Comments for Chapter 501 Aged and Disabled Waiver

Effective Date December 1, 2015

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
1	09/29/2015	Page 23 states Medicaid prohibits legally responsible persons from providing ADW services for purposes of reimbursement. It mentions spouse, parent of a minor child and court appointed legal guardians. What about legal guardians that volunteered to become the legal guardian? Does this apply to the guardian/MPOA etc. if the person receiving services does not have capacity?	C	**501.3.3 Personal Attendant Qualifications** Added to the second paragraph: A Medical Power of Attorney (MPOA), Power of Attorney (PA), Health Care Surrogate, or any other legal representative may provide services. However, if an MPOA, PA, Health Care Surrogate, or any other legal representative is providing services they must: 1. work for an ADW provider agency; or 2. if the person self-directs, they must have a Program	

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				Representative that is not the MPOA, PA, Health Care Surrogate, or any other legal representative.	
2	09/24/205	501.34 Include instruction that providers will use the Unsafe Environment and Non-compliance Procedural Guide when requesting closures.	**C**	**501.34 Discontinuation of Services** Updated bullet B. c. to state: The provider must follow the steps in the ADW Procedural Guidelines for Non-Compliance and Unsafe Closures. This can be found at: http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/ADWProgram/Pages/ADW-Manuals-and-Forms.aspx	
3	09/29/2015	Does the RN need to check the blood pressure according to the MD/PA/ANP's written prescription? Example:	**C**	An RN does not need a prescription	Blood pressures can be completed by the

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		daily blood pressure checks. Does that mean the RN will have to do daily blood pressure checks and if so, is that billable. Also, does that mean the RN will need to check the person's blood pressure on weekends as well? Can blood pressure checks be done by personal attendants if they are specially trained to do them?		to take a blood pressure. It will be removed from the list of RN duties. 501.18.2 Skilled Nursing Page 50 removed bullet I.	Personal Assistant if there is a prescription signed by the appropriate medical staff, the Personal Attendant has been trained and it's on the Personal Attendant Log.
4	09/29/2015	Several pharmacies in our area do not sync medications to be picked up once per month. How is the RN to address that situation? Can the RN bill more than once a month to work on the pill box? Also, if a client is ordered a couple of new prescriptions throughout the month, does that mean the RN would essentially have to go back and put those new meds in the pill box if there is nobody else to assist? Is that billable as well?	**NC**		Some pharmacies will mail prescriptions. The RN can pre-fill the person's medication box monthly if ordered by the appropriate medical staff per written prescription. Documentation to support the need for this service must be included in the Service Plan and Assessment to substantiate the need. If a medication box pre-fill is a

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					documented need, the Case Manager should assist by contacting the person's pharmacy and/or appropriate medical staff to resolve any problems identified with the medication schedule. The RN may need to make an additional visit during the month if a new medication is ordered and needed to be included in the medication box as long as no more than 6 units per month is billed.
5	09292015	We are concerned about the 1 unit per month for members POC's. There are times when our nurses spend a lot more time than that reviewing these POC's to make sure that they are done appropriately. It is unfair to deny the nurses pay for their time, when it is necessary at times for them to use more than 15 minutes a month on members POC's. We pay our homemakers weekly, therefore, we have more POC's a month than most agencies. It is more work, but we feel it is important to pay our homemakers weekly. Some of our members can	**NC**		Through input of the QIA council. BMS has been advised that 15 minutes per month per member is plenty of time to review POCs. If your agency policy is a barrier to following ADW policy, you

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		have up to 5 or 6 POC's per month, especially if they have split shifts. It is impossible for our nurses to go over each weeks POC's for some of our members in 15 minutes. I would appreciate your feedback.			might want to consider changing your policy.
6	09/30/2015	Page 34 of the Manual Draft: Medical Re Evaluation: A referent's signature (physician, nurse practitioner, PA-C) is required annually and must include the ICD diagnosis code(s). Previously, if PCP had not changed from previous year, a signature was not required. Also, diagnosis codes have never been required. Annually, is the C Mgr now required to obtain a new MNER with signature (physician, nurse Practitioner, PA-C). And, now, does any dx documented on the MNER require dx Codes?	**NC**		This is a change in procedures. The MNER does have to be signed by the appropriate medical staff every year. This was added due to the required ICD-10 codes and as a systemic quality improvement due to missing diagnoses. Medical staff who can sign the MNERs has been expanded. BMS feels this will make getting them signed yearly easier. ICD-10 codes are a new requirement and comes from CMS. BMS does not advise providers on what diagnosis codes to bill. There are several conversion

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					tools available on the internet. A provider could use the tools to convert ICD-9 codes to the appropriate ICD-10 codes. Code Conversion Tools: http://www.icd10data.com/ http://www.icd10codesearch.com/ https://www.aapc.com/icd-10/codes/ http://www.lussierlab.org/Web-Tools/index.html
7	09/30/2015	Page 48 of the Manual Draft: (half way down the page) Personal Attendants shall note the condition of the person on the Personal Attendant Daily Log by documenting on the person's wellness response on the ADW Wellness Scale (located on the log). QUESTION What is the Personal Attendant Daily Log? Is it the same as the POC? Where can I see a Personal Attendant Daily Log? I would like to see the ADW Wellness Scale before I make a comment.	**NC**		The Personal Attendant Log (PAL) has taken the place of the POC. It is one of the new forms developed as part of the Service Plan. The Service Plan and the PAL were developed by the Forms Committee which is a subcommittee of the

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					Quality Improvement Council. The PAL is page 3 and 4 of the Service Plan. The reason for the change is as follows: 1. By not transferring information from the Service Plan to the POC, it will reduce errors on the plan and providers repayment for those errors. 2. It reduces paperwork and builds the RN into the team, with their level of expertise. 3. Eliminates the need for a Service Plan Addendum.
8	09/30/2015	Page 52 of the Manual Draft: 501.19.1 Non-Medical Transportation Services 300 mile cap on non medical transportation	**NC**		There is no cap on mileage for medical transportation

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		QUESTION: Is there no mileage cap on MEDICAL Transportation?			through Non-Emergency Medical Transportation.
9	09/30/2015	Will there be a separate billing code for medical transportation (mileage cap for medical transportation, medical appointments, etc.?	**NC**		There is no separate billing code. There is no cap on mileage for medical transportation through Non-Emergency Medical Transportation.
10	09/30/2015	POC – Essential Errands Section Essential Errands relating to physicians reads on our POC as follows: 'medical appointments as scheduled' The transportation destination section: the HMer documents the physician & office location; date, total miles driven, QUESTION: Is it a requirement that all Physicians must be listed & appointment dates listed.	**NC**		The list of physicians is no longer on the Service Plan and was moved to the assessment. It is not necessary to have a list of all of the appointment dates, unless a CM is making appointments for the member. Then, the CM would need to know this information. For most, it is not necessary. It would be important to document the date of the PCP visit as there

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					is an area "Coordination of Healthcare" which is a new CMS requirement.
11	09/30/2015	Previously, the Svc Plan was not required to be this specific? Am I interpreting this correctly >SPECIFIC to date, miles driven, travel time, destination, purposes of travel, type of travel (EA or CA)? Or is this an error?	**NC**		The PAL on page 3 and top of page 4 is completed by the RN (old Plan of Care). This does not include this level of specificity. The worker completes the daily documentation on page 3 and 4. On page 4 is where the specificity is documented by the worker. It is the same as the daily documentation on the Plan of Care.
12	09/30/2015	I noticed in the slideshow by TBI that once a provider stops serving someone for unsafe, even though the person may ask for a hearing within 13 days, services will not continue when services were stopped due to unsafe. This needs to also be stated in ADW policy.	**C**	501.34 Discontinuation of Services – Added "However, due to the nature of unsafe environment closure, the person is not eligible for the	

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				option to continue existing services during the fair hearing process."	
13	09/30/2015	In Section 501.17.2 (Personal Attendant Responsibilities), it states, **"At no time, may the time spent on incidental services exceed the amount of time spent on hands-on personal care assistance."** My question is what if the member prefers their informal support (i.e. family or someone they trust) to address some of the personal care (i.e. bathing and dressing), due to not feeling comfortable with the Personal Attendant seeing them exposed (i.e. naked)? Knowing that bathing, dressing, and grooming can take up to 1-2 hours (depending on how much assistance one needs with these activities), does this mean that in this situation the member will be deemed non-compliant with the ADW program if they use their Personal Attendant primarily for incidental services such as meal prep, light housekeeping, assistance with ambulation, essential errands, etc.?? **Suggestion:** If CMS and BMS will allow it, to guarantee that "That time spent on Incidental Services does not exceed time spent on Hands on Personal Care Assistance," have a Personal Attendant Log (PAL) of the Service Plan mirror the Personal Care program in regards to planning how much time will be needed to address each Personal Care task and each incidental service task.	**NC**		This is a cumulative sum for the entire month, not day by day.

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		Members, based upon their service level are allotted a RANGE of hours. So, if a personal care attendant is not assisting a "B" level of care member with Bathing, Dressing, and Grooming, then the amount of time that it requires the informal support to address these ADLs, should be subtracted from 93 hours per month that the member receives in Personal Attendant Services.			
14	09/30/2015	Also in Section 501.17.2 (Personal Attendant Responsibilities), it states, **"Personal Attendant services can be provided on the day of admission and day of discharge from a nursing home, hospital, or other inpatient medical facility."** My question is once the member is discharge from an inpatient medical facility, prior to Personal Attendant services beginning, is a Post Hospital Visit or call required by the RN first?	**NC**		It is not standard practice to make a home visit following every hospitalization and would increase cost of service unnecessarily. We have always supported the nurse to make a judgment call based on the reason for the hospitalization. A person may require a visit due to new dx and a need for the nurse to evaluate the current PAL (formerly POC) and others may not such as someone with a chronic health problem that requires

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					routine hospitalization.
15	09/30/2015	It should be mandatory for every provider (including PPL) to write policy and procedure around back-up staffing so that none of the recipients go without being seen by qualified and trained staff. I understand that a back-up worker may not do everything that the PAL calls for that day, but the back-up could take a few minutes and do the most emergent things that the recipient needs done that day, whether it be pick up something necessary from the store or bathe the person or help the person change clothes, etc. I understand that some providers already have this written into their usual operations.	**NC**		This is up to the individual providers. Also, unplanned interruption in staffing should be addressed on the person's risk assessment.
16	10/05/2015	There is potential for a very serious issue with the ADW program no longer allowing medical transportation. The MTM in Hampshire County is very limited and cannot even help us with all the needed transportation now. There will be many who will not be able to get to their appointments or go for labwork, etc. Senior Drivers help many people who do not have ADW and some who do have ADW but there are only 4 in the county and they are usually fully booked now when I try to get help from them. Many are younger than 60 that are on ADW and so there is even less options for them. The population that I serve and have been serving 16 years are most often individuals who do not have any family/friends to help them and that is why they have ended up on ADW for assistance. I believe this is the greatest disservice to this community of aged and disabled individuals.	**NC**		BMS understands you concern. The Center for Medicare and Medicaid, our federal partner that approves our waiver application, would not permit waiver transportation being used for medical appointment. However, the same Personal Attendants (Homemakers) who are transporting now can sign up as a Friends and Family

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					driver. For instructions on how to use provide NEMT as a Friends and Family driver, please go to: https://www.mtm-inc.net/wp-content/uploads/2014/09/West-Virginia-Trip-Log-Final-11-6-14.pdf. In addition, the PA may bill transportation time and wait time with the person for medical appointments per the ADW training. Should the person opt to use an NEMT driver, if they need assistance getting to the van/car, if the person tells MTM that when they call to set up the trip, they will get assistance. If there is a problem with any with any NEMT

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					transportation, the complaint line number is 866-436-0457. You can also file a complaint online at https://www.mtm-inc.net/contact/
17	10/06/2015	Summarization of letter received from ADW participant – Concerned about the Personal Attendant not being able to transport to medical appts. Also concerned about living in a rural area and the options for grocery shopping.	**NC**		See response to comment 16 for medical appts. The 300 mile cap on essential errands and community outings is adequate. Your CM agency can help plan when and how often trips to larger grocery stores may take place. There is a process for requesting more miles.
18	10/06/2015	I am writing with concerns about the new T19 manual that is scheduled to go into affect around the first of the year. I am presently the T19 RN in Hampshire County and am extremely concerned about my clients who are receiving T19 services continued ability to remain in their home. If the rules change, as stated in the draft, my clients homemakers will not be allowed to transport them	**D**		See response to comment 16 for medical appts.

