# Public Comments for Children with Serious Emotional Disorders Waiver (CSEDW) Application Renewal

## CSED 1915(c) Waiver Amendment Proposed Effective Date of March 1, 2024

## Public Comment period responses from September 26 – October 30, 2023

| Number | Date Received | Section Reference | Comment | Bureau for Medical Services (BMS) Response: |
|---|---|---|---|---|
| 001 | 10/27/23 | Financial Eligibility (p.6) | Does not include waiver income and resources for the medically needy. This means that the State is not using institutional income and resources rules to permit youth to be served through the waiver instead of in an institution, setting up a potentially bifurcated system.<br>Recommendation: Request a waiver of income and resources for the medically needy to serve the comprehensive population of youth who meet the medical necessity criteria. | No Change: Effective September 1, 2022, applicants who have an institutional level of care need and meet program medical eligibility requirements, but do not meet Medicaid financial eligibility requirements, are able to utilize the Special Home and Community Based Services (HCBS) Waiver Group (§435.217 Group) of the Social Security Act to enroll in West Virginia (WV) Medicaid during the duration of their enrollment in the Children with Serious Emotional Disorders waiver (CSEDW). |
| 002 | 10/27/23 | Eligibility (p.30) | The CAFAS/PECFAS score of 90 or higher is required for enrollment. However, in the 2022 SME analysis, the Aetna Discharge Planning Report was discussed, which included an analysis of children with a CAFAS score of less than 80. There were 311 youth with a CAFAS score of less than or equal to 80 for 1/22-7/22 in both RMHTF and shelters. If youth are being served in RMHTFs and other residential settings with lower scores, they won't be eligible for enrollment in the waiver.<br>Recommendation: Review CAFAS/PECFAS scores to ensure that youth who are most likely to benefit from the CSEDW can be enrolled. | No Change: CSEDW eligibility requires a Child and Adolescent Functional Assessment Scale (CAFAS) / Preschool and Early Childhood Functional Assessment Scale (PECFAS) score of 90 or higher. The State continues to review the continuum of care in West Virginia to help ensure the right service, at the right time for each individual seeking services. |

| | | | | |
|---|---|---|---|---|
| | | | May want to implement a different cut score for younger children to help prevent their entry into institutional settings. | |
| 003 | 10/27/23 | Level of Care Evaluation/Reevaluation (p.46-47) | a. Members are not enrolled in the CSED waiver until they are discharged from the Psychiatric Residential Treatment Facilities (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.<br><br>Recommendation: It would benefit the child and family to have waiver services begin 30 (and ideally 90) days prior to discharge from a PRTF. | a. No Change: Individuals who are residing in an institutional setting are not eligible for CSED services per 42 CFR 441.301(c)(4)(5). As an individual prepares for discharge from a PRTF their care coordinator at the facility and at the MCO, if enrolled, will assist the individual and family in seeking community services appropriate to the individuals needs to help ensure a safe discharge. Additionally, the State continues to monitor utilization of all community resources and close any gaps for those who do not meet CSEDW level of care. |
| | | | b. Annual medical eligibility redeterminations require the use of the CANS by the Wraparound facilitator and the CAFAS/PECFAS by the Medical Eligibility Contracted Agent (MECA).<br><br>Recommendation: Use the CANS for redetermination to limit the number of reassessments completed, including by an agency that has not been involved with the youth and family directly. If maintaining the use of two tools, ensure that the MECA has sufficient documentation and information to complete the PECFAS/CAFAS, and not just the CANS. | b. No Change: BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. |

| | | | | |
|---|---|---|---|---|
| | | | c. Revaluations are being conducted by someone at the Administrative Service Organization (ASO) with a bachelor's degree and at least one year of experience with training in the CAFAS/PECFAS. This seems insufficient to determine medical eligibility for this waiver service.<br><br>Recommendation*:* A licensed mental health clinician should be completing or at least supervising the reevaluation. | c. No Change: The MECA independent evaluators include licensed psychologists, licensed independent clinical social workers (LICSW), licensed professional counselors (LPC) and supervised psychologists who have completed training in completing the CAFAS/PECFAS and Behavioral Assessment System for Children (BASC) (for applicants who are residing at home and not currently in a PRTF). The ASO is responsible for completing initial eligibility requirements including the CAFAS/PECFAS. The MECA is responsible for final determination of annual eligibility. |
| 004 | 10/27/23 | Participant Services<br><br>(p. 12, 56, 84-86) | a. States that the family support worker will use an evidence-based therapeutic approach to assist the member and family. No approach is named nor is a policy for approval of the approach outlined. Workforce shortages suggest that this may not be practical for implementation. Similar language later in the service description, requiring "evidence-based therapy sessions."<br><br>Recommendation: Change the language to state that the family support worker will use a clinically, developmentally, and culturally appropriate therapeutic approach. | a. No Change: BMS encourages the use of evidence-based practices for family support services. Providers can determine the appropriate evidence-based practices to meet the needs of the communities they serve.<br><br>CSEDW providers must use nationally recognized evidence-based practice based on the high-fidelity model from the National Wraparound Implementation Center (NWIC). |

| | | | | |
|---|---|---|---|---|
| | | | b. No provider requirements are provided for the In-Home Family Support worker who supports the family therapist.<br><br>Recommendation: Outline basic requirements for these individuals, including minimum training and supervision requirements, given the list of responsibilities they may have. | b. No Change: Staff credentials for In-Home Family Support Services can be found in Chapter 502.25.2 Children with Serious Emotional Disorder waiver (CSEDW). |
| 005 | 10/27/23 | Participant Services<br><br>(p. 73-76, 89-99, 131-136, 166, 207) | a. Acuity Levels - p. 91 "Each member will be assigned to "acuity tier" defined by BMS. The acuity tier determines a per member per month (PMPM) rate for the member." p. 91 High: CAFAS score > 140; p. 207: 1125.16/monthly.<br><br>p. 97 Moderate: CAFAS score of 90 to 130; p.207: 449.88/monthly.<br><br>Recommendation: 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 need population. Staffing should be capped at 12 members (ideally 10) per wraparound facilitator. Also note that PECFAS ranges are missing and there is a gap between 130 and 140. | a. No Change: BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. |

