services that are utilized via telehealth within approved guidelines.
43	9/16/2024	Should this be wraparound facilitator?	**Change:** The language will be changed.
44	9/16/2024	There is no way a CANS assessment can be completed by the initial POC. There is much information that needs to be obtained to be able to accurately complete the assessment.	**Change:** The change will be made to the requirement that the CANS assessment should be completed ahead of the master POC.
45	9/16/2024	Who determines this? The Wraparound Facilitator? The Aetna CM?	**No change:** The wraparound facilitator and MCO care manager will collaborate to support the evaluation of goals for children/adolescents in CSEDW. Additional training will be facilitated for providers to ensure effective goal evaluation. The goals will remain programmatic and consistent across waiver members.
46	9/16/2024	How long will the wraparound facilitator be able to have to execute the discharge period?	**No change:** BMS does not provide a specific time frame for the discharge period, as this should be a person-centered process, which prioritizes safety and

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			coordination of care and will vary based on the child's/adolescent's specific needs.
47	9/16/2024	This service can only be provided in public community locations, but can also be tele-health 25%? There should be an option for in-home as well.	**No change:** The service must be provided in public community locations or via telehealth as permitted for planning purposes. In-home will not be an option at this time.
48	9/16/2024	How should this be documented? Past experience? Current experience?	**No change:** Experience should be documented through resumes, transcripts, and other forms of documentation of either past or current experience.
49	9/16/2024	If an agency is not providing this service, what staff training and credentialing is required?	**Change:** Language pertaining to the mobile crisis state plan service and family therapy will be updated.
50	9/16/2024	Where will this be documented and whose responsibility is it to document?	**No change:** It is the wraparound facilitator's responsibility to document. The documentation can be made in the form of a progress note indicating efforts and the responses to the invite.
51	9/16/2024	A Supportive Counselor supervises a Peer Parenting Support Worker? Why?	**No change:** While peer parenting support workers do not have a clinical background, they possess valuable lived experience. The current supervisory structure, with in-home family support workers overseen by family therapists, ensures that peer support workers receive appropriate guidance and support, including access to clinical expertise when needed.
52	9/16/2024	Does this mean the child/adolescent and/or family/legal guardian could chose to be 100% tele-health?	**No change:** A child/adolescent and/or family/legal guardian cannot choose to be 100% telehealth. Rather, the service modality can change within the guidelines of the specific service policy definition in the manual.
53	9/16/2024	• Socia Work is no longer an approved degree?	**Change:** Social work is still an approved degree and will be added.
54	9/18/2024	PG 4: references NWI model; the training website references NWIC Recommendation: Replace "NWI model" with "National Wraparound Implementation Center (NWIC) model" throughout. PG 4: ages listed as 3- 20; CSEDW website indicates 21 Recommendation: Replace with 3-21.	**Change:** Language will reflect "National Wraparound Implementation Center (NWIC) model" throughout the manual. **No change:** The website will be updated to reflect up to age 20.

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		PG 5: "The length of enrollment in the CSEDW is based upon individual needs, with an average [continuous] enrollment of nine to twelve months." Average enrollment is **12-18 months**. Recommendation: Look at whether historic data supports 9-12 months. Replace with 12-18 months. PG 6: "wraparound facilitator works with the child/adolescent and their family/legal guardian to identify and develop a plan of care (POC) that includes family voice and choice, person-centered goals, supports, and potential known barriers." Recommendation: Replace with "Wraparound facilitator works in **partnership with the family and the rest of the Wraparound team** to identify…."	**No change:** Program data will be continually monitored and evaluated to determine if adjustments to the average enrollment language are warranted. **Change:** Language will be modified to reflect the partnership with the wraparound facilitator, child and/or family, and CFT.
55	9/18/2024	Recommendation: Consider outlining specific required trainings within 3 months of hire: • Introduction to Wraparound • Engagement in the Wraparound Process And add annual requirements: • Intermediate Wraparound • Improving Wraparound Practice	**No change:** Training requirements are continually evaluated to ensure staff competency in wraparound facilitation. BMS will consider adding specific training in the future based on program needs and availability.
56	9/18/2024	Unable to find the trainings on the linked CSEDW website. They are referenced in the second a bullet from the bottom on PG 20. Recommendation: Ensure trainings are listed and aligned with other training guidance throughout.	**No change:** The website will be reviewed for content and updated as needed to help ensure accuracy and relevance.
57	9/18/2024	Staffing ratios of 1:15 are too high. Recommendation: Consider 10-12.	**No change:** Caseload capacity thresholds will be reevaluated later to ensure appropriate staffing ratios and service quality.
58	9/18/2024	Members are not enrolled in the CSED Waiver until they are discharged from the PRTF. This means that there is no transitional support from the care coordinator or team to support the transition and to begin to put services in place. Recommendation: It would benefit the child and family to have waiver services begin 30 (and ideally 90) days prior to discharge from a PRTF.	**No change:** While 1915(c) HCBS waivers preclude providing billable services within a PRTF, the importance of effective case coordination during transitions is recognized.