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		to medical appointments or any medical related event. We need to stop and look at the reason T19 was established….. to allow seniors to stay in their homes instead of going to skilled nursing facilities including transportation to/from medical appointments!! I have several clients in this county, that if it weren't for my homemakers they would be in a skilled facility. These clients have no family or family that doesn't care, and my homemaker that I have put in that home is there lifeline. Medical needs transportation is not being allowed but yet we can take the out for social events!!! I do not get the reasoning behind that at all!! If the client cannot get to the doctor to get their medications, leading to client becoming ill, leading to client going to hospital BUT you are worried about their SOCIAL wellbeing???? I have to question the thought process, or lack thereof, behind this rule. It appears to me that someone(s) cannot see the forest for the trees. You really need to go back and rethink this entire manual. I will apologize now for stepping on toes but I am very sensitive when it comes to the clients that I serve. Someone needs to take a stand for these seniors who have worked so many years to enjoy their "golden years" and someone is trying to jerk it right out from under them.			
19	10/14/15	Questions to submit for ADW Draft Manual that related to Training 19.1			

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		19.2 p.23 Person Centered Planning and Service Plan Development. Providers must use training modules provided by the OA for these mandatory trainings. When and where will these trainings or training materials be available? Are we required to train current staff? If so, what is the time frame to have it completed?	NC		Mandated trainings will be available on the Bureau of Senior Services Learning Management System on or before December 1. Providers may also develop their own trainings for those mandated as long as all components are present. All staff must have these trainings completed by December 1, 2016.
			NC		There is a post-test and Person Centered Planning Certificate at the end of the training. There is a Training Record form that will be available
		19.3 p.24 Person Centered Planning and Service Plan Developmen training for RN/CM. Questions as above. Is there a state form to document training on? If so, where can it be found?	NC		

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		19.4 p.25-lncident Management. For falls that are simple incidents, will the computer entry form change to allow simple incident v/s critical? What is a dietary error? Can you provide examples?	**NC**		on Dec. 1. When entering an incident, you must choose the incident type: simple, critical or abuse/neglect or exploitation. There may be a comment box for adding additional detail about the type of incident. The new IMS will not be in effect by the time the new policy manual is implemented. Example of a dietary error: Member's physician recommends mechanically blended food. Daughter visits from out of town and does not understand this. Member is given potatoes for dinner with no adverse outcome. Example of dietary

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					error: Member's physician recommends no citrus foods due to a history of a citrus food allergy. Member is not competent. Member is given orange juice, drinks half a glass but has no adverse side effects. • There are 2 types of deaths that should be entered into the IMS: • Deaths related to an incident. Example: Member's husband physically abuses her, hits her on the head, has a head injury and dies. • Unexplained, unanticipated deaths:

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					Example: Worker goes to the home. Member is found on the floor, deceased. Apartment is a mess with the window broken. Example: Family goes to the home. Finds member deceased from a gunshot wound. Example: Worker goes to the home. Finds member deceased in the bedroom. Member is not terminal, is young and no known explanation for the death. Pill bottles are missing. Please note that all deaths will be required to be reported on the new mortality form (first half of the form). For unexplained deaths, the second half the

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					form must be completed.
		19.5 p.27-Do all deaths need to put in as an incident and reported on the WV IMS?	C	Section 501.7 will be updated to include: Within 2 business days after receiving a fully completed MNER, the UMC will send a letter to the applicant notifying them that they must complete financial eligibility before they can proceed with medical eligibility. The letter will include a yellow DHS-2 form and a Case Management Selection form.	
		19.6 p.29-30-Financial eligibility, Medical eligibility determinations will not occur until the yellow DHS2 form is returned to the UMC and states that the applicant is financially eligible. How long does the UMC have to	D		CareConnection© Notifications “Annual Eligibility Alert” are generated

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		get the DHS2 form to the applicant after receiving the MNER?			at 90 days prior to the member's anchor date.
		19.7 p.34-Medical Re-evaluation. A referent's signature is required annually and must include ICD diagnosis codes. As PCP does not have to sign the form annually, unless there is a change, who will supply the ICD codes for the re-evaluation MNERs with the new manual? (PCP were not required to provide the codes previously.	NC		See response #23.4
		19.8 p.34-501.9.3 Medical Re-Eval B. The request can be submitted up to 90 calendar days prior to the expiration of the current PAS, as dictated by the Anchor Date (We have been going by the anchor date not the PAS date and no later than 45 calendar days prior to expiration of the current PAS. A person's medical eligibility is at risk if the PAS request is submitted less than 45 calendar days before it expires. The expiration of a PAS does not constitute a reason for an appeal. We have been getting annual re-evaluations done by the anchor date and not the PAS date. Could you please clarify this as APS is posting notifications by Anchor dates not PAS dates?	D		The RN must send the updated PAL to the Case Manager. The CM attaches the PAL to the Service Plan, initials and dates receipt of the updated PAL on the PAL form. It becomes a part of the Service Plan. The PAL Updates are for simple changes such as changes in hours, days or Personal Attendant activities.

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		19.9 p40-A new assessment must be completed when a person's needs change. Changes in a person's needs are to be incorporated into the service plan. Can this be done with an addendum or is a new SP required?	NC		
		19.10 p.41- The CM is required to document the person's approval of the change in the plan by telephone or in person on the changed Personal Attendant Log. Please clarify, as the CM does not access the Personal Attendant log, the ADW RN documents changes on the PA log.	C	These definitions will be added to the Glossary. Amount: The amount refers to the number of hours in a day a service will be provided. Example: 4 hours per day. Frequency: The frequency refers to how often a service is provided. Example: Monday-	

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		19.11 P41-SP must include a risk plan, service plan(service amount, frequency and duration) and resource plan with referral source. Please clarify service plans amounts, frequency and duration.		Friday, daily, etc. Duration: The length of time the service will be provided. Example: 6 months, 3 months, 1 month.	
20	10/9/15	I work as a Case Manager with XXXXX covering XXXXXX County. (1)The proposal for Non Medical Transportation not allowed to transport people on the ADW program to medical appointments is of great concern to me. It is clearly stated in your program description that "services are **person centered**, including choice, preference, individual need, cultural considerations, **ensure health and welfare**, reasonable , and identify a person's strengths and goals". In working with these individuals I have many, who without this program, would have no support of any kind. This is identified for many reasons. As per your statement our services are person centered. Many live alone, they do not drive or have a vehicle. Some have no family; family members do not live in the area, family member's work and in some cases, even though member's have family, they are of no support to the individual. Unfortunately our society today does not always have the close family unit of days gone by when we took care of our own. The area in which we live, and cover, has multiple family or general practitioners, we have some	**D**		16

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		eye physician's but in regard to specialist our member's must travel anywhere from 1-2 hours , or more, to access services. Some physician's do not accept WV Medicaid which forces member's to travel further to secure providers to meet their health needs. We have some public transportation but there must be more that 1 person traveling in the general area. There are instances where one individual may have an appointment at 9 am and the next an appointment at 3 pm. At times these appointments may be traveling distance another ½ to 1 hour apart. The earlier appointment may be dropped off prior to the physician's office opening and may be left again after the provider office closes depending upon the completion of the 2nd appointment and return of the transport service. Other options may be available for services through DHHR but this process is very difficult and a "complicated" process which these individual's cannot understand. It is difficult for many of our member's to tolerate traveling. They have very poor stamina. During this time frame they may go all day without eating because they have no access to obtain food or drinks ; they may not have the money to purchase outside food. Some member's have altered mental status. The transport personal are limited to how much assistance they can provide to an individual. They can help them on and off the bus but who is there to help them find where they need to be, get on an elevator or maneuver them self in and out of the doctor's office. In my opinion, all of these factors contradict and jeopardize a service stated to "ensure health and welfare" for our			

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		members. Should the denial of Non Medical Transport be initiated I fear a great detriment for the health and well being of our members. I foresee many will "just not go to the doctor" because they have no other option. It is clear what the outcome would be for these individuals if this were to occur. For the most part, the individual's which we serve have a proud and determined spirit. They fight everyday to maintain their current existence. But as more and more services "are taken" from them they just want to give up feeling that "no one cares". I respectfully ask for your further consideration for the continued provision of this service within the ADW program.			
21	10/13/15	**Scanned Document #141520** 1. Why do the annual evaluations need sent to the PCP. Any diagnosis that an individual has stays with them. Getting doctors to complete the evaluations is difficult. The diagnosis such as angina, dyspnea, dysphagia etc. annually I understand.	**D**		6
22	10/13/15	**Scanned Document #141520** 2. Taking member's to Dr. Appts is one of the most important travel needs. Many of our members do not have family available to transport them to appts. Family	**D**		16

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		members have to work to meet their obligations. Some members do not have family. Members need homemakers present to know information given to them by their PCP's or Specialist. Some members need assistance getting in the Dr. office and need assistance while they are there which is not provided by office staff.			
23	10/13/15	Summary of letter sent by member- 1-Does not want medical transportation removed from Homemakers. Homemakers need to be allowed to go appts. With member to assist them with several things like walking, understanding medications. 2-Cases should not be closed in one month if no services are received. Many reasons a person may not use services. 3-If member says they don't need help with ADLs their case should not be closed. Often members need some time to get use to their homemaker before letting them help them. Some members prefer to have family help them bathe.	**D**		16 Cases won't necessarily be closed in one month. It depends on the circumstances. There is an expectation that a person needs the services if they are on the program. If family members are available to provide services, what is the purpose for being on the