| | | | | |
|---|---|---|---|---|
| | | | b. P.73, 89, 95: Develops and updates the Plan of Care (POC) in partnership with the member and parent… POC development also referenced on p.133<br><br>Recommendation: Develops and updates POC in partnership with the wraparound team that includes the member and parent/legal representative/foster parents… as well as service providers and informal or natural supports. | b. No Change: BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. We appreciate your support for this program. |
| | | | c. P.73, 89, 95, 134: administering CANS around significant life events may be challenging<br><br>Recommendation: Administer CANS on a regular schedule like initial/intake, every 6 months, and at reauthorization. | c. No Change: Per Chapter 502.20.2 Children with Serious Emotional Disorder Waiver (CSEDW), the wraparound facilitator administers the CANS to the member at any identified 'significant life event(s),' and in preparation for formal POC development at least every 90 days, but not more than one time in a calendar month. |
| | | | d. P.134: The CANS instrument will be administered by the wraparound facilitator at any identified "significant life event" (as determined by the CFT) that may alter the member's existing level of care status, as well as in preparation of for the member's six (6) month CFT meeting, however, the CANS instrument cannot be administered more than once a month. The wraparound facilitator is responsible for scheduling and coordinating CFT meetings, monitoring the implementation of the POC, for initiating CFT meetings as the needs of the members dictate. The member and parent-legal representative of the member have the ability to request a meeting of their CFT at any time should needs or circumstances | d. No Change: WV BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. |

| | | | | |
|---|---|---|---|---|
| | | | change. The member and parents/legal representatives of the member ultimately determine participation in the POC development, the identification of POC goals, and the designation of POC services and supports. If at the member's six (6) month POC review the CFT determines he/she has not benefited from waiver enrollment (i.e. no progress has been made on the member's treatment goals and objects), then the CFT will refer the member to the IEN to re-determine level of care placement. Likewise, the CFT may determine the member has benefited from waiver enrollment and no longer requires services delivered by this program, at which time discharge planning will commence. Every person must have a redetermination of medical eligibility completed at least annually. The anchor date of the member's annual redetermination is the first day of the month after the initial medical eligibility was established by the MECA. If the reevaluation results in waiver eligibility the final decision will be made by BMS<br><br>Recommendation: 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. | |

| | | | | |
|---|---|---|---|---|
| | | | e. P.73, 89, 95: Works with the MCO Care Manager to identify service providers….<br><br>Recommendation: Consider removing because outlined above are inclusions around the POC and where the POC is developed OR Submits plan to the MCO care manager to authorize wraparound team POC decisions regarding needed service provision | e. No Change: BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. |
| | | | f. P.74, 90, 96: Unclear why it is the responsibility of the wraparound facilitator to "Assure that children are only placed in Therapeutic Foster Care (TFC) homes through Bureau for Social Services (BSS) that comply with the CMS Integrated Settings Rule." On p. 123, it states that the settings checklist is completed when BSS completes the initial home study when licensing the therapeutic foster homes. It further outlines the expectations that the Wraparound facilitator will review potential new homes or placements prior to moves to ensure they meet requirements. It states that the Wraparound facilitator will complete the settings checklist "monthly during one of their weekly home visits." However, the Wraparound facilitator may not always be meeting with the family in the home but may be in another community-based setting, including if there is a team meeting responsible for completing the checklist.<br><br>Recommendation: Make oversight of the TFC homes the responsibility of the State Agency, not the wraparound facilitator. The placing entity should be responsible for ensuring that the setting meets all requirements, not the Wraparound facilitator. It says that children in TFC homes are visited twice monthly by the agency, so that is when the agency can complete the checklist. | f. No Change: Per the Centers for Medicare and Medicaid Services (CMS) Integrated Settings Rule (42 CFR 44.301c-4-i.vi/441.71-a-1/441.530a-1), BMS requires routine assessment of the members setting, which occurs at identified intervals by the care team. BSS maintains oversight responsibility of TFC homes. |

| | | | | |
|---|---|---|---|---|
| | | | g. P. 76, 99: Wraparound facilitators are required to be licensed or have certification in the online case management training developed by BMS. Reference to the Agency being certified by the ASO as meeting standards for high-fidelity Wraparound.<br><br>Recommendation: Update requirements for facilitators and supervisors to align with NWIC recommendations. Separate out the agency requirements from the facilitators or supervisors. Require that the agency provide clinical supervision for all enrolled families under a licensed mental health practitioner. | g. No Change: BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. |
| | | | h. P.131: BMS can approve a licensed behavioral health agency to provide Wraparound Facilitation and other waiver services if they are the only qualified entity within a 15-mile radius or if there is no willing and qualified provider with a common language or background. The 15-mile radius seems small given the number of health professional shortage areas in the state. Later, on p. 133, it says it must be within a 25-mile radius.<br><br>Recommendation: Update the radius to align with the distance reasonably expected in West Virginia based on the number of available providers. | h. Change: Thank you for your recommendation. The State will review the mileage language and provide more clarification. |
| | | | i. P.133: A wraparound facilitator with the chosen Wraparound Facilitation agency will contact the member and parent/legal representative/foster parent to begin engagement in the POC development process prior to the seven (7) day meeting taking place. During this contact, the wraparound facilitator assures the delivery of the CSEDW enrollment information describing the waiver services, free choice of providers, and how to report abuse and neglect. A | i. No Change: BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. |