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59	9/18/2024	Recommendation: Historical CAFAS/PECFAS scores should be reviewed to ensure youth who will benefit from the CSEDW can be enrolled. Consider implementing a different cut score for younger children to help prevent their entry into institutional settings.	**No change:** While BMS recognizes the potential benefits of this approach in identifying and supporting children at risk of PRTF admission, the current CAFAS/Preschool and Early Childhood Functional Assessment Scale (PECFAS) thresholds will remain. BMS will keep this suggestion in mind for future consideration.
60	9/18/2024	PG 27: "A Wraparound Facilitator with the chosen Wraparound Facilitation agency will contact the child/adolescent and/or parent/legal guardian to begin engagement in the POC development process prior to the seven (7) day meeting taking place." Recommendation: Consider aligning with Wraparound practice and fidelity reviews. Contact family within 3 days; face-to-face meeting within 7 days; team meeting within the first 30 days at which time the POC is developed. Define the 7-day meeting as a face-to-face to gather the family story and identify team members.	**No change:** Mandatory contact with family is 72 hours (three days) and initial POC meeting within seven days of assignment date. Master POC is to be completed within 30 days of assignment date.
61	9/18/2024	Recommendation: There is a need for intentional transition planning with the CFT and time to transition out of Wraparound should be recognized. Wraparound best practices indicate that a minimum of 90 days is needed for effective transition planning. Members who do not meet criteria at reassessment should still experience an intentional transition out of Wraparound rather than just have services cease. Length of stay averages for members receiving Wraparound are approximately 12-14 months.	**No change:** BMS does not provide a specific timeframe for the discharge period, as this should be a person-centered process, which prioritizes safety and coordination of care and will vary based on the child's/adolescent's specific needs.
62	9/18/2024	Recommendation: CFT attendance includes the caregiver(s), youth, system agency representative if involvement is noted, service providers who are included in the POC, and at least one natural/informal support ~ model and fidelity reviews	**No change:** The composition of the CFT has already been defined and includes the caregiver(s), youth system agency representative (if applicable), relevant service providers, and if possible, at least one natural/informal support.
63	9/18/2024	Recommendation: Amend this statement: "…development of the POC is the responsibility of the CFT" to "development, ***modification, and implementation*** of the POC is the responsibility of the CFT"	**Change:** The sentence will be modified to reflect the recommended language.
64	9/18/2024	Initial POC Recommendations:	**No change:** While the initial POC can address immediate safety/crisis concerns, the master POC may

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		The initial POC should be used to support any immediate safety/crisis concerns to stabilize the family until the first CFT where the full POC is developed. It is further stated that the date of the master POC must be included in the initial POC "**if not being completed at this initial meeting**" – this reference to the possibility of the POC being completed at the initial meeting should be deleted. Master POC Recommendations: Remove "(unless completed at the 7-day meeting)" from: "The master POC is developed within 30 calendar days of waiver enrollment assignment date **(unless completed at the 7-day meeting)** and must include…" It also states: "A date for review of the plan of care which includes time considerations for the expected duration of services." Wraparound team meetings are every month and the POC needs to be updated at each meeting so the 'date for review' needs to fall within the next month and not a random date based on length of service of other services. Monthly POC Review Recommendation: "The CFT will meet to review and discuss the current POC and update as needed." Add clarification that the CFT must meet monthly, change to: "The CFT will **meet at a minimum monthly to review, discuss, and updated= the current POC**."	be developed at the initial meeting if all necessary parties meet attendance criteria and all master POC requirements are met. **No change:** The master POC may be developed at the initial meeting if all necessary parties meet attendance criteria, and all requirements are met. The date of review is the date in which the CFT meets to review the POC, which also includes the expected duration of service from all providers. **Change:** The language will be modified to clarify that the CFT will meet at a minimum monthly to review, discuss, and update the current POC.
65	9/18/2024	See comments below to 502.17.5 regarding seven calendar day requirements. Last line in the first paragraph, top of page 37, states, "It is important to remember that, although coordination of the plan of care process is the responsibility of the wraparound facilitator, development of the plan of care is the responsibility of the	**No change:** The composition of the CFT, including the member, parent/legal representative/foster parents, service providers, and informal or natural supports, has already been identified previously in the manual, specifically in section 502.17.1.

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		CFT." Recommendation: After CFT add "that includes the member and parent/legal representative/foster parents as well as service providers and informal or natural supports." The last bullet under Documentation on p.37 has POC signature and CFT meeting participation requirements. Recommendation: Prior to last line that requires therapist POC review and signature within 10 business days, add instruction that clarifies that with documentation of meeting notice, CFTs should not be cancelled due to therapist's inability to attend the CFT. Recommendation: Change treatment team meeting to CFT throughout section. PG 38, first paragraph after bullets "states that POC meetings can take place without youth and family" Recommendation: All CFT meetings must include the caregiver and youth. There should not be any exceptions.	**No change:** All CFT members must receive adequate notice of meetings, which is defined as at least seven calendar days prior to the treatment team meeting. **No change:** While BMS strongly encourages the active participation of the caregiver and child/adolescent in all CFT meetings, BMS recognizes that unforeseen circumstances or emergencies may occasionally arise that prevent their attendance. In such cases the wraparound facilitator will work closely with the CFT to ensure that the child/adolescent and family/legal guardian's voice is represented, and their needs are prioritized, in accordance with the person-centered planning principles of 1915(c)HCBS waivers. Each instance where the child/adolescent and/or family/legal guardian are unable to attend will be reviewed on a case-by-case basis, and the CFT will make necessary adjustments to accommodate their needs and ensure their ongoing engagement in the planning process.
66	9/18/2024	High fidelity Wraparound/NWIC requires the first meeting be held at the 30-day mark. This gives the Wraparound Facilitator enough time to do all the activities in Phase 1, including creating the initial crisis plan, gathering the family story, create needs, family vision, engage team members, prepare for the Initial Wraparound Team meeting. Seven days is not enough time to complete all this. While the initial crisis plan and possibly the family vision and some strengths will be completed within 7 days, all of the required Phase 1 information needed for the first CFT will not be available by the 7-day mark. Recommendation: Add clarifying language that the POC is not expected to be finalized by the Seven-Day CFT Meeting. This initial plan is also not the master POC as that must be created during the first CFT meeting.	**No change:** This is the initial meeting that occurs within the first seven calendar days of the wraparound facilitator being assigned. The initial POC describes the services and/or supports the child/adolescent can receive until the assessment process is complete and the master POC is developed. Please refer to section 502.17.3 for initial POC requirements.
67	9/18/2024	If a new service/support need is identified or the POC needs to be revisited the goals and progress on those goals that are being facilitated by each CSEDW provider. These reviews are	**No change:** The current services, barriers, and identified goals in the POC are reviewed at minimum every 30 calendar days by the CFT to help ensure the POC is accurate and addressing all identified needs.