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			NC		Waiver. People may not be on the waiver to simply have access to Medicaid.
		4-Doing a new CM assessment and Service Plan every time there is a change in need is ridiculous. This takes a lot of time. Progress notes and/or SP Addendum is much quicker.			A new CM Assessment and Service Plan is not needed every time there is a change.
			NC		PAL: Changes in Service time, days of the week or Personal Attendant Activity (changing type of assistance with ADL's for example).
			NC		For a change in the Personal Attendant service times, schedule, days of the week or PAL activities, the RN may make the change on the PAL and documents on the back of the PAL that the member approved

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					of it. This can happen either in person or by phone. This enables the member to receive services much sooner as a simple change can happen by an over the phone approval. Previously, the RN and the member had to wait on the Service Plan Addendum to be written and sent to the RN to make any changes. Sometimes changes in hours need to happen quickly for members. A copy of the PAL is sent to the Case Manager. It is attached to the Service Plan which makes it an actual change in the Service Plan. The Case Manager simply initials and dates the

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					receipt of the new PAL on the PAL itself. Service Plan: Case Manager can make changes. It is a “fluid document”. For minor changes in the Service needs the Case Manager may simply go the Service Plan, add a line that documents the need, date it and initial it. Resources Needed: Provider/ Referral See initials and date of Case Manager below: Needs New Wheel Chair Best DME Company *CB* 11/10/15 You can add a line for a new item

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					needed by the member under the Risk Plan, Service Plan or the Resource Plan. This allows you to easily make a minor change to the Service Plan. On the front of the Service Plan is a box labeled “Change in Need/Service Level”. Add a date in this box so it is clear that a new item was added to the Service Plan at a later date (before a 6 month or an annual is due). Need for a new Assessment and Service Plan: For major changes in the member’s needs, a new assessment and Service Plan is needed before a 6 month or annual plan

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					is due. Example: Member goes into the hospital and rehab for 20 days. Member had a stroke and has major changes in their needs and care. Member is moving in with daughter whose home is not handicap accessible, now is confined to the bed and needs 24/7 care, needs bath chair, ramp, new wheel chair; potential for many new risks for the member due to level of physical incapacity; potential for change in all services/needs for the member due to the stroke.

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		5- Requesting an emergency transfer if services cannot be provided, initially in 5 days should be changed. By the time the other agency did their assessments,		Section 501.14 Initiation of Personal Attendant	

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		developed SP and hired someone and trained them it would take longer than if you just give the first agency a few more days to hire the right person and train them to meet the members needs. 6-CM cannot coordinate Home Health Services. Doctor's order this directly from HH agencies. Only service that could be duplicated is bathing assistance and HH agencies have stopped this because of staff shortages as soon as PC or waiver services are started.	**C** **NC**	Services has been changed back to 10 calendar days.	Section 501-29 – Rights and Responsibilities F Responsibilities - Notify the ADW providers and/or Resource Consultant of any change of medical status or direct care need. People receiving services have the responsibility of informing all providers/Personal Options staff if they need home health services. Once an MD Home Health order/referral is received, the Home Health RN does the initial assessment

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					visit. The person on the ADW should be informing the MD that the they are also receiving ADW services (and visa versa if HH services start prior to ADW services). To prevent duplication of services from both providers the HHA nurse and ADW case manager must work together by submitting their member's POC to each other to prevent duplication. If the MD orders an aide to assist with the bath from the HHA, the HH nurse can inform him that the member gets this service through an ADW provider. All providers are responsible to for not duplicating services.

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					The section on Home Health was included in the ADW manual because some people on the ADW may need Home Health services in addition to ADW services.
		7-Having people do financial application first will deter people from applying and overload DHHR staff and delay time person can be put on wait list.			BMS feels that this is an appropriate step to take. Why be on a wait list for months, only to find out that the person was never financially eligible? It delays those who are financially eligible getting a slot.
		8-Most doctor's office don't have time to put ICD-10 codes on paperwork. We are lucky to get the information we do get now. These codes do not always reflect the condition of a person. Purpose for this is not clear at all since waiver is not a medical service.			Doctor's offices should be very familiar with ICD-10 codes as they are now required to use them. BMS disagrees that Wavier services are not a "medical service". The person

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					must meet nursing home level of care to be eligible for the waiver.
24	10/8/15	I understand that waiver cannot be used for medical transportation any more, But, I would suggest adding medical appointments back the description of essential errands since the time spent driving to medical appointments is billable, even though the mileage isn't.	**NC**		BMS feels that it is clear in other areas of the manual and in the forms that medical appointments are essential errands.
25	10/8/15	Summary of written letter by a homemaker- 1-member needs assistance while at the doctor's office. Homemakers should be allowed/paid to attend doctor's appointments. 2-allow homemaker to transport to medical appointments.	**D**		See response to #16.
26	10/9/15	Summary of written letter by a member- 1-allow my staff to take me to medical appointments and stay with me there	**D**		See response to #16.
27	10/8/15	Summary of written letter by member- 1-allow my caregiver to take me to medical appointments	**D**		See response to #16.
28	10/12/15	Summary of written letter by adult child/legal power of attorney and care taker of member- 1- I do not feel my mother should be expected to ride the MTA bus to appointments. 2- I should be allowed to take my mother to doctor's appointments to assist her with walking and communicating with the doctor.	**D**		See response to #16.
29	10/13/15	Summary of written letter- 1. If homemaker not allowed to take her to medical	**D**		See response to #16.

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		appointments she would not go.			
30	10/13/15	Summary of written letter- 1. He would have to cancel appointments. He could not do the long waits waiting for a bus. This all would make him tired.	**D**		See response to #16.
31	10/7/15	Summary of written letter- 1. Medical transportation-I the homemaker need to take him because he needs assistance to walk, pivot, standing, with the bathroom and understanding what the doctor says. He will be at risk for falls. He will forget appointments. He goes by ambulance now but when he gets better I will need to take him. He is being treated for wound care.	**D**		See response to #16.
32	10/13/15	Summary of written letter- 1. Medical transport should be allowed by the homemaker staff. She refuses strangers to assist her with things.	**D**		See response to #16.
33	10/08/15	Summary of written letter- 1. I need assistance from my homemaker to go to doctor appointments. I cannot push my wheelchair. I need help remembering things the doctor says. My pain doctor is across the state line and I am told NEMT does not transport across stateliness. Please let my homemaker transport me to medical appointments.	**D**		See response to #16.
34	10/13/15	Summary of written letter- 1. I want my mother's homemaker to be allowed to take her to doctor's appointments. She cannot be left alone. I have my own medical issues and	**D**		See response to #16.

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		cannot take her myself.			
35	10/7/15	Summary of written letter- 1. I don't think MTM will travel as far out in the country as I leave to take my husband to doctor's appointments. I cannot drive in big cities. 2. He needs his caretaker to assist him with walking and things while at doctor's appointments.	**D**		See response to #16.
36	10/8/15	Summary of written letter- 1. Needs homemaker with him at doctor's appointments. He is a fall risk, has dementia, has incontinence, confusion and help understanding what the doctors says and with questions from the doctor. Family works and cant take him. The senior center van cant take him cause it is out of area.	**D**		See response to #16.
37	10-2015	Summary of written letter- 1. Let my caregiver take me to doctor appointments. I need help walking even with my walker.	**D**		See response to #16.
38	10/7/15	Summary of written letter- 1. I want my worker to be able to go to the doctor with me. My worker helps me remember what the doctor says and what I need to ask my doctor and helps me while I am at the doctor with what I need.	**D**		See response to #16.
39	10/8/15	Summary of written letter- 1. Allow my worker to take me to medical appointments. I have had a procedure and my worker picked me up at 4:00am to take me.	**D**		See response to #16.
40	10/13/15	Summary of written letter-	**D**		See response to #16.

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		1. Allow my worker to take me to medical appointments. MTM is sometimes too busy to take me. They require a five day notice and sometimes I don't always know I am going to have another appointment five days before.			
41	10/13/15	Summary of written letter- Allow my worker to take me to medical appointments. MTM is sometimes too busy to take me. They require a five day notice and sometimes I don't always know I am going to have another appointment five days before. MTM doesn't provide assistance with someone in a wheelchair. They expect the person to be able to get on and off the lift and in and out of the doctor's office by themselves. I cannot do this alone.	**D**		See response to #16.
42	10/13/15	Summary of written letter- 1. Allow the aide to take her to doctor's appointments. She is blind and needs assistance and cannot ride the bus by herself. I cannot take her due to my husband's medical issues and care and her daughter works 6 days a week and cannot take her. She doesn't go very much.	**D**		See response to #16.
43	10/9/15	Summary of written letter- 1. I need my aide to take me to and from my medical appointments. I need assistance with my oxygen. I have no family close by to take me.	**D**		See response to #16.
44	10/7/15	Summary of written letter- 1. I am bi-polar and get nervous waiting for rides. Wait times can be 1 or 2 hours and sometimes in the cold. Let my aide take me to doctor's appointments.	**D**		See response to #16.

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		2. Don't take away my community time. That is the only time I get out.			
45	10/9/15	Summary of written letter- 1. I need my careworker to help me at doctor's appointments. I cannot walk far or without assistance. I have many medical conditions. I cannot use a bus.	**D**		See response to #16.
46	10/7/15	Summary of written letter- 1. I do not have friends or family to take me to medical appointments. I have used privately contracted agencies in the past and was late or missed my appointment altogether. They also don't provide help getting into the doctor's appointment. I cannot take a bus. I need help at my appointments. Taking away this service will cause people to stop going to doctor's appointments they need.	**D**		See response to #16.
47	10/8/15	Summary of written letter- 1. I wear a brace and use crutches. I need assistance going to doctor's appointments. The city bus driver does not assist me with getting on/off the bus. Allow my aide to take me to my appointments.	**D**		See response to #16.
48	10/7/15	Summary of written letter- 1. The people I work with need assistance getting to and at their doctor's appointments. Allow me to continue helping them.	**D**		See response to #16.
49	10/13/15	Summary of written letter- 1. Please don't stop her mileage. I help her go to get her hair done, get her medication and go	**D**		Mileage has not been stopped. There is a

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		shopping. Her son works all the time and cannot take her. 2. She needs help getting in/out of a car. She cannot ride a bus or van. They don't help her get in/out. I help her walk and at doctor's appointments.			cap of 300 miles per month. See response to #16.
50	10/8/15	Summary of written letter- 1. My sister and her husband are elderly as well with medical issues and cannot take me to doctor's appointments any more. No other family lives close by. I need assistance to get in/out of car and in/out of doctor's office. I also need assistance to walk. Allow my worker to go to my appointments with me. 2. Using other transportation often takes so long and their trips are timed 2 hours apart. I am concerned as to how I will keep my appointments.	**D**		See response to #16.
51	10/8/15	Summary of written letter- 1. I need my aide to help me get ready for doctor's appointments. I get very confused and need her to help get the information from the doctor and to give information to the doctor. Allow my aide to attend doctor's appointments with me.	**D**		See response to #16.
52	10/7/15	Summary of written letter- 1. My family cannot take me to medical appointments. I need my aid to help me remember what the doctor says and what to tell my doctor. Allow my aide to take me to doctor's appointments.	**D**		See response to #16.