| | | | | |
|---|---|---|---|---|
| | | | mutually agreed upon date will be set for the initial POC meeting within seven (7) days of the CSEDW referral; the wraparound facilitator will also schedule and administer the CANS instrument for use in development of the annual POC. The member may have a CANS already begun or completed within the previous 30 days. The team may review this CANS to determine if a new one needs completed. Although the wraparound facilitator should begin administration of the CANS instrument at the seven (7) day meeting, the expectation is that the CANS will be completed within thirty (30) days of intake to assist with POC development. The POC shall be developed within seven (7) days and completed within thirty (30) days of referral to the wraparound facilitation provider. Also p. 135, The POC shall be developed within seven (7) days and completed within thirty (30) days of assignment to the Wraparound Facilitation agency. An initial POC is developed based on initial application information within seven (7) days of assignment to the wraparound facilitation provider.<br><br>Recommendation: 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. The recommendation | |

| | | | | |
|---|---|---|---|---|
| | | | made previously to rectify this issue is to remove the requirement of holding the 7-day meeting. | |
| | | | j. P.136: Each POC is required to contain a crisis plan. Crisis plans are developed in conjunction with the CFT during the POC meeting based upon the individualized preferences of the member and parent/legal representative/foster parent of member. As with the POC itself, the member and parent/legal representative/foster parent of member may choose to revise the crisis plan at any time they feel it is necessary. Each crisis plan is individualized to the member; crisis plan to include clinical and non-clinical events. A potential crisis (risk) and appropriate interventions (strategies to mitigate risk) are specific to the member and identified by the CFT. Training provided to the wraparound facilitator highlights the need to identify different levels of intervention on a crisis plan, the different stages of crisis, and how a crisis may be defined differently by each family.<br><br>Recommendation: Clarify that initial crisis plan is developed at the first face-to-face meeting between the wraparound facilitator and the child/family. | j. No Change: The crisis plan is developed with the initial POC per Chapter 502.18.2 Children with Serious Emotional Disorder Waiver (CSEDW) CSEDW is based on family voice and choice principles and should be honored. |
| | | | k. P.166: The initial POC is developed within the first seven (7) days of waiver enrollment; the annual POC must be developed within the first thirty (30) days of waiver enrollment. The wraparound facilitator together with the CFT will develop the POC. The MCO will review all annual POCs for approval as the BMS' contracted oversight entity. It is the responsibility of the wraparound facilitator to send the POC to the MCO prior to requesting service authorization and service delivery. The MCO will review the POC to determine | k. No Change: BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. |

| | | | | |
|---|---|---|---|---|
| | | | that requested services are listed on the POC prior to authorizing payment.<br><br>Recommendation: See above comments regarding 7-day meeting. | |
| 006 | 10/27/23 | Participant Services (p. 105-106) | a. P. 105: The soft limits for the service are up to 2 hours/week using a 15-minute billing increment. This approach does not lend itself to having peer parent support workers engage deeply with caregivers and develop trusting relationships that will enable them to empower and support the caregivers. Initial engagement may be several hours more per week in the beginning and again when there is a crisis or if the youth is transitioning out of the program.<br><br>Recommendation: Increase the soft limits for this service—at a minimum, double the limits to 16 hours/month and do not limit it per week. | a. No Change: Peer Parent Support services have a soft limit of up to eight hours per week, additional unit can be requested with documented medical necessity based on the individual needs of each member. |
| | | | b. P. 106: Provider qualifications for this service are limited to having a contract with the MCO and being a licensed behavioral health center. This does not mean there are qualified individuals with lived experience positioned to provide this service or to receive necessary supervision or mentorship from others with lived experience.<br><br>Recommendation: 1) Require that providers of this service have lived experience as a caregiver or family member of an individual with serious behavioral health needs or involvement in public | b. No Change: Currently we have no certification for parent peer support providers and will consider this in the future. Supervision of peer parent support staff is required per Chapter 502.25.3 Children with Serious Emotional Disorder waiver (CSEDW) |

| | | | | |
|---|---|---|---|---|
| | | | systems (child welfare, juvenile justice) or that the individual themselves has lived experience in child welfare, juvenile justice, or with the behavioral health system as a child or young adult. 2) Require training and certification for peer support providers through an identified curriculum. 3) Require ongoing supervision and support for peer support providers. | |
| 007 | 10/27/23 | Participant Services (p.67) | The billing increment is a 15-minute increment for an overnight service. This is unnecessarily burdensome and complicated.<br><br>Recommendation: Change the billing increment so that one unit equals a 24-hour period. It may be billed in full if the child spends at least 16 hours in the setting and the child leaves prior to the end of the 24-hour period if planned or if there is an urgent circumstantial need to return home, both of which should be documented. | No Change: BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. Overnight respite is currently not allowable. |
| 008 | 10/27/23 | Participant Services (p.78) | a. The limit of $1,000 per year of this service, combined with assistive equipment, is confusing. Many youth who want to use specialized therapy will have no need for assistive equipment. Other youth who have needs for assistive equipment will have very limited funds available for specialized therapy, which could be particularly relevant for their needs. Participating in a specialized therapy once or twice per month for one year would exceed the $1000 available even if no assistive equipment is needed.<br><br>Recommendation: De-link specialized therapy and assistive equipment. Pay for specialized therapy | a. No Change: BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. |