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		documented in the Home Visit Form (WV-CMS-CSED-03) for the visit and attached to the POC. Recommendation: Provide clarification that POCs are updated in monthly CFT meetings.	This is a living document and needs to be reviewed on a regular basis depending on the need of the child/adolescent and may need updated more often than every 30 calendar days. The Home Visit Form (WV-CMS-CSED-03) is attached to the POC.
68	9/18/2024	Service limits indicate 12 units per POC year – this does not account for crisis or single life event (SLE) meetings. Recommendation: Consider increased annual amounts.	**No change:** Wraparound facilitation services are provided on a per member per month (PMPM) rate. The PMPM rate covers all wraparound facilitation activities in a month.
69	9/18/2024	Recommendations: CAFAS/PECFAS ranges are missing and there is a gap between 130 and 140. Wraparound serves youth with the highest and most complex behavioral health needs and their families. Using and defining acuity levels within this hospital/institutionalization diversion population is not recommended. It is common for acuity levels to fluctuate throughout all phases of Wraparound making acuity tiers impractical. The moderate rate is not sufficient as staffing ratios should remain the same given this high needs population. Staffing should be capped at 12 members (ideally 10) per Wraparound Facilitator. Face-to-face requirements do not include monthly CFT – align to 1 or 2 face-to-face in addition to the monthly CFT meeting. Consider contact limits to be driven by the POC, identified needs, and the EBP standards as applicable. For example – if weekly therapy is occurring, then the facilitator needs to check in weekly with the clinician. This needs to be outlined in the POC.	**No change:** CAFAS/PECFAS scores are in increments of 10. **No change:** A caseload intensity matrix is being piloted. Data from this study will inform the need for changes in caseload distribution. **No change:** Minimum requirements for face to face and number of contacts is set based upon the child's/adolescent's acuity level.
70	9/18/2024	Recommendation: See above. CAFAS/PECFAS ranges are missing and there is a gap between 130 and 140. It is common for acuity levels to fluctuate throughout all phases of Wraparound making acuity tiers impractical.	**No change:** CAFAS/PECFAS scores are in increments of 10. Federal and State mandates require that all children/adolescents presently enrolled in the CSEDW program, as well as those on the managed enrollment list (MEL), have their eligibility annually redetermined.

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			In West Virginia, the date by which this must be completed is referred to as the child/adolescent anchor date. To remain in the CSEDW benefit program, the child/adolescent must continue to meet the eligibility criteria as previously defined. Medical eligibility requires input from the CFT.
71	9/18/2024	Recommendations: Require training and certification for peer parent support providers through an identified curriculum. PG 60. Peer parent support services may not be provided during the same time/at the same place as any other direct support Medicaid service. A fundamental feature of peer parent support is that the services are provided in the natural environment as much as possible. Recommendation: Parent peer support should be billable at the same/time place as Wraparound. Parent peer support is a separate service. The CFT is one of the natural environments that families need and benefit from the service. PG 65 "Reimbursement for CSEDW services cannot be made for services provided outside a valid POC. To be considered valid, the POC must be current (dated within the past year and reviewed **quarterly** by CFT), signed by all required CFT members, and include all provided services. Recommendation: Replace quarterly with **monthly**. All Wraparound teams meet monthly. This is in the fidelity reviews and most importantly, this is a high need population that necessities frequent meetings to address needs and ensure successful implementation of the POC. Planning doesn't occur outside the team meeting and for all these reasons, monthly team meetings are necessary. For reimbursement they should have to show a team meeting sign-in sheet that shows more than the Wraparound facilitator and family.	**No change.** Currently, the focus is on lived experience as an individual or family member/legal guardian of a child/adolescent with a serious emotional disorder (SED), coupled with a high school diploma or General Educational Development (GED). This approach recognizes the unique value of peer support providers' firsthand understanding. BMS will continue to evaluate the peer support program and explore additional training opportunities. **No change.:** Peer parent support services may not be provided during the same time/at the same place as any other *direct support Medicaid service*. Wraparound facilitation is an indirect service. **Change:** Language will be modified to reflect the required monthly CFT meetings.
72	9/18/2024	PG 79 indicates a change for CFT every 30 days. This change is not found.	**Change:** Formal CFT meetings are required every 30 days to align with NWIC standards.