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		2. My aide also take me to get prescriptions. It upsets me to know that this necessary service could be taken away from me.	NC		Picking up prescriptions is an essential errand and still allowable.
53	9/30/15	Summary of written letter- 1. Locally we have two grocery stores and a dollar store. It is more cost effective for me to go a little further to the Walmart to get what I need. I have a very limited income. 2. My husband is the only other person who could take me to doctor's appointments but he has to work. I depend on my worker to take me to several doctor's appointments. Where I live there is only 2 drivers to sever hundreds of people. I don't think I can count on them to get me to all of my appointments.	D		This is still permitted. However, there is a 300 mile per month cap. See response to #16.
54	10-2015	Received 22 comments requesting that homemakers be allow to provide transportation to participants because they require assistance getting in/out of vehicles and while at doctor's appointments with things like walking, toileting, obtaining and providing information to/from the doctor. They have difficulty with long waits.	D		See response to #16.
55	10/15/15	Please note that due to technical difficulty these comments will arrive after 5pm, however I would ask that you please consider the following comments pertaining to the Proposed ADW manual. 55.1*501.2.1.4- Question the definition of "direct on-site" supervision for provisional employees.	NC		There must be a fully qualified staff person working on-site with

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					the provisional employee.
		55.2 *501.14 - Appears that Traditional Model and Personal Options are being treated differently, with Traditional Model being held to no making up of services on a different day and Personal Options only being limited to carrying the hours to a different month.	**NC**		The Traditional Model and *Personal Options* Model are two different service delivery models. There would be no expectation that they would operate exactly the same way. See Response to #21 (9).
		55.3 The elimination of transportation to medical appointments is our agency's main concern. Concerns with the MTM services in our area and the frailty on many of our members leave many questions concerning the health and safety of our members. If the direct care worker is going to be able to accompany the member or be able to be the MTM Transporter then this needs to be addressed in the manual. Many of our members are unable to go to appointments alone due to physical and mental limitations. MTM does not allow for physical assistance needs. We feel that the medical transportation	**NC**		See Response #16.

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		is much more necessary than the community activity. 55.4 *501.17.2 - The addition of the wellness response that is to be documented by the Personal Attendant seems to be a task outside of their scope of training. This seems to be an assessment skill.	**NC**		BMS is not asking the PA to work outside of their scope of practice. The response on the scale will be via self-report only by the person receiving services.
56		Section 501.17.2 Personal Attendant Responsibilities The Personal Attendant must inform the RN of any changes in the person's health, safety or welfare and document the person's wellness response on the ADW Wellness Scale. What kind of information will the Personal Attendant be gathering on the Wellness Scale. Is this something that will require the Attendant to make medical assumptions that they have not been trained to do. It is my understanding that the member will need to make arrangements for their transportation to medical appointments through means other than their workers. I have had a few of my members tell me that they have had a difficult time obtaining transportation through MTM because of their home location, the member just did not understand the process or there was no one available to take them . Many of our members do not have family available to help either.	**D** **D**		55.4 See Response #16

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		Thank you for allowing us the opportunity to comment in order to give the best possible care to our members.			
57	10/15/15	We feel an agency should not be able to represent a client on both an in-home care level and case management level simultaneously. Case management serves as an advocate and also provides a checks and balance if there are problems with the in home care services. When the same agency provides both services this potentially damages integrity and can create client manipulation resulting in the members not having a voice when things are not satisfactory. If an agency provides in home care to a client then they should not be able to provide case management services to that same client and vice versa.	**NC**		For some of the reasons stated, BMS included Conflict Free Case Manage Policy Requirements and Training in the manual as well as consequences for those that violate the policy.
58	10/15/15	As a nurse working in the field with our members and with the homemakers assigned to the members…there are SEVERAL areas of this manual that are NOT conducive to adequate care for these people….. 1. 501.19 Not allowing any medical transport for these members esp. those who live in very rural areas is a problem. There is not specifics on perhaps HM being MTM approved to take members on medical runs…would this then be a permissible thing for members to get to appointments. Many MTM or other van transport may not be able to get to areas where some of our members live…and if the HM's do become MTM approved for medical transport…are they permitted to be paid hourly on the program for care of the client while being reimbursed for mileage through MTM? (this is under	**D**		See Response #16

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		the assumption that the homemakers/personal attendants will be able to be MTM approved) 2. 501.17.1 HUGE issue… you are potentially going to require homemakers/personal attendant of whom are working in a NON-skilled position to "note the condition of the person on the Personal Attendant Daily Log by documenting the person's wellness response on the ADW Wellness Scale"….(have not viewed the scale…did not see it for comment online) however, the manual then states in the same paragraph that the Personal Attendant staff cannot perform any service that is considered to be a professional skilled service…and functions/tasks that cannot be performed (K.) specifically states that they are NOT to make judgments. In my professional opinion, a worker, who perhaps may not have a high school graduate diploma (educational and situational aspects need to be considered), is NOT an adequate person to be judging the wellness of a member. Furthermore, Personal Attendants who may go in a home as a temporary sub may see a member far more debilitated than what they may be accustomed to working and feel that this members "wellness" is very poor when it may be that individuals norm…Also if this scale is based on the comment of the members themselves-contingent upon the attention seeking of the member or behavior issues individually displayed ….they may inappropriately misuse this "wellness scale". Homemakers/Personal	 **D**		 55.4

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		Attendants are NOT qualified to be assessing anyone's wellness criteria. This is asking something WAY beyond their scope of care and job qualifications. We have many people who have the heart to love and care greatly for our members, but lack the capabilities to adequately assess or question a person in relation to their wellness.			
59	10/15/15	**Scanned Document #141019** Title of Document: ADW Draft Manual – Concerns **1) 501.2.1.3 -** Employ Fitness Determination - paragraph 4, "no criminal history record information will be disseminated to the applicant or hiring entity:' **Since BMS (WV CARES) is withholding the results of the background checks from the provider(s) it appears they are accepting the responsibility of all provider hires. Providers may not elect to hire an applicant that has a previous DUI if they know about it.**	**NC**		As far as hiring people to work in the ADW program, the provider only needs to know whether they have been determined employable per ADW policy. However, it is always up to the provider whether they elect to hire the person or not. As far as your example is concerned, providers will be able to check DMV records, so if someone has a DUI, you can see that and decide if you want to hire them or not.

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					BMS is not accepting responsibility for all agency hires.
60	10/15/15	**Scanned Document #141019** Title of Document : ADW Draft Manual – Concerns **2) 501.2.1.4** - Provisional Employees - "All provisional employees shall receive direct on-site supervision by the hiring entity until an eligible fitness determination is received". **Please clarify if an ADW or PC homemaker is prohibited from working since they have no "direct on-site supervision.**	**NC**		If an employee is in provisional status, they may receive training, but they cannot have direct contact with a person on the ADW without on-site supervision.
61	10/15/15	**Scanned Document #141019** Title of Document : ADW Draft Manual – Concerns **3) 501.3.4** - Personal Attendant Initial Training Requirements – (D) Personal Attendant Skills must be provided by the agency RN. The PC program allows a documented specialist. (H) Health and Welfare for Person Receiving Services - requires agency RN. **The PC program allows a documented specialist. The trainings for both programs should be the same for consistency.**	**NC**		BMS feels the RN is the best person to conduct the trainings for Personal Attendant Skills and Health and Welfare. BMS working on a new Personal Care Manual and will make the change in it.
62		**Scanned Document #141019** Title of Document : ADW Draft Manual – Concerns **4) 501.3.9** - Providers must verify the homemaker has a	**NC**		That will be up to the individual agency to come up with a

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		valid vehicle license, registration, and inspection sticker upon hire and annually thereafter. **The inspection sticker will be a nightmare for the Providers to track. How will they manage this'?**			process for ensuring that all vehicles used for ADW transportation have current inspection stickers per stat law. Proof of this must be documented in the personnel files.
63	10/15/15	**Scanned Document #141019** Title of Document : ADW Draft Manual – Concerns **5) 501.19** - Non-Medical Transportation - no transportation to any type of medical appointment permitted by agency homemaker. Member must use MTM for all medical appointments. **This is the most outrageous move that BMS has ever made. I expect this change will result in severe consequences for the member, which will result in lawsuits being filed against BMS and their contracted entity.**	**D**		Please see response to #16.
64	10/15/15	**Scanned Document #141019** Title of Document : ADW Draft Manual – Concerns **6) 501.9.3.1** - "The Case Management Agency is responsible for sending the Notice of Approved Continued Medical Eligibility to the Personal Attendant Agency." **Doesn't the Personal Attendant Agency have access to this in Care Connection'?**	**NC**		The PA Agency has access to CareConnection©, however, they are not notified when a document is uploaded. The PA agency may continue to provide services for someone who is

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					no longer eligible. The CM Agency should also notify the PA agency if the person is no longer financially eligible.
65	10/13/15	**Scanned Document #141116** 1) Three is no Drug Profile with the Assessment.	**NC**		It is a separate form. It is called the Medication Profile. RN's wanted it separate from the Assessment so they can make changes even when the assessment is not being completed. It is to be used like a log.
66	10/13/15	**Scanned Document #141116** **66.1** 2) Layout for the time on the Log sheet is limited. It will be difficult/impossible to record hours that are complicated. One of my member's hours are Mon 8:00-4:00; Tue/Thurs./Fr 9:00 - 3:00; Wed 12:30-7:30. The current proposed format does not allow for a clear recording of times.	**NC**		The forms will be available in PDF format as well as Word. In the Word document, you may expand the area on the form. While it may print more pages, it is fine to do that. That is why we have the option of using a Word

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					document as well as a PDF document. We heard from providers that the PDF version didn't allow for any expansion of the section. Word will allow that accommodation in the formatting of the form itself. You cannot change the content of the form though.
		66.2 I can see many homemakers being confused by the statement where they are to initial, "PA Initial: I served one person today". What is the need for this? Why not just PA Initial?	**NC**		This was a required section that we had to add to the form. The reason for this section is that it was a requirement from Medicaid fraud. Example: This service is a 1:1 service (one worker to one member). It is not a "ratio code" that

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					they can bill for a husband and wife during the same 4 hours they are in the home. Medicaid fraud wants to ensure that the worker did not provide services to two people at the same time which would result in a duplication in services. Fraud wanted us to make sure we asked this question. It will be up to the provider to educate the worker as to what it means, how to answer it and why it is required. The instructions should clarify this section as well.
67	10/13/15	**Scanned Document #141116** 3) Hopefully the draft documents in Word are for	**D**		66.1