| | | | | |
|---|---|---|---|---|
| | | | through a set rate per unit, with a 50-minute, 75-minute, and 90-minute option. | |
| | | | b. It is unclear what the standards are for providers of specialized therapies. Do they have to be certified by a national agency? Which specialties are permitted? There are different accrediting and certification bodies depending on the modality.<br><br>Recommendation: Provide a list of therapies and the required certification or accreditation for each, with the ability for a provider to request approval if they provide a specialty not otherwise covered. Recommend the list of types of specialties include play, dance, music, drama, art, equine, and horticulture to begin. | b. No Change: Staff credentials can be found in the Chapter 502.23 Children with Serious Emotional Disorder Waiver (CSEDW) Specialized therapy services must be directed and provided by professionals who are trained, qualified, and/or certified to provide activity therapies. |
| 009 | 10/27/23 | Cost Neutrality Demonstration (p. 230-239) | a. The average cost per unit are low, given that they are paid to agencies and not individuals. Although the costs are estimates and the MCOs determine the rates, the amount estimated is too low for quality workforce recruitment and retention. For example, the job development rate is $19.92/hour but the hourly wage needed to afford a 2-bedroom apartment in West Virginia is $16.64/hour. That would mean the agency only takes $3.28/hour out of the wage to cover all of its costs for supervision, overhead, transportation, insurance, telecommunications, etc.<br><br>Recommendation: Increase the cost basis for units of service and ensure that the MCOs provide their contracted agencies with rates that will pay livable wages to support a strong behavioral health workforce. | a. No Change: BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. |

| | | | | |
|---|---|---|---|---|
| | | | b. As noted above, the number of estimated units for Wraparound Facilitation, peer parent support, and Specialized Therapy seem too low.<br><br>Recommendation: Increase the number of units per year to align with NWIC recommendations to account for collateral contacts, travel, meetings, assessments, etc. for Wraparound Facilitation. Increase peer parent support hours to 192 hours/year, not 48. Separate specialized therapy from assistive equipment. | b. No Change: BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. |
| 010 | 10/31/23 | Participant-Centered Planning and Service Delivery<br>(p. 146-152) | Currently, CSED therapists cannot bill for attending POC meetings, annual redetermination meetings, or Significant Life Event meetings. It is a requirement per CSED policy that the therapist attend these meetings. These meetings occur frequently and typically last 1.5-2 hours. If the therapists are required to attend, the agencies should be compensated for that time. The rate needs to be higher to reflect training, extra time<br><br>Recommendation: Case rates or per diem rates | No Change: Only the wraparound facilitator can bill for case planning meetings. Per policy, BMS cannot pay two providers for the same activity. |
| 011 | 10/31/23 | Participant Services<br>(p. 83) | Allow all travel time to be billable. | No Change: As part of rate development travel time and associated cost assumptions have been calculated into the rates for waiver services. |
| 012 | 10/31/23 | Participant Services<br>(p. 83) | Allow Wraparound Facilitators to transport youth – this would be beneficial to the families that we serve and it is allowed in Bureau of Behavioral Health (BBH) wraparound, but not CSED wraparound | No Change: The wraparound facilitator PMPM rate includes transportation costs. Non-emergency transportation services may be used where applicable per Chapter 502.27 Children with Serious Emotional Disorder waiver (CSEDW) |

| | | | | |
|---|---|---|---|---|
| 013 | 10/31/23 | Participant Access and Eligibility (p. 49) | Currently, CSED agencies are required to place a child's spot-on hold for up to 365 days if the child transitions to a residential facility or an out-of-home placement. For example, if a therapist or wraparound facilitator's client transitions to a residential placement and then a few months later discharges back into the community, Aetna expects the agency to resume services with that client right away. This has been a frequent issue as it is not realistic for an agency to hold spots on caseloads for up to 365 days.<br><br>Recommendation: 30 days | No Change: BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. |
| 014 | 10/31/23 | Cost Neutrality Demonstration (p. 230-239) | Wraparound Facilitation should have a monthly case rate that is comparable to the current Wraparound Facilitation (WF) rate for Safe at Home (SAH) wraparound. This will ensure WF are able to be employed, and are able to fulfill the job duties considering time that is not allowable to be “billed” such as accounting for staff time off, sick, or on vacation; training/coaching; supervision time; etc. | No Change: Thank you for your comment. |
| 015 | 10/31/23 | Participant Services<br><br>(p. 80-82) | Wraparound Facilitators should be permitted to bill for assessments required, again like the SAH method. If there will be no allowable billing such as in the case of assessments; the monthly rate should include this ability. | No Change: The wraparound facilitation service PMPM rate includes required assessments. |
| 016 | 10/31/23 | Cost Neutrality Demonstration (p. 230-239) | Rates for both the high acuity and moderate CSEDW WF need to be shared so providers are able to determine if those rates are adequate to provide a quality service and meet all the requirements outside of service provision such as training, coaching, supervision, quality improvement, etc. | No Change: All rates for CSEDW are subject to CMS approval and must be consistent with the provisions of §1902(a)(30)(A) of the Act and the related federal regulations at 42 CFR §447.200-205. |

| | | | | |
|---|---|---|---|---|
| 017 | 10/31/23 | Participant Services<br>(p. 83) | The CAFAS scoring should be redetermined for High Intensity and moderate intensity for WF. A youth that has a CAFAS score of 120 and above typically needs a higher intensity wraparound to keep these youth and families from home removal. For youth returning from a residential care facility to home, this is also an intensive transition for youth/families. It would be suggested this be redetermined.<br>*Suggestion: Moderate Level WA: 100 and below; High Intensity 120 and above. | No Change: BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. |
| 018 | 10/31/23 | Participant Services<br>(p. 83) | Will there be a process for youth that may need to move from a moderate level of intensity for Facilitation to intensive or vice versa? What will this process be? It is suggested this not be a cumbersome process and youth/families are able to seamlessly receive the level of care necessary to prevent removal. | No Change: Individual acuity determinations are based on CAFAS/PECFAS scores, if at time of redetermination the individual's change in acuity will be documented and will be seamless to the individual and family. |
| 019 | 10/31/23 | Participant Services<br>(p. 80-82) | Will there be a way for providers to receive necessary reimbursement (WA Facilitation) if a youth is not in the program the full month? For example-if a youth discharges on the 15th of the month, will there be reimbursement for the youth for that period re: a pro-rated method? It is recommended the provider receive a level of payment for youth who may not be in the program the full month versus receiving nothing. | No Change: The proposed rate structure for Wraparound Facilitation is a per diem per month rate, one claim per month can be submitted for any wrap around services provided in that month that meet the minimum threshold regardless of what day the services are delivered. |
| 020 | 10/31/23 | Cost Neutrality Demonstration<br>(p. 230-239) | It is suggested the WF rate for moderate level youth be adequate to properly serve youth in community and to have the ability to provide what is necessary to prevent removal or a seamless transition back to the community. Rates have not been shared, so this is difficult to comment on. | No Change: All rates for CSEDW are subject to CMS approval and must be consistent with the provisions of §1902(a)(30)(A) of the Act and the related federal regulations at 42 CFR §447.200-205. |
| 021 | 10/31/23 | Cost Neutrality Demonstration | Overall, providers want to increase community-based services, the barrier has been the funding and funding structure to do this in a fiscally responsible manner. It | No Change: BMS appreciates your time reviewing the proposed changes to the |