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		PG 71 has the definition for an Informal POC Meeting and references a formal POC meeting with the CFT. Recommend deleting. This should all be done at the CFT.	
73	9/21/2024	Mobile Respone was removed from the policy. It is still referenced through the draft and continues to be listed under Family therapist services. A more thorough breakdown of the responsibility of the Family therapist relating to this service when their family access it. Policy also states an incident report is to be written relating to accessing mobile response, yet Family therapist or even the WF are getting the information from the family 24 hours or later after the incident. Who is to provide the WF or the family therapist to review the incident report completed by the mobile crisis response service to make needed changes to the therapy plan and the POC?	**Change:** Language will be removed for responsibility of mobile response.
74	9/21/2024	Family therapist cannot bill for phone calls as a service per draft. However, it is a common that families call their family therapist to assist in de-escalating conflict between the youth and them in lieu of mobile crisis response being called. Who should the family therapist direct the family to call when an interaction between them escalates? Or, would this be considered as a telehealth service? Clarification is needed relating to this statement in the draft.	**No change:** While phone calls for crisis de-escalation are not billable as a separate service, they remain an essential component of crisis planning and ongoing support. The POC should clearly outline strategies for managing escalating situations, including contact information for crisis resources, such as mobile crisis teams. Telehealth, which involves live audio and video communication, is an allowable service modality for family therapy and can be utilized for up to 50% of the total services per year. This offers an additional avenue for families to access support during crises or other urgent situations that require real-time, interactive communication with their therapist.
75	9/21/2024	Is the 400 Statewide transition planning training no longer required as training in this program?	**Change:** The training is required and will be added to the policy manual.
76	9/21/2024	Transitioning out of the CSEDW program must begin at the initial POC under section 502.13. How is this to occur when the CFT has not developed a plan to address their needs nor have met? Should this not be moved to the Master POC?	**No change:** Successful discharge from the waiver program should be the goal of the CFT. Services are designed to be intensive short-term services, with the end results being the child/adolescent and/or

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			family/legal guardian having the tools and knowing the steps to remain in their home and community setting successfully. Discussion with the child/adolescent and/or family/legal guardian and CFT regarding discharge planning should be part of the POC process to include ongoing evaluation of the child's/ adolescent's ability to self-manage successfully in their home or community.
77	9/21/2024	Section 502.13 relating to caseload numbers. Draft policy stated youth on hold do not count towards caseload number. WFs must be "assigned 10 active case and can have 5 on hold." This statement contradicts that. a. relating to waitlist. Draft states the WF must be assigned 10 active cases before youth can be placed on waitlist. However, most provider agency WFs provide wraparound in CSEDW and Safe-at-home. A WF may have 8 active CSED youth and 4 Safe-at-home youth. Per this policy statement, the WF agency would not be permitted to put a youth on their capacity waitlist. What safeguards will be put in place to allow wraparound as a cross-over service between statewide programs to be accounted for? b. How is a WF to provide a review of the youth every 90-days when they are on hold? Does the WF provider agency continue to get the PMPM flat rate payment even when youth is on hold? A better definition of what the review is to encompass should be outlined in policy. c. The term "active" and "hold" should be defined in policy relating to referrals. d. How does the caseload intensity matrix impact this section of policy relating to caseload assignments? Clarification is needed.	**No change:** A caseload intensity matrix is currently being piloted to assess equitable case distribution. **No change:** Section 502.18.1 Child/Adolescent Acuity Levels provides guidance on service provision for wraparound facilitation. No, PMPM rate is not provided for youth who are placed on hold. **No change:** "Active" refers to youth actively receiving services through CSEDW. "Hold" refers to youth for whom there is no active CSEDW service being provided. **No change:** A caseload intensity matrix is currently being piloted to assess equitable case distribution.

COMMENT LOG

Chapter 502 Children with Serious Emotional Disorder Waiver (CSEDW)

Public Comment Period: August 22, 2024, to September 22, 2024

Comment Number	Date Received	Comment	Action
78	9/21/2024	502.15.1: Prior policy stated WF was to contact the family 72 hours after assignment. This section just lists the WF must begin engagement prior to 7-day initial POC meeting. Is the 72 hour no longer in effect?	**No change:** Section 502.15.1 does not exist within the manual. The wraparound facilitation services agency will initiate services within 72 hours of assignment from the MCO.
79	9/21/2024	Targeted case management policy was billed for services prior to the initial POC meeting. With movement to flat rate, can the agency bill the MCO as soon as youth is assigned or does the provider need to wait until day of initial POC? a. Is the flat rate prorated? For example, if the youth is assigned to a provider on the 8th of the month, will the flat rate be the entire monthly rate or will adjusted be made since the services did not begin until the 8th?	**No change:** Billing for services cannot occur prior to the initial POC meeting. Services are not prorated.
80	9/21/2024	502.15.4: This should state WF or Aetna. The vague statement of "or any member of the CFT" will more than likely lead to incident reports being late. An informal support isn't going to think to contact the WF and the nonprofessional staff are going to assume that the WFs and family therapist already know about the incident. I think the assignment of this responsibility of the family to contact need to be specifically assigned to reduce incident reporting timeline discrepancies.	**No change:** The current process is to notify the wraparound facilitator and one other member of the CFT. The wraparound facilitator will then notify the MCO care manager. This process may be revisited in the future.
81	9/21/2024	502.16: Who at the ASO do you submit all the new documentation review and completed by the CFT 45-90 days before redetermination? The SSF who completed the redetermination assessment or someone else? Should the WF not submit the redetermination information to the assigned MCO care coordinator? Additionally, what determines re-eligibility when the CANS fall above 90 score, but the CAFAS qualifies them? What assessment of needs trumps the other?	**No change:** The documentation is submitted to the SSF. Redetermination of eligibility is designed to consider multiple factors, including both the CANS and CAFAS. However, a CAFAS score below 90 initiates discharge from the CSEDW.
82	9/21/2024	502.16.1: Can exceptions be made for this to be emailed to families? Deadlines are being missed to file appeals to decisions because of the delays associated with standard mail delivery. The written notice of decision is supposed to be provided to the families, MCO and the WF. This is not consistently being completed. What safeguards can be put in place to ensure the WF received the information in a timely	**No change:** Currently, BMS is maintaining its process to use standard mail. This may be revisited in the future to allow encrypted emails, but at this time the process will remain in place.