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		demonstration only?			
68	10/13/15	**Scanned Document #141116** 4) Are the Homemakers/Personal Assistants going to be able to provide NEMT under MTM and still be "on the clock" for Waiver? Many of our members cannot enter or exit the PCP offices without assistance. They also cannot transfer unassisted into or out of vehicles. Many of our members have great difficulty scheduling/keeping appointments now. The homemakers assist with all of this. If the homemakers are not allowed to transport under MTM and assist, many of our members will begin missing appointments, or just not going. The health and well-being of our members will suffer. The overall cost will escalate due to increased admissions and increased ambulance use. The ideal is that our members will have informal support, the reality is that many do not. Many of my members have little or no family support. Our homemakers are "it!"	**D**		See Response #16
69	10/13/15	**Scanned Document #141116** 5) The overall feel of this proposed document screams "State/Federal Centered", definitely NOT "Person Centered." Choice has been taken away. The "Persons" are being forced to make choices they do not want. Repeatedly we hear, "Why do I have to choose a day to go to the grocery store? I might not need anything that day, but need something later. As long as I go once a week, what does it matter?" Also, "Why do I have to choose a specific day for laundry? My girl does it when we get enough or I have the money for the machines." I	**NC**		The ADW is a Medicaid funded program. As such, BMS has a duty to ensure that services are provided within the guidelines of the approved CMS application. Service Plans are at the center

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		know our agency, and I feel most are the same, tries to make sure the members have and get what they need. The changes made in these programs are being done by those that have not worked in the field, or it has been a very long time since they've been there. Things that look good and seem to make sense on paper do not always translate well when actually put into practice. That rules and guidelines are necessary is understood by everyone.			of the program and must be specific as to how the person's needs are going to be met, when they will be met and how long the service is needed.
70	10/9/15	**Scanned Document #141045** To Whom It May Concern: Following are my comments to the ADW Draft Manual: I have read the draft ADW Waiver manual and the most glaring change, or omission in this case, is that medical transportation of members to medical provider appointments is not even mentioned. If medical transportation is eliminated from the ADW program, in my opinion, it would create a serious hardship for our members. Although there seems to be a move toward the services being more "person-centered," the outright exclusion of medical transportation flies in the face of this concept. I realize that there is an alternative to the personal attendants' transporting members in the form of the NEMT program. However, I also know that there is a disparity between transportation services provided by personal attendants and those provided by NEMT providers, a literal gap between the vehicle and the door. The transportation providers are not allowed to assist the members beyond getting them from "point A" to "point B," and within this rift lies the issue. Our ADW members, in many cases, are simply not physically able	**D**		See response to #16

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		to bridge this gap. By virtue of this inability and the potential for members to neglect their health as a result, I believe that the ultimate by-product of this change will be a decline in health outcomes for our members. While I don't believe that this is the intention of the stakeholders in this process, we who are "in the trenches" know that this will be the likely result. The above change is the one that I believe will negatively impact our members the most; however, I would also like to point out some other concerns with the proposed changes:			
71	10/9/15	**Scanned Document #141045** 1)Under section 501.2.1.3, Employee Fitness Determination, it appears that individual agencies will no longer receive information regarding background checks on potential employees, beyond whether or not they are eligible for hire as determined by the WV CARES system. Our agency has exceptional hiring standards, and the information that we currently receive assists us in determining who will be most suited to care for our members. The proposed changes will effectively take away our ability to do this, as well as increase our potential for liability, by limiting the information we have access to as an employer**.**	**D**		59
72	10/9/15	**Scanned Document #141045** 2) Under Section 501.2.1.4, Provisional Employees, we would like clarification as of what constitutes "direct on-site supervision" of provisional employees. Is this provision meant to state that a member of our office staff (coordinators, RNs, case managements) should be in the clients' home with these employees, directly supervising	**NC**		It means actual direct supervision by an employee in your agency by a fully qualified staff while the person is in provisional employee

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		their work while their background checks or variance requests are pending? This obviously would present a huge obstacle to effective care, in that the staff who would be providing this supervision Would, in the meantime, not be able to do their jobs! Currently, our provisional employees are hired, again based on our standards, are thoroughly trained before being sent out, and are closely monitored by staff by way of frequent contact with the employees and the members they serve.			status.
73	10/9/15	**Scanned Document #141045** 3) Section 501.2.1.7, Responsibility of the Hiring Entity, seems to contradict section 501.2.1.3, in that while the WV CARES system would determine the new employees' fitness for hire, any negative findings in the ongoing monthly checks would have to be researched by the employer. If the employer would be provided with the information necessary to do this research in the ongoing checks, why would the information not be provided before the initial hire?	**D**		59
74	10/9/15	**Scanned Document #141045** 4) Under section 501.3.3, paragraph 2, clarification of the portion stating that, "[court appointed legal guardians are also prohibited from providing reimbursed service," would be appreciated. Does this apply to the parents of children over the age of 18?	**NC**		If they have been appointed by the court to be the legal guardians, then it applies.
75	10/9/15	**Scanned Document #141045** 75.1 5) Under section 501.3.4, Personal Attendant Initial Training Requirements, subsection A" National Safety Council has been removed from the approved list of CPR	**NC**		The National Safety Council has not been removed from the BoSS website as an approved CPR

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		training providers. Is there a reason for this change? 75.2 Also, under subsection I., "Person-Centered Planning and Service Plan Development" has been added as a training requirement for personal attendants. Since PAs are not involved in planning, but rather in service provision, why has this requirement been added?			training provider. BMS feels that it is important for all staff involved to understand the premise behind Person-Centered Planning and Service Plan Development in order to more effectively serve people on the ADW.
76	10/9/15	**Scanned Document #141045** 6) Under section 501.4.1, Reporting Requirements, Incident Management Documentation and Investigation Procedures, paragraph 3, "For unexplained deaths, the Case Manager must report on the Notification of Death the cause of death. This simply doesn't make sense.	NC		Any ADW Recipient Death: For all ADW recipient deaths, the Case Manager must complete the Notification of Death form (first section). The form must be completed by the next business day of learning of the recipient's death and must be forwarded to

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					the OA. Unexplained Deaths: In addition, the Case Manager must complete the second section of the Notification of Death form for any unexplained death. An unexplained death is defined as "the cause of death is undetermined at the time of death". This section outlines the source that reported the death to the Case Manager, actions that occurred and actions that did not occur (CPR performed, called 911, police report, etc.). The completed Notification of Death form must be forwarded to the OA.
77	10/9/15	**Scanned Document #141045** 7a) Under section 501.14, Initiation of Personal	**D**		23.5

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		Attendant Services, first paragraph, the timeline for initiation of services after service plan development has been shortened from 10 calendar days to five calendar days. In addition, the agency is required to request an emergency transfer if this timeline is not met. Due to the staffing challenges faced by all providers, the end result of this change would likely be that the member would go without service for an even longer period than if the current 10-day window remained in place.			
78	10/9/15	**Scanned Document #141045** 7b) Under section 501.14, Initiation of Personal Attendant Services Also, the third paragraph states that, "ADW services not provided as scheduled ... cannot be made up on a different day." However, "[in] the Personal Options, services not provided as planned, may not be carried over into a new month." This appears to create a disparity in the treatment of Personal Options members over those who choose the traditional model of service.	**D**		55.2
79	10/9/15	**Scanned Document #141045** 8a) Under section 501.17.2, Personal Attendant Responsibilities, 2nd paragraph, "Personal Attendant services can be provided on the ... day of discharge from a nursing home, hospital, or other inpatient medical facility," we have previously been informed that services provided on the day of discharge would not be paid, and in particular RN post-hospital assessments, because inpatient services would have also been billed for that day. Because a hospitalized member's needs may have	**NC**		Only Personal Attendant services can be billed on the date of admission and/or discharge. It is not an ADW policy that a nursing assessment be conducted upon discharge. A hospital

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		changed, it is our policy that an RN assessment be done prior to the restart of services after a hospitalization. We would like clarification as to whether an RN assessment could also be billed for the day of discharge from an inpatient facility.			admission does not necessarily mean there has been a change in needs.
80	10/9/15	**Scanned Document #141045** 8b) Under section 501.17.2, Personal Attendant Responsibilities Also, the 8th paragraph states that, "all personal care needs as outlined on the Service Plan must take place before essential errands or community activities can occur." This seems to say that essential activities and/or community activities cannot be planned for a different day than personal care, e.g., member prefers to grocery shop on Mondays when the sale at the local market starts, but likes to bathe and wash hair on Tuesdays. In other words, what constitutes personal care's taking place before essential errands or community activities?	**NC**		The Service Plan should clearly detail what is to occur on each day. The idea behind this is to make sure a person's personal care needs are taken care of before other activities to ensure health and safety. Essential Errands and Community Activities can be planned on different days. BMS is just saying personal care needs are a priority.
81	10/9/15	**Scanned Document #141045** 8c) Under section 501.17.2, Personal Attendant Responsibilities The following paragraph refers to the PA's noting the condition of the member daily using an "ADW Wellness Scale." Beyond a member's ability to understand and respond to the question, "How do you	**D**		55.4

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		feel on a scale of 1 to 10," this provision requires, in essence, an assessment of the member's condition by the PA, which is outside the scope of practice for that level of care provider.			
82	10/9/15	**Scanned Document #141045** 9) Under section 501.18.1, Skilled Nursing Annual Assessment, Documentation Requirements, 2nd paragraph, "One unit of Nursing Services per month can be utilized for review of the Personal Attendant Log(s} to assure services were provided as planned .... " This disregards the fact that some members are served by multiple PAs, creating additional work for the RNs at the end of the billing period that will have the potential to be unbillable if the time spent exceeds one unit.	**D**		5
83	10/9/15	**Scanned Document #141045** 10a) Under section 501.19, Non-Medical Transportation, "Essential errands should be completed before mileage is used for community activities to ensure the person's needs are met." To which time period does this refer? Are all essential errands to be done for the billing period before a person will be allowed to participate in a community activity? This is very unclear.	**NC**		The time period would be for one month. The cap for miles per month is 300.BMS wanted to ensure that miles are available at the end of the month for essential errands if needed. There needs to be adequate planning for this.
84	10/14/15	**Scanned Document #141045** 10b) Under section 501.19, Non-Medical Transportation, Also, with regard to NEMT medical transportation (paragraphs 5 and 7), will the transportation providers	**NC**		NEMT will cover out of state travel regardless of who is doing the