| | | | | |
|---|---|---|---|---|
| | | (p. 230-239) | is our hope rates and structure of rates will allow for significant growth in serving youth in community. WV Youth in need have very complex family/living situations that are a vital part of service delivery. | application and your feedback for continued program improvement. |
| 022 | 10/31/23 | Participant Services (p. 80-82) | Suggestion to share more explanation on Moderate Level of WA being able to implement an evidence supported model verse the High Intensity having to implement the high-fidelity WA model. Again, what does funding look like for both of these models of WF and are rates/funding adequate to provide quality of care and build additional capacity to grow community-based services. | No Change: All rates for CSEDW are subject to CMS approval and must be consistent with the provisions of §1902(a)(30)(A) of the Act and the related federal regulations at 42 CFR §447.200-205. |
| 023 | 10/31/23 | Participant-Centered Planning and Service Delivery (p.145) | Per the signing of the no-conflict document, does this mean providers could be able to provide services in addition to WA without this being burdensome, restricted? | No Change: Providers can provide both Wraparound Facilitation in addition to other CSED services with the expectation and assurance that they meet conflict free case management standards. |
| 024 | 10/31/23 | Participant-Centered Planning and Service Delivery (p. 143) | It is strongly suggested that CSEDW in Treatment Foster Homes be reconsidered. This could be more efficient if the CPA were able to provide services in our own foster homes such as crisis response, family support, etc. There is little conflict with this model, as CPA foster homes prefer the agency supporting them to do these duties. | No Change: Services cannot be duplicative. |
| 025 | 10/31/23 | Participant-Centered Planning and Service Delivery (p. 149) | Adjustment needs to be made and accounted for when members are not attending meetings. When the member does not attend, that means the meeting is not valid and is not a reimbursable service. It is not reasonable as the WF agency has no control over other entities, emergencies, etc.<br>Recommendation: reporting who didn't attend and reason could be added in place of the stringent current practice which is not realistic in practice. | No Change: The treatment team consists of the member and/or guardian, and/or member's representative (if requested), the member's case manager, representatives of each professional discipline, and provider and/or program providing services to that person (inter- and intra-agency). |

| | | | | |
|---|---|---|---|---|
| 026 | 10/25/23 | Transition Plan (p. 12) | Page 12: In the “Attachment #1: Transition Plan” section. “It is anticipated that mobile response service will be provided as a Medicaid State Plan Service (SPA #23-0003) in January 2024. CSEDW members are eligible for the new service and should experience a seamless transition and maintain the existing service provider.” If BMS has elected to transfer mobile response services to a State Plan Service. It is DRWV’s position that CSEDW members shall experience a seamless transition and maintain the existing service provider. | No Change: BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. |
| 027 | 10/25/23 | Transition Plan (p. 12) | Page 13: Typo, third paragraph, remove “the” just before character. “…due to the limited the character count…” | Change: The appropriate correction will be made. |
| 028 | 10/25/23 | Waiver Administration and Operation (p.17) | Page 15: In the “MCO: Responsible for managing,” section. Bullet 4 is listed twice. It also appears as though some items are not bulleted. | Change: The appropriate correction will be made. |
| 029 | 10/25/23 | Waiver Administration and Operation (p.17) | Page 15: “The MCO Care Manager will contact the child/family periodically to monitor the implementation of the POC, Care Coordination (differs from the CSEDW Wraparound services) of enrolled CSEDW members” DRWV believes that there should be a set minimum number of contacts made by the MCO Care Manager. | No Change: The MCO requires care managers to meet weekly with the member. |
| 030 | 10/25/23 | Participant Access and Eligibility (pg. 38) | Pages 30, 44, 45, & 46: There is similar/overlapping language throughout the application that refers to “Medicaid-eligible Children.” “Additionally, this waiver prioritizes children/youth with SED who are in PRTFs or other residential treatment providers out-of-state, and those who are in such facilities in-state. Then, Medicaid-eligible Children with SED who are at risk of | No Change: Effective September 1, 2022, applicants who have an institutional level of care need and meet program medical eligibility requirements, but do not meet financial eligibility requirements, are able to utilize the Special HCBS Waiver Group (§435.217 Group) of the Social Security Act to enroll in |