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		manner to assist the family in filing an appeal if that is their wish?	
83	9/21/2024	502.17: policy states meetings should not occur at a provider's office. What is the process or documentation if the family requests to have it at the provider agency's office?	**No change:** The policy states that meetings *typically* should not occur at a provider's office. While it is preferred that the meeting takes place at the child's/adolescent's home or in a private community setting, circumstances at times may make the provider's office the best location for the meeting. It is expected that the CFT will use their best judgment pertaining to the meeting location, and that the location and reasoning for the location be documented in case notes.
84	9/21/2024	502.17.2: policy moves back and forth between submission deadlines for WF's of calendar days vs business days. It should be consistent between documentation/activity requirements to reduce confusion. HOw does the CANS submitted by the CFT after a SLE meeting possibly change the level of care of a youth prior to the 6-month review when the CAFAS is completed by the ASO and not the CFT?	**No change:** The use of calendar and business days is to best describe timelines for various activities within the waiver. Business days factor in weekends and holidays, which may be necessary for certain activities. The CANS being completed at significant life events will not change the child's/adolescent's acuity level prior to the six-month assessment. However, the CANS can indicate additional services and support needed or whether discharge is likely for a child/adolescent. These changes would be considered changes to level-of-care without immediate changes to acuity within the program.
85	9/21/2024	502.17.3: Policy state the initial POC goals may be derived from the initial assessment and referral information. However, what trainings will be provided to assist WFs in understanding the outcomes of the BASC and CAFAS scores to accurately derive goal recommendations to the CFT? a. It states the POC goals derived from assessment. However, family voice and choice are philosophy underlining WF services. What occurs if family's requested goals are not supported by the assessments (BASC, CAFAS, CANS)?	**No change:** Additional training for wraparound facilitators on the Behavior Assessment System for Children (BASC) and CAFAS will be considered for provider development. a. The POC goals should be informed from the assessment results, referral information, and family voice and choice. BMS recognizes that some goals will be family specific even if not directly related to the assessment information. b. It remains necessary to attach the family therapy plan to the POC.

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		b. The goals listed in the POC developed by the CFT which includes the family therapist, are typically different than the goals listed in the therapy plan. Is it still necessary to attach a separate therapy plan to the POC? c. As part of the initial POC section, it states that the master plan can be finalized at the initial if all components are provided in this section of the master POC. How can you write a therapy plan if the therapist has not met the family yet? It is the current understanding that a POC cannot be finalized without a therapy plan? d. In SLE section, it states that the POC may be updated at any time. All updated must be signed by the child and/or legal guardian. Why have a CFT? How does the CFT keep up to date with changes in services if their signature is not required per this statement in policy draft?	c. The POC cannot be finalized without the therapy plan. The language in the policy indicates that the POC can be the master POC if appropriate—for example, if the provider has a history of working with the child/adolescent—not that it must be. d. The CFT is an important component of the wraparound facilitation care model. While updates to the POC may occur outside the CFT meetings, if necessary, most updates are expected within the CFT meetings.
86	9/21/2024	502.17.4: policy draft states that wraparound can only bill for POC development. However, direct services providers are required to attend POCs as a member of the CFT. How do you expect consistent monthly participation by direct service providers if they can not bill for their participation in the POC? a. draft policy states the WF may be involved in the development of a residential plan, day treatment plans, work training plans, education plans, etc. Is this saying the WF is now responsible for developing independent living /job coaching goals? This has fallen before on the responsibility of the family therapist as part of the therapy plan. Is the family therapist only responsible for their goals now in the therapy plan? If so, why is the family therapist still responsible for CSED 6 training of paraprofessionals.	**No change:** BMS is maintaining its current policies on compensation. a. The wraparound facilitator is not responsible for developing independent living/supported employment goals, but rather a general plan that is described in the POC. This remains part of the family therapist's responsibility.

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		b. Who develops the "behavior support plan?" The WF? c. "separate documentation" statement in form of an activity note. Does reference of activity note mean meeting minutes? Is this documentation only required for the WF or is it also required for direct service staff? If so, shouldn't their signature on the POC be documentation enough?	b. The behavior support plan is developed by the wraparound facilitator in collaboration with the CFT as a part of the POC. c. Yes, documentation is expected. Documentation assists with recording decisions that may impact the child's/adolescent's care and therefore is best practice.
87	9/21/2024	502.17.5: How is the CFT created and information gathered to complete the Master POC within 7-calendar days to align with NWI? a. a POC has not been considered complete unless a therapy plan is attached. A family therapist cannot write a therapy plan if they have not met the youth. This may violate their ethical guidelines dictated by their governing licensing boards. It is not feasible to have the initial serve as the master POC.	**No change:** If the POC created from the seven-day CFT meeting is comprehensive and meets all the necessary criteria, then it may be used as the master POC; the policy does not state that this must be the master POC. a. A therapy plan remains a requirement for the master POC if all program and professional requirements can be met.
88	9/21/2024	502.17.6: Is this "review" referenced the required monthly POC or is this statement referring to documenting needs only as justification for an addendum or a SLE meeting? a. the reviews are documented on the homevisit form. However, the CFT does not have to be present during each homevisit by the WF.	**No change:** The review referenced is the 30-day CFT meeting, which reviews the POC. This meeting is not a home visit. a. The Home Visit Form is used for the 30-day CFT meeting to document mileage. Additionally, a home visit can be conducted on the same day, which can be recorded on the form, but the home visit must be separate from the CFT meeting.
89	9/21/2024	502.17.7: This does not specifically state the transfer documentation and meeting is the responsibility of the WF. With that being said, it states the transfer-from agency is responsible to submit the CSED 15 to the MCO. Why does this no longer fall under the WF responsibilities? If that transfer-from agency is a direct service agency, they are now also responsible in submitting the csed 15? a. Is the originating agency required to send records docs to the receiving agency? Also,	**No change:** Yes, the originating agency is required to send records to the receiving agency. If the receiving agency does not receive the documents from the originating agency, they may reach out to the MCO for assistance. While the process should be Health Insurance Portability and Accountability Act (HIPAA) compliant, there is no required method for sending the documents. They may be sent via standard mail, fax, or encryption.