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		under this program be allowed to transport members over state lines for medical care, as the PAs are for non-medical transportation? Thank you for your consideration of the above comments.			transporting. There is a process for special approval for out of state travel.
85	10/14/15	**Scanned Document #140854** 85.1 • To the extent that DHHR intends for this manual to have the legal force and effect of an administrative rule, the procedure used by the DHHR to promulgate the manual does not appear to satisfy either the Administrative Procedures Act. W.Va. Code § 29A-3-1, et seq.,or 42 C.F.R. 447.205. Accordingly, the "manual" should not be entitled to the force of a regulation, and instead should only be considered as suggested guidance. o The APA requires that any proposed rule be filed in the State Register, along with a notice summarizing the action and a fiscal note itemizing the cost of implementing the rule. It does not appear that the manual changes were filed with the requisite notice or cost report. The APA also requires that the notice filed in the Slate Register fix a date, time, and place for the receipt of' public comment, and it does not appear that such a notice was filed.	NC		This comment is misplaced under the law. Specifically, under federal law, Medicaid must be run by a "single state agency" within the state. See 42 U.S.C. §1396a(5). Further, "[t]he Medicaid agency *may not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.*" 42 C.F.R. §431.10(e). [Emphasis added]. This is inaccurate. BMS

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		85.2 o Likewise, 42 C.F.R. 447.205 requires: (1) prior notice; (2) publication; and (3) the opportunity for comment. It does not appear that these requirements were fulfilled. Moreover, the fact that the comments are due on October 15 and that training will be conducted on October 19 - less than a week later - seems to suggest that the act of soliciting comments is merely a formality and that comments will not be given due consideration.			posted both the application for the updated waiver manual on the BMS website and received public comment and also posted the proposed updated waiver manual itself.
86	10/14/15	**Scanned Document #140854** 1) With respect to the guidelines regarding Pre-Screening, Employment Fitness Determinations, and Variances, the DHHR by exercising significant, detailed control over the hiring process, is arguably assuming the role and legal status of a joint employer with a hiring agency. Essentially, the DHHR will serve as a super-personnel department and assume Human Resources functions that had traditionally been performed by the hiring agency- which arguably, could translate to the assumption or liability by the DHH R as a joint employer. It is the DHHR, not the hiring entity, which is effectively making hiring decisions when it comes to an applicant's background. This level of control is particularly evidenced with respect to Variances. Regarding Variances, it seems that the DHHR will be	**NC**		BMS disagrees that by placing guidelines to ensure appropriate background checks are performed on potential employees before they begin working with members of the age and disabled waiver program that it is becoming a “joint employer”. Addition ally, BMS notes that these provisions are

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		assessing - using criteria which are quite flexible and very subjective - whether an applicant poses a danger or threat to a client/resident or their property. What happens if, when the DHHR's assessment of an applicant's suitability for hire is wrong? Arguably, the DHHR could be liable under the theories of joint employer and negligent hiring in the event that its subjective assessment of an applicant's suitability for hire turns out to be incorrect, and the applicant causes harm to a client resident.			required by the West Virginia Clearance for Access: Registry and Employee Screening (WV CARES) Program, enacted in 2015 (Senate Bill 88).
87	10/14/15	**Scanned Document #140854** 2) The "Provisional Basis Employment" guideline, particularly the requirement to provide "direct, on-site supervision,' is overly burdensome and will be nearly impossible for an in-home care provider to implement from a practical, financial and operational standpoint. In the case of a group home setting, it seems that an employer could comply with the Provisional Employment Guideline by having a single employee provide direct, on-site supervision over multiple provisional employees. However, in the case of in-home care providers, the concept of "on-site supervision" becomes much more complicated. Compliance would essentially require each and every provisional employee to be accompanied by another employee whose job is merely to provide direct, on-site supervision over the provisional employee in a client's home. This is cost-prohibitive. What incentive would an in-home care provider have to endure the expense and operational burden or provisionally employing applicants if doing so	**NC**		BMS disagrees that the provisional basis requirement is unduly burdensome. Additionally, BMS notes this requirement is mandated by the WV CARES program.

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		would require the employer to fully compensate not only the provisional employee, but also a second employee whose job is merely to shadow the provisional employee during the 60-day provisional period?			
88	10/14/15	**Scanned Document #140854** 3) The Employment Fitness Determination guideline has the potential to deny employment to an entire class of employees - i.e. ., those who have a criminal conviction. In cases where a prospective employee receives a fitness determination or "not eligible," what incentive would an employer have to invest the time and expense of seeking a Variance on the applicant's behalf? Likewise, how would the hiring entity even have enough information to make an informed decision as to whether or not to seek a Variance if the hiring entity only receives the WV CARES' fitness determination (*i.e.,* "eligible" or "not eligible") and does not receive the underlying information regarding the applicant's criminal history record?	**NC**		BMS disagrees that the employment fitness program has this potential. Consistent with the WV CARES program, any employee with a negative finding is provided a chance to directly file for a variance – the employer does not have to do this for them. So the program will not eliminate a whole class of employees.
89	10/14/15	**Scanned Document #140854** The above and enclosed comments from our staff, supervisors and members are requested to become part of the official comment record. Please let the record reveal that the comments represent our beliefs and experiences while serving the Aged/Disabled Waiver population. We all are concerned if the draft manual is put into effect as	**D**		16

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		is without accepting the comments from those people in the trenches who perform the work every day. I remain concerned with 'wait time' or PA/HMs and the fact that in many instances, the medical provider is many miles from member's home! Thank you for the opportunity to respond.			
90	10/15/15	**Scanned Document #141213** 1) TMH Demonstration –Issue: They only receive services for 365 days. The TMH client needs to keep slot, they are very vulnerable and will need continued support.	**NC**		TMH participants receive additional services for 365 days. They do not lose their waiver slot after the 365 days.
91	10/15/15	Scanned Document #141213 2) 501.2.13 – Issue: State Police notifies WV Cares When working in Child Care the providers got held up waiting for fingerprints to come back from State Police.	**NC**		BMS has found that the speed of the process has greatly improved. Some results are coming back the next day. Also, there is no online system in place for Child Care providers at this time, so it wouldn't be comparable.
92	10/15/15	Scanned Document #141213 3) 501.2.14 – Issue: Direct on-site supervision by the hiring entity until an eligible fitness is received transportation How would we do this? Do we have staff to supervise till we get the approval?	**D**		55.1

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93		Scanned Document #141213 Members are not able to ride MTM transportation because they receive no assistance on and off the van. Also they can't wait for two hours for the van to pick them up. A lot would choose not to go to their doctors. Also, there is safety concerns too. One may get lost or may not feel safe being alone.	**D**		See #16 Response
94	10/15/15	Scanned Document #141213 4) 501.2.3.5 – Issue: Training and Technical Assistance When will the training occur? Is there a cost? Will it be available thru the state? Will they really do the training when needed?	**NC**		BMS contracts with the Bureau of Senior Services, the OA, to provide training and technical assistance for ADW providers. There is no cost. Providers may call BoSS at any time for technical assistance.
95	10/15/15	Scanned Document #141213 5) 501.9.2 Section E – Issue: If MNER form indicates Alzheimer's, multi infarct, senile, dementia legal rep has to sign the MNER. The members has rights and if they still have capacity they should not have to use their MPOA. The MPOA does not come into play till they lose capacity from the physician.	**NC**		According to *Cyrus v Walker* if an applicant has any of these diagnoses, a legal representative must be present to assist with the interview at the assessment. The physician is the one who gives the diagnosis.

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96	10/12/15	Scanned Document #141146 This letter is to express my concern over the proposed changes in the ADW policy manual. The main concern I have is over the changes to be made in the allowed travel. Not allowing personal assistants to transport ADW members to their doctor appointments will be detrimental for some of our members. Several of my members have no family or informal support that can take them. Some have attempted to use MTM services and it has been a nightmare. If they have an unexpected doctor appointment (ie, sick) and it is not in the allotted time frame for notice to MTM, they will not transport them. Some have scheduled with MTM and the driver did not show up to get them and they missed their appointment. This has resulted in members not being able to get some of their much needed medications, because the doctor would not refill it without seeing the member. Members have also tried to have informals sign up to be drivers through MTM and have not gotten reimbursed until several months later (over 6 months in some cases). Some infornals cannot afford to provide this transportation without being reimbursed in a timely manner and have subsequently stopped providing transportation. Some of my members have a mental and/or physical need for someone to be with them at their appointments and if I understand correctly, they are not allowed to have someone ride the MTM with them. If this is the case, many of my members will not: be able to keep their appointments for this reason. 1 cannot understand while travel is being allowed for community	**D**		16

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		activities such as going out to eat, but not for something as essential as a doctor appointment. I ask that you please reconsider this and add doctor appointments to allowed travel for members.			
97	10/12/15	**Scanned Document #141146** Another concern I have in the new proposed policy is the statement that legally responsible persons of the member are not allowed to provide ADW services to a member. Does this also mean that a member's MPOA is not allowed to be their personal assistant? If so, does this only take effect upon the member's incapacity? If the answer to either of these questions is yes, then many members are going to be forced into nursing homes because their MPOA is the only family willing/able to assist them or is the only person the member is comfortable letting in their home to care for them. In conclusion, I do not feel many of the proposed changes to the manual are client centered and this is supposed to be the basis for the waiver program. I ask that you take these matters into consideration before finalizing this policy. Thank you for your time.	**D**		1
98	10/9/15	**Scanned Document #141308** I wanted to take this opportunity to comment on a specific change in the Draft ADW Manual. This change is in regards to 501.3.9 Non·Medical Transportation. As a Case Manager, I am concerned with my clients not having access to the medical providers. My specifics concerns are as follows: 1) NEMT Services will not transport clients across the state line. My clients are located in the Eastern Panhandle	**D**		Response 16

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		of WV, and many have specialists in either Winchester, VA or Hagerstown, Md. Both of these are within a 30 mile radius of the Eastern Panhandle, and my clients rely on their Personal Attendants for transportation to these physicians. Clients see specialists in these locations because specific specialists are not available within the Eastern Panhandle. Cutting out medical transport for my clients would literally cut them off from much needed medical care.			
99	10/9/15	**Scanned Document #141308** 2) Clients require personal assistance to ambulate or transfer. NEMT Services will not help these clients with getting in/out of wheelchairs, or pushing them into/out of medical provider offices.	**D**		#16
100	10/9/15	**Scanned Document #141308** 3) NEMT will not physically assist those with sight deficiencies. I have several clients who are legally blind, and only make out shapes or colors. These clients rely on the PA's to assist them with safely ambulating to/from the vehicle and in/out of the office and home. With this assistance, these members would have no other access to assistance.	**D**		#16
101	10/9/15	**Scanned Document #141308** 4) Many clients do not have family in the immediate area, or at all, to assist them. For these clients, the PA transporting and assisting with medical appointments is what allows them to remain in their homes, rather than a long-term care facility. I realize that you are trying to do the best you can with	**D**		16