| | | | | |
|---|---|---|---|---|
| | | | institutionalization are the target group." DRWV understands the order in which program eligibility is prioritized for children and youth that are placed in facilities. However, DRWV believes that children/youth who are not Medicaid-eligible should be considered for the program. Similar to other HCBS waivers that do not consider the families' income to determine financial eligibility for HCBS waiver services. | WV Medicaid during the duration of their enrollment in the CSEDW. |
| 031 | 10/25/23 | Participant Access and Eligibility<br>(p.49) | Page 46: "…and the ability to respond to treatment." This language is reference with a series of eligibility requirements. However, this requirement is not listed in any other portion of the application where eligibility requirements are outlined. | No Change: This language is found in the level of care evaluation and reevaluation section of Appendix B and describes criteria used for final determination by BMS. |
| 032 | 10/25/23 | Participant Access and Eligibility<br>(p.49) | Page 46: "If an individual is found eligible for CSEDW services and has received notification of a funded slot but is not yet deemed eligible for discharge from the facility, the member will have up to 365 days, unless the member ages out of eligibility to access their funded slot in the community before being discharged for non-use of their waiver slot." How does BMS determine if an individual gets the full 365 days, if needed as opposed to any number of days less than 365 days? DRWV suggests removing the "up to" language from this section of the application. | No Change: The MCO, MECA and CSEDW providers maintain documentation on the eligibility determination date of each individual. |
| 033 | 10/25/23 | Participant Access and Eligibility<br>(p.49) | Page 46: "Additionally, if at the member's POC review the CFT determines he/she has not benefited from waiver enrollment (i.e., no progress has been made on the member's treatment goals and objects), then the CFT will refer the member to the IEN to re-determine level of care placement." Does this mean that the member will be terminated from the CSEDW program? How does the CFT and/or the member of the IEN | No Change: The CAFAS/PECFAS takes into account services and caregiver supports along with functional progression. |

| | | | | |
|---|---|---|---|---|
| | | | determine if lack of progression is due to the member's needs or due to the lack of support/services? | |
| 034 | 10/25/23 | Participant Access and Eligibility (p.56) | Page 56: Typo, there is no period at the end of the first sentence in paragraph two. | Change: The appropriate correction will be made. |
| 035 | 10/25/23 | Participant Services<br>(p. 56-103) | Pages 56, 59, 74, 83, 90, 96, & 103: "Due to the overwhelming response from HCBS providers, members and families during the COVID-19 Public Health Emergency, BMS is implementing telehealth as an allowable service modality for CSED waiver." This language is noted throughout the CSEDW application under In-Home Family Support, Day Habilitation, Case Management, Other Mental Health & Behavioral Services, and Caregiver Support. It is DRWV's position that the individuals on the CSEDW program need to have routine monitoring of their health and safety. For this reason, DRWV asserts that in person services are essential to the members. | No Change: Family voice and choice principles support a member or family/legal guardian's request for in person services and must be supported by providers. |
| 036 | 10/25/23 | Participant Services (p.58) | Page 58: Add protective service language to "provider qualifications." | No Change: In-Home Family Support provider qualifications currently require staff to complete training in First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect. |
| 037 | 10/25/23 | Participant Services<br>(p. 72-74) | Pages 72 & 74: C-1/C-3: Service Specification/Case Management. "Meets at least monthly with the member and their parent/legal representative or foster parents. The purpose of these visits is to determine the progress of the person receiving services and resources, assess achievement of training objectives, to identifying unmet needs and provide for the appropriate support as necessary…" Is this service provided in person at least monthly? If not, DRWV | No Change: Yes, the wraparound facilitation service is provided in person at least monthly for every member. |

| | | | | |
|---|---|---|---|---|
| | | | suggest that this service be provided in person at least monthly. | |
| 038 | 10/25/23 | Participant Services<br>(p. 91, 97) | Page 75: Telehealth is an allowable service modality for wraparound facilitator. Telehealth may be utilized to deliver services for up to 50% of the total services the member receives per year of enrollment (one calendar year from the members anchor date). DRWV does not agree with up to 50% telehealth service for wraparound facilitator. DRWV believes this service should be delivered in person 100% of the time. | No Change: Monthly in-person meetings are required for every member also following family voice and choice principles. Telehealth may be utilized for Wraparound Facilitation up to 50% of the time only when requested by the member or family/legal guardian for the total services the member received per year of enrollment. |
| 039 | 10/25/23 | Participant Services<br>(p. 112) | DRWV strongly recommends that all direct care staff working with CSEDW members be screened through the State's Protective Services Record Check (WV PATH). | No Change: CSEDW providers must be compliant with WV Medicaid Provider Manual Chapter 700 – West Virginia Clearance for Access: Registry & Employment Screening (WV CARES). https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20700%20WV%20CARES%20Policy%20FinalApprovedforManual.pdf. |
| 040 | 10/25/23 | Participant Services<br>(p. 57-110) | DRWV agrees with the "soft" unit limits referenced in the application. | No Change: BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. |
| 041 | 10/26/23 | Attachments (p. 12) | "It is anticipated that mobile response service will be provided as a Medicaid State Plan Service (SPA #23-0003) in January 2024. CSEDW members are eligible for the new service and should experience a seamless transition and maintain the existing service provider. The MCO will receive training, the Medicaid Provider Manual Chapter related to mobile crisis, and be required to monitor that the waiver service remains in the member's POC once the service is available through the Medicaid State Plan. The wraparound | No Change: As of January 2024, there is no CSEDW service approved by CMS that allows for the administration of mobile crisis response. Please continue to use the children's crisis and referral line. If an entity would like to become a mobile crisis provider, please contact BMS. |

| | | | | |
|---|---|---|---|---|
| | | | facilitator will be the primary point of contact through this transition. All members will be notified in writing by the MCO and from the wrap facilitator of this change thirty days prior to the implementation date of the new service. Notification will include guidance on fair hearings. The new service is called community-based mobile crisis intervention services and is accessed the same way as mobile response. An individual calls the 1-844-435-7498 (HELP4WV) referral line or the toll-free crisis hotline (988). The toll-free crisis hotline connects members to mobile crisis response teams that are available throughout the state and staffed 24 hours per day, seven days a week. The Mobile Crisis Response Team provides timely intensive support, stabilization of the crisis event, and time limited rehabilitation intervention services intended to achieve crisis symptom reduction. In addition, the team will help restore members to their baseline function and maintain them in their homes when possible"<br>○ Although Wrap Facilitators do not currently provide Mobile Crisis Response in CSEDW, and we have relied on MCR accessed through the Helpline in our current CSEDW cases, historically there were times that MCR teams have not responded or have been unreachable. While this is few and far between, in the instances that the MCR team is unavailable or unresponsive, is there a payment mechanism for CSEDW team member (Facilitator/Family Support Worker/Direct Service Worker/Etc.) crisis response? Would they simply bill Wrap Facilitation/Family Support/etc. in these instances? Or would their response to the crisis be unbillable? | |
| 042 | 10/26/23 | Cost Neutrality (p. 206 – 213) | For WF: "Each member will be assigned an acuity level defined by BMS. The acuity level determines a PMPM rate for the member. Providers will be paid | No Change: The PMPM rate for Wraparound Facilitation is inclusive of the administrative activities and service components required for |