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		how is this transfer of records to occur? Certified mail? How is the transfer-from agency going to ensure HIPAA?	
90	9/21/2024	502.18.1: Can a family choose 100% telehealth only and override CMS face-to-face contact requirement? a. What is the online case management training developed by BMS? Is this in addition to the conflict-free case management certification? b. If this service is now a flat rate, why are WFs being required to continue to write activity notes/progress notes for their services? Policy continues to reference billable activities or services/activities billed in draft policy. c. Is the homevisit form completed and signed weekly not sufficient enough documentation along with the monthly POC that services are being rendered based on acuity level? Why are progress notes still required?	**No change:** A family cannot override the CMS face-to-face contact requirement. Telehealth may be selected for up to 50% of the total services the child/adolescent receives per calendar year of enrollment, the backup plan is for 50%. a. The online case management training BMS developed includes the conflict-free case management certification. b. Documentation is best practice for the highest standard of care and is factored into the wraparound facilitator's PMPM rate. c. Progress notes are an important best practice for documentation.
91	9/21/2024	502.18.1.1: WF required with monthly or bi-monthly contact with the family therapist based on acuity level. These services updated by the family therapist are not a billable service for them. If you want direct services agencies to participate in the process, then you will need to compensate them for their time. Direct services providers will have to pay respite workers, therapist, independent living staff, etc. for their attendance and writing of summary report to the WF if they cannot attend. This should be a billable service for staff and therapist. a. define contact? If emails or phone calls go unanswered, how does the WF document? Why is weekly contact needed when the CFT has moved to monthly meetings from quarterly> Asking for weekly updated from the therapist and staff to the WF is asking too much when direct services are on the road most of the workday. I think policy needs to prioritize participation in a monthly CFT than dictate	**No change:** BMS is maintaining its current policies on compensation at this time. a. Contact is defined as attempts at contact via phone or email. The frequency of attempted contact is based on NWIC standards. The wraparound facilitator should document the attempt even if it remains unanswered.

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		weekly contact/updates to the WF when it continues to not be a billable service for therapist and staff. b. under assessment/social history/progress review section: How can the CANS assessment be completed at the initial POC. There is just too much information to cover and complete for this to also be a requirement.	b. **Change:** The CANS assessment required for the completion of the master POC rather than initial POC.
92	9/21/2024	502.18.2: a. How is this backup telehealth plan paid for? Will specialized equipment request be permitted to pay for internet access or computer to provide services through telehealth? b. Can enrollment for a government cell phone plan be part of this telehealth back-up plan? This service can only be provided in public community locations, but can also be telehealth 25% of the time. Contradiction? c. There should be an option for in-home as well since this service covers teaching of chores, hygiene skills, etc. d. This service was moved from indirect supervision by in-home support to services supervised by the family therapist. Why not maintain indirect supervision of this service by the in-home support to reduce load on family therapist? e. With shortages of staffing to provide this service by providers, why continue to require a bachelors or associates plus the 1-year experience requirement? This continues to reduce the availability of applicants providers can hire. The required training all new hires must be provided should allow for experience along with the CSED 6 training provided.	**No change:** Specialized equipment requests will not be permitted for backup plans for telehealth options. If a backup plan is not feasible, services may be rendered in person. Independent living skills must be provided either in the community or via telehealth. Enrollment in a government cell phone plan will not be a part of the backup plan. Independent living skills must be provided either in the community or via telehealth. It will not be offered in home at this time. Direct supervision from the family therapist can assist with providing clinical insights for this service. Staffing credentials will remain in place at this time but will be reconsidered in the future. BMS seeks to balance provider capacity and hiring with necessary experience requirements.