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		the resources you have. However, ADW program must realize that it's primary responsibility it to its members. I fear that the transportation changes alone could result in the loss of many ADW clients, and facilitate the need for more Long Term Care clients, which would ultimately be more costly to the state.			
102	10/12/15	**Scanned Document #141433** I have a few comments/questions regarding the drafted policy per your request: 1) Page 13, section 501.2.1.4- We need clarification on direct on-site supervision by the hiring entity for provisional employees until an eligible fitness determination is received.	**D**		72
103	10/12/15	**Scanned Document #141433** 2) Page 23, section 501.3.3· It states a court appointed legal guardian is prohibited from providing reimbursed services. Does this include a MPOA?	**D**		1
104	10/12/15	**Scanned Document #141433** 3) Page 12, section 501.2.1.1-if WV Cares makes the hiring decisions of caregivers, are we to assume they will accept responsibility in the event something goes wrong after an applicant has been hired?	**D**		59
105	10/12/15	**Scanned Document #141433** 4) Page 32, section 501.9.1.2- If you are saying this drafted policy is "person-centered", they should have the right to choose who assists with hands-on ADLs. It states if a person reports formal Personal Attendant services to assist with ADLs are not needed, a request for closure needs submitted. What's the magic number of days for ADLs not needed? The client's physician and APS	**D**		23.2

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		reviewers determine whether or not a client needs assistance. They should have the right to choose if they'd like a spouse or family member to assist at times.			
106	10/12/15	**Scanned Document #141406** After reading the proposed new manual I am wondering where the "Person Centered" Plan of Care is, this manual sounds like it has been written by people who have been blessed to have never had a loved one need services. Let's take a look at some of the areas of concern: 1) As far as medical transportation the client's needs should come first. The changes in the transportation policy clearly do not take the client's needs into consideration. The majority of ADW clients are unable to walk or wheel themselves and by this new policy will be picked up on the street and then dropped off at the entrance and left to their own devices to get where they need to be. What is the difference between paying this private company and paying a personal care attendant? The personal care attendant will also be there to assist in transport, toileting and if needed to take notes from the doctor to relay to family and the Personal Care Co. Some examples of poor care that have already been seen are: Client's being dropped at a doctor's office and unable to get inside the office on their own. One client was left sit at an office that had dosed and had to wait for over an hour by herself on her ride to return. The State and or transport company would be liable if something would to happen to this client while on their watch. A	**D**		16

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		client was incontinent during a visit to a doctor's office and was left to sit soiled for so long that skin breakdown occurred, now there are added costs related to possible hospital stay, home health being called in to treat. Again the State makes themselves liable' by this policy.			
107	10/12/15	**Scanned Document #141406** 2) There is a provision that has the personal attendants completing with the client a Wellness Scale daily. How is this to be done lf a client has dementia, Alzheimer's or other mental incapacity?	**D**		55.4
108	10/12/15	**Scanned Document #141406** 3) Page 48 of the policy, half way down, states that all Personal care needs must be met before essential or community activities. Again this is supposed to be "Person Centered" care, but this clearly is not. What if the essential errand dictates that it be done before. Our client's lives cannot be dictated on a piece of paper, they are human beings not pawns to be played with at the Governments whims.	**D**		80
109	10/12/15	**Scanned Document #141406** 4) Page 43 states that no services can be made up if missed. So for example a client who gets a bath 2-3 times a week is feeling ill one day and misses a bath, then they are being told they can't have it the next day because the service can't be made up? What about a client who has a doctor's appointment one day so misses their laundry day, which is only once a week, they are being told they would have to wait a week to have laundry done?	**D**		78
110	10/12/15	**Scanned Document #141406**	**D**		59

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		5) In regards to taking over the determination of hirability of personal attendants and the Joint Employer Relationship does this mean that the state is now going to assume joint liability for the actions of the attendants?			
111	10/12/15	**Scanned Document #141406** 6) It is' unclear through the last several months of this policy making if the rules for review policy as set forth by State Code has been followed? Especially regarding public hearings? 30 minutes in 1 day and no notification to the clients is not acceptable. These changes and many others outlined in this policy show a gross negligence of the elderly and disabled population in West Virginia and is nothing short of neglect of our seniors. It makes me wonder what the politicians in the state would feel if they knew about the policy.	**D**		85.2
112	10/2015	**Scanned Document #141458** To Whom It May Concern: After reviewing the draft ADW Draft Manual dated 8/17/15, I have the following concerns: 1) no medical transportation, 2) reliance on MTM for medical transportation and 3) refusal of MTM to transport ADW clients to VA facilities. 1) I have several ADW clients that have no informal support or family/friends to rely upon for transportation to/from physician's appointments, testing, etc. The client also needs physical assistance to get in/out of a vehicle and to ambulate or utilize a wheelchair to get into the facility/building. It is my understanding that the MTM driver or company is not responsible for the individual once they are out of their vehicle. They will simply drop them off and leave the location. This leaves our client's to	**D**		16

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		find their own way into the building 'without anyone to supervise or assist them for safety. The client could fall or become confused and forget what they are to do once they are dropped off. I also have a dialysis client, who is so weak, ill and confused after receiving their treatments that they would be unable to maneuver getting in or out of a vehicle or getting to and from the vehicle without someone to physically assist.			
113	10/2015	**Scanned Document #141458** 2) I also have concerns that MTM cannot transport clients on short notice, such as when being discharged from the hospital or if an emergency test or appointment is ordered. If our clients have no informal support, then how are they to get home following discharge from a facility or to an appointment that occurs outside of the MTM notification period?	**D**		16
114	10/2015	**Scanned Document #141458** 3) It is also unfair for MTM to refuse transport of an ADW client to a VA facility. If our Veteran's choose to visit a VA facility/physician, then they should be given the same opportunity to be transported by MTM or preferably by the personal assistant who can supervise or assist with ambulation/transfers.	**NC**		NEMT only covers transportation to a Medicaid reimbursable appointment. Waiver transportation can be used for trips to the VA, but the 300 mile cap applies. Also, a letter from the VA must be in the person's file that the trips are not reimbursed by them.

Comments for Chapter 501 Aged and Disabled Waiver

Effective Date December 1, 2015

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115	10/9/2015	**Scanned Document #141340** I am a case manager with Central WV Aging Services. I have reviewed the draft of the new policies governing Aged and Disabled Waiver services and have several concerns. As an advocate for the needs of my clients, I feel it is necessary to voice these concerns. 1) Referring to the draft page 23 Section 501.3.3 states that "legally responsible persons" are prohibited from providing ADW services for purposes of reimbursement. Am I to understand that those who are MPOA, Guardians or Committees for clients are unable to work for them as the homemaker? I have several of these situations in my case load. In the event that the caregiver was unable to work for that client, they would have to go and work at another job outside the home which would necessitate placing the member in a nursing facility or mental institution. How would this benefit the member or the Medicaid system? It would cost much more to pay for the placement of these individuals in facilities than it does to pay the "legally responsible person" to care for them in the home known to the member. Moving them to an unknown place would cause great distress and unneeded turmoil in their lives.	**D**		See Response 1
116	10/9/2015	**Scanned Document #141340** 2) In reference to page 51, Section 501.19 the draft states that all community activities are to be in the local home community and "must be the closest location to the person's home". I have clients who live in Richwood, WV. The only local grocery store has closed and the	**NC**		This just needs to be documented on the Service Plan and would be permitted.

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		closest one to Richwood is located in Craigsville . All my clients in Richwood and Craigsville report that the local grocery store is much more expensive then the Walmart in Summersville. Basically, it would be more expensive for them to shop at the closest store than go to the neighboring town to a bigger store. For those on very limited resources for food purchase this is a big problem. Also, the local store in Craigsville does not offer selections needed for some medical diets that clients are to follow. In this line of thought also, many clients depend on food pantries which are not located in their immediate community. Without these pantries, clients may go hungry. While I realize that grocery shopping is not classified as a "community activity" it is necessary to go outside the immediate community to meet the needs of the client in the outlying, rural areas of our state.			
117	10/9/2015	**Scanned Document #141340** 3) Continuing with the non-medical transportation issue, I would like to discuss the change related to Section 501.1 which states "Non-Medical Transportation cannot be used to transport people on the ADW program to any medical appointment". Many of my clients have NO family who can transport them to needed appointments. The only options would be to either not have any medical care, or ride the NEMT bus. This, as you know, requires that the transportation be scheduled 5 days prior. Many times, doctors' offices call with changes in appointment times without giving a 5 day notice. Then there is the issue of members requiring assistance ambulating, with toileting needs, visual blindness issues and such. As I	**D**		16

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		understand it, NEMT staff cannot/will not offer hands on assistance to any of the riders. What happens with the members with dementia who must have direction and would be unable to find their way into the physician office? What about the members with dementia or memory remembering where and when to catch the bus back home? I also have blind members who cannot find their way without a guide assisting them. To expect the mentally and physically disabled to ride a transit bus 'without assistance places them at risk. If cuts are needed in the transportation division, the best place to cut would be the community activities.			
118	10/9/2015	**Scanned Document #141340** 4) On page 52 of the draft, Section 501 19.1, the documentation requirements state that the service plan must include "the date, miles driven, travel time, destination, purpose of travel and type of travel (essential or community activity)". This should be included on the Personal attendant log, not the service plan. On the service plan we do specify the day, location (store and town), and the purpose (groceries/bank/pharmacy etc.). We as case managers do not have the mileage from client home to store and back. We do delineate between where essential errands are and community activities. Nor do we know the rate of speed/travel time of the driver for these activities. Such details should be included on the log sheet for the homemaker for travel pay, not on the service plan.	**D**		69
119	10/9/2015	**Scanned Document #141340** 5) Page 54-55, Section 501.25 pertains to home health	**D**		Once you become aware, the Service

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		agencies. "The need for home health services must be documented in the person's Service Plan. Documentation of the referral from the person's attending physician must be maintained in the person's records of both the ADW provider agency and the home health agency". I have found many times that I am not notified by client, homemaker agency or home health agency of planned home health services. These are found out incidentally on monthly monitoring phone calls or many times after the fact at 6 month or annual home visits. I do not see how this can be done with any consistency. I am sure that the home health agencies are not aware of the presence of ADW services in the home of these clients unless the homemaker is there during their visit, and then most likely assumes it is a family or friend visiting. I know as for Central WV Aging, we are proud of the job that we do and strive every day to be the best possible agency and member advocate. We are not unwilling to follow policy when we fully understand it. I feel there are areas of this draft that need reconsidered not only for the benefit of the agencies compliance, but more importantly, for the health and welfare of our clients on ADW. I would appreciate your reconsideration of the draft of the policies.			Plan should be updated to ensure no duplication of services. Also see response to 23.6
120	10/12/2015	**Scanned Document #141244** One client has told me that she has difficulty climbing the steps to board the MTM bus, she said her bus driver cannot and will not help her, she has been carrying a step stool with her to assist with getting up the steps then has	**D**		16