| | | | | |
|---|---|---|---|---|
| | | | more for high acuity members" Application lists the following rates: Wraparound Facilitation (no intensity listed) - $14.35 per 15-minute unit; Wraparound Facilitation (Moderate Intensity) - $449.88 PMPM; Wraparound Facilitation (High Intensity) - $1,125.16 per month.<br><br>How will billing operate for monthly member reimbursement? Will there be a separate invoice submitted for these members? Will documentation billing (POC; CANS entry) be included in this monthly rate, or is this additional billing billed under Wrap Facilitation at the 14.35 rate? The current Wraparound Facilitation Rate is $15.07 per 15-minute unit, so this new rate is a decrease. What percentage of youth will fall under the (assumedly) low-intensity wraparound rate of $14.35 per minute unit versus the monthly reimbursement rate for other cases? Could a member's intensity level and billing rate change during their CSEDW case or at annual redetermination? | care coordination. We appreciate your time and review. |
| 043 | 10/26/23 | Cost Neutrality (p. 206 – 213) | For In-Home Family Support (IHFS): New Rate is listed at $16.92 per 15-minute unit; For In-Home Family Therapy (IHFT): New Rate is listed at $30.84 per 15-minute unit; For Out-of-Home Respite (OOHR); New Rate is listed at $5.01 per 15-minute unit.<br><br>○ The current IHFS rate is $17.77 per 15-minute unit; The current IHFT rate is $32.38 per 15-minute unit; The current OOHR rate is $5.26 per 15-minute unit. This means all cases running on the supportive services track will operate under reduced rates moving forward. Agencies already struggle to maintain CSEDW cases at current rates. If Wrap Facilitation and Supportive Services tracks continue to run independently of one another, how will support services agencies be | No Change: These rates have not changed. |

| | | | | |
|---|---|---|---|---|
| | | | able to maintain staff and provide adequate services with this reduction? As an example, assuming a therapist sees a caseload of ten families for one hour each week, under the new rates that would be a loss of approximately $246.40 each 4-week month versus current rates. An IHFS worker who sees ten families for an hour each week would see a loss of approximately $136.00 each 4-week month versus current rates. For an agency providing both of these services, assuming a maintained caseload of 10, that is a loss of $4,971.20 in 52 weeks (one year) of service. | |
| 044 | 10/26/23 | Participant Services<br>(p. 56, 97) | For WF and IHFS: "Telehealth may be utilized to deliver services for up to 50% of the total services the member receives per year of enrollment (one calendar year from the members anchor date). Providers will discuss with the member the allowable service modalities. Service selection, modality, scope, frequency, and duration are person-centered and represent the choice of the member and family. The member may utilize telehealth in alignment with the frequency and duration outlined in the member POC, if telehealth is selected by the member and family a telehealth backup plan must be discussed and added to the POC, the telehealth backup plan must include alternative service connections available to the member and family, for example switching to an in person face-to-face visit, emergency power supply or a mobile device that allows connection."<br>How will this be tracked? Will all Plans of Care be required to outline the total number of units provided virtually versus the total number of units provided in person? | No Change: CSEDW providers must document how services are delivered in treatment documentation and when claims are submitted by using a modifier indicating the service was delivered via telehealth. It is the responsibility of the CSEDW to ensure that they are complying will all CSEDW requirements. |

| | | | | |
|---|---|---|---|---|
| 045 | 10/26/23 | Participant Services<br><br>(p. 97) | "Privacy is paramount in any health care and telemedicine interaction. The use of video conference, video monitoring, or any type of surveillance is not at any time permitted in bedrooms and bathrooms."<br><br>○ I appreciate this for the level of privacy protection, but in some circumstances where multiple people/families live in the same home, parents and children might need to use a bedroom as a meeting space to separate themselves from other individuals in the home, especially if they reside in a small home with lack of options for meeting. For example, if a POC meeting is being held virtually, in the winter, due to inclement weather and the youth, mom, dad, and several siblings are sharing residence with Grandma, Grandpa, and an Uncle and his child, to maintain privacy during the meeting the family may need to separate from Uncle and Grandparents, if they are not participating. The only option may be a bedroom away from the common living space. Is there some way to accommodate these rare instances? Perhaps noting that a bedroom may only be used in instances where all team members are present at the meeting and the youth and guardian are together in the bedroom? Or, in these instances should the meeting be rescheduled? | No Change: Thank you for your comment. |