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93	9/21/2024	502.18.8: HOw should the trauma-informed care be documented? Past experiences? Current experiences? Certificate of training? a. Why is independent living staff not listed in this section as staff that a family therapist indirectly supervises? It is listed in the independent living service section.	**No change:** This should be through resumes, transcripts, and other forms of documentation of either past or current experience. **Change:** Independent living will be added to this section.
94	9/21/2024	502.18.9: Why is peer parent support supervised by the in-home support staff? This service should be supervised by the family therapist to ensure the peer parent is not providing counseling services accidentally. a. respite worker should be supervised by the in-home support and not family therapist. The respite worker completes no programming that the family therapist would oversee.	**No change:** BMS decided upon the structure of supervision considering provider capacity, and services where additional clinical knowledge may be necessary.
95	9/21/2024	502.18.10: Peer parents now have to have goals in the POC they document on their progress notes? Why? what goals would they be implementing? They are providing support which could changes based on variables that may not be predictable to write in a POC goals.	**No change:** Peer parent support workers must document on their progress notes items related to the POC goals discussed with the CFT. The goals guide the peer parent support worker's priorities but do not dictate all that is written on progress notes.
96	9/21/2024	502.10: Does this mean the child/youth and/or family guardian could chose to be 100% telehealth?	**No change:** A family cannot choose 100% telehealth. Rather, the service modality can change within the guidelines of the policy. Services approved for telehealth have specific allowable percentages. If telehealth is selected, a backup plan outlining alternative service connections (e.g., in-person visits, emergency power, mobile device access) must be included in the POC.
97	9/21/2024	502.21: H2017-HA was removed from policy yet it is listed in this section.	**Change:** H2017-HA will be removed.
98	9/21/2024	Social work is no longer an approved degree? Also, LSW can no longer qualify as a family therapist?	**Change:** Social work is still an approved degree and will be added.
99	9/21/2024	removal of language of information POC held every 30 days. All POCs are formal and held every 30 days.	**Change:** The language will be modified to reflect that all 30-day POC meetings are formal.
100	9/20/2024	PMPM method: Wrap Facilitators are to meet either once month or twice a month with the CSEDW member and in the same month complete the Plan of Care meeting. What happens when	**No change:** Wraparound facilitation face-to-face contacts cannot be combined with POC meetings.

Comment Number	Date Received	Comment	Action
		we have a family that is unable to meet with the WF this often due to schedules and other providers being in the home, are the WF allowed to count the POC meeting as a monthly visit face to face, or what does the WF do?	
101	9/20/2024	Page 33 and 37 of the Ch. 502: Regarding WF must document the following information to bill for POC (CFT) meetings. Where is the WF supposed to document if another team member was unable to attend and why? Does the WF add this information in the Meeting Minutes notes. Following that, what is the WF supposed to do when a provided doesn't respond with a reason by providing a summary of the progress or recommendations for the member?	**No change:** The wraparound facilitator is responsible for documenting CFT attendance and any provider non-responses within the meeting minutes or designated records. Provider training will address documentation expectations, and they may contact their MCO care manager for further assistance.
102	9/20/2024	**POC Requirements pages 34-36 and 37: There is additional information that is needed to be added to the POC documentation but at this current time there is no additional sections to add said information. Such as; the Signature sheet there is a change that providers must add credentials and title and the agency they are representing. The WF need to add a Start and Finish time which is currently not on the Signature sheet.**	**No change:** The POC that is in development will include a signature sheet and start and finish time.
103	9/20/2024	Master POC requirements Page 35-36: The Family story, there is not enough time in 20 days for the WF to complete this requirement. Between completing the Initial POC, the CANS assessment, scheduling meetings with other providers, and finding other providers and resources in the community for the member and their families. The POC with the meeting minutes and the WF notes already include detailed information regarding the member and their family, making the family story repetitive and not needed extra work for the WF's.	**No change:** The Family Story is updated as the POC is updated. The Family Story may be brief in the initial POC and become more comprehensive in the master POC as the wraparound facilitator gets to know the child/adolescent and family/legal guardian.
104	9/20/2024	POC goals and objectives must be based on the problems identified in the Initial assessments causes issues due to a lot of the times these assessments are a year old or they are not identified as issues any longer with the member and their families by the time the WF agency accepts the member for WF.	**No change:** POC goals and objectives are based on the initial assessments or subsequent reassessments. Updates to the POC goals and objectives may also be made through a CFT meeting.
105	9/20/2024	502.17.8 page 40: Clarification on who determines if a member no longer meets CSEDW requirements? Who decides if a discharge is needed. What if it is the member and/or the family	**No change:** The child/adolescent, family, legal guardian, and CFT may be involved in the discharge

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		not improving in the POC or even the treatment plan goals, and the CFT has met multiple times to revise the POC but at the next 30 day POC meeting again no improvements. What do the WF do in this case?	process. POC progress should be discussed with the MCO care manager.
106	9/20/2024	Page 46: Assessments/Social Health…: Completing the CANS assessment during the Initial POC, there is NO time to have this assessment completed during the first meeting. Prior to the change the WF had until the Master POC to complete the CANS assessment which was still a very small timeframe. The IPOC can take up to an hour to complete, at this time most if not all WF take this first meeting to answer any questions families may have, and get to know each other. The CANS Assessment takes up to two hours to complete and this timeframe does not include if the member is a high acuity.	**Change:** The CANS assessment is to be completed prior to or at the master POC meeting.
107	9/20/2024	502.18.6 Assistive Equipment and Specialized Therapy: Agencies need more information how this process is to be completed. Regarding how and who to send the request too, and most important once this service is approved who is responsible for paying and ordering the equipment? The same question when a member needs Specialized therapy there is current confusion regarding what form is to be completed and who is to retrieve this information. Added fact Specialized therapy normally is a three or more-months services but agencies are capped at a $1000.00 maximum when Specialized therapy starts around $200.00 a session. More clarification for agencies, WF, and Aetna Care Manager is really needed regarding this.	**No change:** The MCO will facilitate training with providers on assistive equipment and specialized therapy to provide more clarification on the service.
108	9/20/2024	Questions: Regarding the POC other than the WF, member and family who else follows the POC goals? I know the idea is the team but this is not the case in reality. On every occasion as a WF, the WF, family and members are the only ones discussing the goals on the POC. Other CSEDW providers follow the Therapy treatment plan. Also prior to the policy changing, the WF's had more time to dedicated to working with the member and the family to build	**No change:** The MCO will provide training on the PMPM rate in relationship to the activities required of the wraparound facilitator.

Comment Number	Date Received	Comment	Action
		rapport and work on POC goal. Now with the updates to the policy and billing units the WF is not going to have time or the billable units to build rapport and actual work with the members to implement the POC goals and objectives for improvements.	
109	9/20/2024	Provider reimbursement and payment policies are addressed throughout the manual. Given that, I submit this public comment generally instead of specific to a numbered provision. It is highly encouraged that the Bureau for Medical Services, and all vendor partners, implement a streamlined provider reimbursement strategy. Specifically, it is recommended that the Bureau work with providers to develop a global payment, or bundled payment, methodology. Providers experience significant administrative burdens under the current billing approach for the SED Waiver. The resources expended on the current fee for service stycled billing approach would be ideally spent on increasing direct service staffing so that providers are able to support more children across West Virginia.	**No change:** BMS will maintain its current compensation policies at this time.
110	9/20/2024	It is recommended that the Bureau for Medical Services develop and release network adequacy standards specific to SED waiver services. It is recommended that Medicaid and the Mountain Health Promise vendor self impose these standards. In areas of the state where an inadequate network exists, resulting in service delays and children going unserved, that rates be increased until the network inadequacy issue is resolved.	**No change:** BMS is continually evaluating network capacity and collaborating with interested parties to address service access.
111	9/19/2024	I first want to say this new plan of care has not been helpful to me or my child. I received mental health wraparound services in the past with another family member, and we created goals as a team and achieved them. My child doesn't feel they have "needs" that should change. I have tried to work with them on changing, but these seem to be long-term issues, and we are not seeing changes. When my other family member was in the program, they had about ten goals throughout the year, and we had small wins then moved on. My child has been working on these needs for almost a year now, and we have not seen change. My facilitator has been amazing; we have adjusted the plan several times, but my child needs things broken down more.	**No change:** BMS will continue to assess the CSEDW's service delivery as it relates to member satisfaction.

Comment Number	Date Received	Comment	Action
		Secondly, I was told that I could have therapy for my child multiple times a week. My facilitator is the only consistent person I see weekly. Our therapist told me that they could only see my child face-to-face every other week once, and the other weeks would have to be virtual. My child doesn't talk to them during the weeks they do virtual. The supportive worker only shows up when my facilitator calls them, and they cancel on me frequently. I miss the team meetings I had in the past. I'm not sure why the other team members come because they don't talk. If I didn't have a WF, I'm not sure I would stay in services. This program is supposed to be helpful to families, but I'm here to tell you it's not. I would like for my child to be in a regular wraparound program if possible. My child needs a mentor, and now my WF is only allowed to see them at home or school. Before, the WF took my other family member out in the community, and that made a difference. I thought that's what I was signing up for, but this seems to be a program all about checking a box. I'm not sure if we will continue, but I wanted to write and ask you to consider us families and what we actually need, not what looks good on paper.	
112	9/20/2024	502.18.8 Family Therapy - CSED therapists are traveling up to an hour or more one way to facilitate in-home therapy sessions. Travel time should be billable, or an increased rate to account for travel time.	**No change:** The established rates are not being redetermined at this time. These concerns will be shared with the MCO because of its responsibility for oversight of the provider network.
113	9/20/2024	CSED, BMS, BBH's Children's Mental Health Wraparound , and the National Wraparound Initiative are not aligned. CSED documentation requirements do not allow for the amount of hands-on direct services that NWI encourages and does not meet high-fidelity Wraparound as more time is spent on documentation than providing services.	**No change:** The CSEDW waiver supports the National Wraparound Initiative and incorporates high fidelity principles when applicable.
114	9/20/2024	502.17.3 POC Requirements - Plan of Care requirements are interpreted differently by each Aetna CM. Whether a POC is denied or finalized is dependent on how the individual Aetna CM interprets to POC check-list.	**No change:** The ASO will assess MCO CM approval as part of the MCO audit review.

COMMENT LOG

Chapter 502 Children with Serious Emotional Disorder Waiver (CSEDW)

Public Comment Period: August 22, 2024, to September 22, 2024

Comment Number	Date Received	Comment	Action
115	9/20/2024	Timelines for CSED providers to submit documentation are mentioned throughout the policy manual, and providers are held accountable to meet required timelines. Timelines for the MCO to review and approve POCs and documentation needs to be included.	**No change:** Streamlining documentation submission timelines for the MCO will be discussed for future program updates.
116	9/20/2024	502.17.1 Child and Family Team (CFT) - Aetna CM's are vital members of the CFT and ultimately approve the Plan of Care. They should attend POC meetings, which could potentially assist in preventing errors made on the POC and assist in identifying available resources.	**No change:** MCO care manager attendance at POC meetings will be discussed for future program updates.
117	9/20/2024	502.15.1 Slot Allocation - Confirmation of when a member is accepted from a wraparound facilitation agency needs to occur and be notified via the referral email list. There have been times more than one agency has accepted the same member unknowingly. Waitlists are sent to Aetna weekly, but our agency is often times note informed when referrals have been accepted and can be removed from our waitlist.	**No change:** Streamlining the waitlist process will be discussed for future program updates.
118	9/20/2024	502.16 ANNUAL REDETERMINATION OF WAIVER ELIGIBILITY PROCESS - With the new wraparound facilitation rate structure, agencies will need to receive CAFAS results in a timely manner. The current process for receiving the results of the CAFAS is not feasible with the new rate structure, as agencies are currently waiting months at times to receive the results. Timeline requirements should be put in place.	**Change:** The policy manual will be updated to reflect the process and timeline requirements.