| | | | | |
|---|---|---|---|---|
| 046 | 10/26/23 | Participant Services<br>(p. 98) | A New Training is required for Wraparound Facilitation: HCBS Settings Rule<br>What is HCBS Settings Rule? Who will provide this training? Is it required annually? | No Change: The HCBS Settings rule is defined in CFR 441.530 and a requirement of the CSED waiver approved by the Centers for Medicare and Medicaid Services. The CSEDW providers are required by BMS to ensure they are following all CSEDW requirements for participation and have required HCBS Setting Rule training for their staff. |
| 047 | 10/26/23 | Participant Services<br>(p. 58) | This Application requires that all staff are trained in Crisis Prevention De-escalation and Restraints - Restraints are permitted in CSEDW as a de-escalation technique, when least restrictive options are not available. Restraint should be applied for no more than half an hour without review of the members condition by a licensed clinician. All restraints used as well as more restrictive alternatives must be documented in the POC to demonstrate that least restrictive option was used.<br>○ How does this apply to restraint-free agencies. We are a restraint-free agency and do not/will not train our staff in restraints/holds, nor do we allow our staff to use restraints/holds or teach caregivers to use restraints/holds. Would this requirement preclude us from providing CSEDW services. | No Change: Crisis Prevention and De-escalation and restraint training has been a requirement since the initial implementation of CSEDW. |
| 048 | 10/26/23 | Patient Safeguards<br>(p. 173) | There were several performance measures listed in the application. I've copied one here:<br>Performance Measure: G-a-1: Number and percent of substantiated cases of abuse, neglect, exploitation, and misappropriation of funds where recommended actions to protect health and welfare were implemented. N-Number of substantiated cases where | No Change: The Quality Improvement Strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. |

| | | | | |
|---|---|---|---|---|
| | | | recommended actions to protect health and welfare were implemented. D-Total number of substantiated cases where there were recommended actions to protect health and welfare. (How is this a performance measure for CSED providers?)<br><br>I'm not sure I understand how this is a performance measure. How would the number of substantiated abuse and neglect cases measure an agency's performance in providing CSEDW services? There are other performance measures included in the application, like "number of restraints used," "Number of Critical Incidents," etc. None of these seem to be performance measures that would accurately measure the performance of an agency providing CSEDW services. | |
| 049 | 10/23/23 | | It should be considered in CSEDW Wraparound Facilitators be permitted to bill for assessments required, again like the SAH method. If there is no allowable billing like in assessments, the monthly rate should include this ability. | No Change: The wraparound facilitation service PMPM rate includes required assessments. |
| 050 | 10/24/23 | Participant-Centered Planning and Service Delivery (p.134) | POC continues to be a barrier with Aetna approval time and the amount of time the facilitator is putting in on revisions | No Change: BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. |
| 051 | 10/24/23 | Waiver Administration and Operation (p. 15) | Independent evaluators are not consistent across the board | No Change: BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. |
| 052 | 10/24/23 | Participant-Centered Planning and | Lack of continuity between interim services and CSED entities- interim services not informed if family is not making appointments or sending in paperwork. Not | No Change: BMS appreciates your time reviewing the proposed changes to the |

| | | | | |
|---|---|---|---|---|
| | | Service Delivery (p.139) | being informed if youths are denied and what the reason is i.e., does not qualify or did not complete necessary steps. We could help with ensuring families are completing things if we know. | application and your feedback for continued program improvement. |
| 053 | 10/24/23 | Participant Access and Eligibility (p. 46) | On hold cases create a barrier to serving more families. The ability to be on hold for a year and the provider agency holding that slot for up to a year is a big barrier. It does not allow the workers to take additional cases and we are holding a slot with no compensation. | No Change: BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. |
| 054 | 10/24/23 | Participant Services<br>(p. 76) | pg. 76 says facilitator must be BA/BS licensed, BA/BS Human service field with 1 year experience, or associate degree with 2 years' experience and complete the online care management (CM) training.<br>pg.77 says Licensed BA/BS, or BA/BS in Human Service Field with 2 years' experience and complete the online CM training. no mention of associate degree with 2 years' experience. | No Change: Please note High and Moderate Intensity wraparound facilitation service definitions will be in effect upon approval of the waiver amendment. The wraparound facilitation service definition found on pages 76-77 will apply to the waiver time period prior to CMS approval of this waiver amendment. |
| 055 | 10/24/23 | Participant Services<br>(p. 84) | The therapy section does not specify the location where therapy must take place. Not being able to provide in school is a barrier to taking additional therapy cases. Families want after school appointments which limit therapist to taking only two therapy sessions a day. If a family is willing to do appointments during the day, it can increase the capacity that therapists can take, but then that youth must miss additional school time for appointments. | No Change: Therapy may be provided in a community-based setting not during school hours or in duplication of the Individualized Education Plan (IEP). |
| 056 | 10/24/23 | Participant Services<br>(p. 86) | Therapy can only be done by at least a master's level licensed staff or under master's level licensure supervision. (Provisionally licensed counselors are not approved under this amendment) LGSW (Licensed Graduate Social Worker) is not included but they did include an LSW which does not make sense because an LSW is a bachelor level licensure. | No Change: BMS is currently reviewing this comment for a potential policy clarification. |

| | | | | |
|---|---|---|---|---|
| 057 | 10/24/23 | Participant Services<br>(p. 129) | pg. 129 If a child receiving CSEDW services is planning to move foster homes the facilitator will use the checklist to review any potential new homes to ensure they meet TFC standards- (facilitator is not a licensing individual in foster care and unsure why we should be doing this?) If any concerns are identified, the facilitator will help the family find other housing options before the move. | No Change: All rates for CSEDW are subject to CMS approval and must be consistent with the provisions of §1902(a)(30)(A) of the Act and the related federal regulations at 42 CFR §447.200-205. |
| 058 | 10/24/23 | Participant-Centered Planning and Service Delivery (p.131) | pg. 131- (1) if providing Facilitation services and direct services for the same case must maintain separate files. Could be an issue without EMR system if we do provide Facilitation and direct care services to a single family. | No Change: BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. |
| 059 | 10/24/23 | Participant-Centered Planning and Service Delivery (p. 135) | pg. 135 (e) signed POC must be distributed within 14 days of the POC, but Facilitators are not meeting this timeframe because it is taking longer than 14 days of back-and-forth corrections with the Aetna CM to get an approved finalized copy. | No Change: BMS appreciates your time reviewing the proposed changes to the application and your feedback for continued program improvement. |