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		to set down and scoot off the steps in order to get off. She states that she feels as if she is a bother because it takes her so long. I asked this client to write a letter, she said she would Friday and mail it to our office. I have one client who is not only deaf but also VERY physically impaired, she has frequent falls in her home and requires stand by assistance even when she is using her walker. Can you imagine this elderly, frail, impaired woman attempting to use MTM?!?! There is no way. She would be terrified! I am almost certain she would fall and be injured if she could even attempt to navigate the hallways of her doctors offices or a hospital for testing. What about the clients like who are receiving Chemo and Radiation treatments, they may be able to board MTM transportation when they leave the house but after treatment they will be sick, worn out, possibly require multiple stops, assistance to, in, and from a bathroom .. .is the van driver going to do that? Our clients with dementia, the ones who have a difficult time remembering who they are, and where they are in their own homes. Can you imagine if that were your loved one being dropped off at UHC or WVUH where they are left to guess at what they are supposed to do next. Let's say they are able to navigate to the correct physician office center, or lab, how are they going to remember what they need to talk with the physician about? How are they going to remember what the			

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		prescriber said, take that knowledge home and put it into effect? I just can't fathom the thinking behind allowing all of this! Then we have the bed bound/ wheelchair bound clients how exactly are they to get to their medical appointments. It would seem the only solution for someone like this would be to go to a nursing home. I agree with the mileage cap, however, I STRONGLY disagree with the way they intend this mileage to be used. Medical transportation should be an essential component of this program.			
121	10/13/2015	**Scanned Document #141706** 1) 501.17.2~ Essential Errands"" Travel must be conducted in the persons immediate Community unless a need is otherwise identified? Many of our members live in extreme rural areas which can limit these members from traveling to their "Immediate" community area. So what is considered to be "Immediate" and would a need be living 60, 70 or more miles away from the "Immediate" area?	**D**		116
122	10/13/2015	**Scanned Document #141706** 2) Continued 501.17.2- Medical appts not considered an Essential Need? Our members w/out informal support, greatly rely on our Personal Attendants to transport them to scheduled Physician appts. Some members have complex diagnosis that require them to see Physician on a scheduled basis. The use of MTM on a day that possibly a Personal Attendant, is not available to	**D**		16

Comments for Chapter 501 Aged and Disabled Waiver

Effective Date December 1, 2015

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		accompany a member to an appt, is just not feasible. Again, many of these members are physically nor mentally able to ride or attend these appointments by themselves. Unable to understand what the Physician is telling them, unable to wheel themselves in a wheelchair and so forth. My question is, how is this benefiting the majority of the ADW population?			
123	10/13/2015	Scanned Document #141814 1) After reviewing the ADW draft manual, I have concerns regarding the change in transportation. Many of my client's rely on the caregiver to take them to their much needed medical appointments. Several of my clients do not have informal or family support that they can count on to get them to their appointments. Most of these clients are not physically able to get in and out of a vehicle unassisted and into a building safely. It is my understanding that the MTM driver's cannot assist these clients. Does this not pose a safety issue to our clients? I have attempted to utilize MTM for a client most recently, unfortunately, the client was never contacted by MTM even though our agency spoke to them that morning and therefore missed his appointment with his specialist whom he sees for his multiple sclerosis.	**D**		16
124	10/13/2015	**Scanned Document #141814** 2) When asking my clients what is most important to them going to medical appointments or going on a community activity; with no hesitation the answer is medical appointments are most important. MTM states they need 5 business days to schedule transport. This makes it difficult for clients who may have gone to the	**D**		16

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		emergency room and need to do a follow up or become ill and cannot afford to wait more than 5 business days to seek medical attention. Please take into consideration these concerns.			
125	10/9/15	**Scanned Document #141907** **I am a Licensed Social Worker and Case Manager for the Medicaid Waiver Program. I have worked as a Case Manager for 23 years for the Medicaid Waiver Program and I have several concerns regarding our members due to the proposed changes on the 2016 ADW Manual out on comment:** 1) I feel the most important impact is the loss of transportation to Medical Appointments: Section 501.19. I feel this will be detrimental for our embers. Not all members are able to ride the MTM bus. Many members are not physically or mentally able to ride a bus and many have families that work full-time jobs and are unable to take their loved ones to appointments. Many members are in wheelchairs, need one person assist with walking, or have dementia and not able to get on a bus. Many members need to hands on assist of their homemaker at the Dr. Appointment either to assist them in and out, assist them to bathroom, assist if they should have an accident while at the Dr. Office. I feel Medical Appointments are more important than the hours or mileage for Community Activities. I would much rather see member attend Dr. Appointments than go to a community event. I have concerns that MTM will not be	**D**		16

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		able to meet all member needs for appointments. I had a case where we called MTM to assist with transport for dialysis 3 x week and member had to be picked up at 5:30 am and was told by MTM they could not transport that early. I have heard that member are also being dropped off at appointments and not picked up for 2 hours after an appointment. We service elderly and disabled population and they are not able to wait this length of time to be picked up.			
126	10/9/15	**Scanned Document #141907** 2) Section 501.3.3 address that court appointed legal guardians can no longer be member homemaker. I have two cases that this would impact. Both these members are severely Mentally Challenged and total care needs. Both members are serviced by their sisters who are the primary caregivers and the legal guardians. Both these members are cared for with their best interests at heart and receive excellent care. These caregivers are not able to work outside the home as these members require 24 hour care. Even if we were to put another homemaker in the home they would still not be able to work as if no aide available they would still have to provide the care. Why should these caregivers not be allowed to be the homemaker and be paid for the care they give for their loved ones just because they are the legal guardians? Why the change as they have been the ones providing care all this time on this program and now they can't? I don't understand the purpose for this change.	**D**		1
127	10/9/15	Scanned Document #141907 3) Section 501.25 addresses Home Health and	**D**		23.6

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		duplication of services. I do understand this and we work with Home Health and Hospice not to duplicate our homemaker services. This can be very trying as Horne Health and Hospice cannot always give time frames for their health aides. I feel it will be an issue to obtain a referral for Home Health in the records. If we as the CM are the ones to call the Dr. and request the referral for Home Health or Hospice obtaining this order will not be an issue. However, sometimes Home Health or Hospice is ordered by the physician and we are not aware until at HV or monthly calls are made and the services have already been implemented.			
128	10/9/15	**Scanned Document #141907** 4) Section 501.17.2 addresses the primary function of the homemaker is personal care and the majority of the hours should be spent on personal care. It also states at no time should more hours be spend on the other incidental services more than hands on personal care. We have several members who request their spouses or other family provide their personal care due to modesty issues. Are we now saying these members will not have the right to make this decision? If a member want a family member to provide their personal care instead of a homemaker, they can no longer be on the program? Is this not a violation of member rights?	**D**		80
129	10/9/15	**Scanned Document #141907** 5) Section 501.13 Addresses if change in need the PAL will be changed for the permanent changes. Once the PAL is changed and sent to CM the CM has to call the member or make a face to face to see if changes are	**NC**		The RN may make minor changes to the PAL such as change in hours, days of the week or activity.

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		agreeable. Are you saying the HMA RN can make the changes and send to the CM without member approval for the change and the CM has to get the member approval for the change? Should the RN not make sure the changes are agreeable with the member before they make the changes on the PAL and send it to the CM?			Example: Member's daughter's work schedule changes and must now work weekends. The RN may change the days of service from Monday –Friday to Wednesday –Sunday (to cover the weekend since the daughter is now working the weekend). The RN must document on the back of the PAL that the change was approved by the ADW participant or legal representative, date it was approved by them and initial it. The RN must not make a change without their approval. The RN must mark whether the approval was on the phone or on a visit.

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					Once the change in the PAL is completed, the RN sends a copy of the PAL to the CM. The CM initials and dates the top of the PAL and attaches it to the Service Plan. It becomes the Service Plan and there is no need for an addendum any longer.
130	10/9/15	**Scanned Document #141907** 6) Section 501.9.3.1 addresses CMA is responsible to send the Notice of Approval continued medical eligibility to the HMA. Why are we going back to this when we have Care Connections and the HMA can get the approval from their own Care Connections?	**D**		64
131	10/9/15	**Scanned Document #141907** 7) Section 501.4,2 addresses CM in monitoring the Service Plan may review or request specific day to day documentation to make sure date, actual time of services and number of units are claimed. Is this saying we have to review and approve HMA timesheets? Is this only if we feel there is a problem or should we be monitoring all timesheets? Are we to assume HMA wi11 not have an issue with providing these timesheets? Will there be a	**NC**		The Case Manager's responsibility is to ensure services are provided to the ADW participant. That does not mean that the CM approves the PAL daily documentation worksheets. It does

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		timeframe they have to get these-to us? If there is a problem who do we take these issue to? Thank you for your consideration.			mean that the CM is to address service related issues reported to the CM by the recipient. The CM now has the authority to request documentation as a part of a follow up to a recipient complaint about service delivery.
132	10/13/15	**Scanned Document #141546** **After reviewing the Aged & Disabled Waiver draft provider manual, I have several concerns:** 1) On page 5 under "Background", the draft states that "Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered." However, throughout the draft there are multiple uses of the language "but not limited to". This seems to be contradictory language.	NC		Sections of the manual that contain the language "but not limited to" are either policies set by agencies or lists that are not exhaustive, such as skilled nursing services. Agencies can have policies more stringent than the ADW requirements. Any time there is a question about an allowable service, it is best to check with

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					BMS first.
133	10/13/15	**Scanned Document #141546** 2) On page 6 under "Program Description", the draft states "A person on the ADW must receive Personal Attendant Services on a monthly basis, unless temporarily in a nursing home, hospital, or other inpatient medical facility." Does this mean receiving case management services What about those that went more than a month without services but not by choice? We frequently see individuals that are difficult to staff who might fall under this situation. Also I have clients that are in poor health, but their family does not live in the area. Once a year, they travel out of state to visit with their family. Due to their health, they tend to stay longer as the trip is not easy for them. One of them generally travels in the fall/winter and has gotten snowed in previously. Will there be exceptions to this rule? Will a hearing be required?	NC		All of this would be taken into consideration before closing a case. A hearing would only be required if there was a closure and hearing rights would be included in the letter.
134	10/13/15	**Scanned Document #141546** 3) On page 26 under 501.4.1, the draft indicates "Any incidents involving a person receiving ADW services must be entered into the West Virginia Incident Management System (WV IMS) within one business day of learning of the incident." This is an improvement from the current 24 hour timeline. However, as we frequently don't learn of incidents until weeks after the fact, there are often more urgent matters when we do learn of it than the incident which has already been resolved. It would be nice to see a little more leniency in this area.	NC		This is a health and safety issue and we must have a complete record of all incidents.
135	10/13/15	**Scanned Document #141546**	NC		Forms are not part of

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		4) On page 28 under 501.5 "Specific Requirements", the draft states agencies may only use forms developed and published by BMS. Were the forms that will accompany this manual made available for public review? If concerns are found in the documentation when they are put to use, will they be updated repeatedly? With the previous manual we saw continuous changes and new forms. While I appreciate the desire to improve things and insure everyone's needs are met, the continuous (sometimes minute) changing of forms results in additional time spent on paperwork thereby reducing the time we have to assist the member.			policy and therefore require no 'public review". There was a group of providers selected to pilot the forms and they were developed by a committee of the Quality Improvement Council.
136	10/13/15	**Scanned Document #141546** 5) On page 30. The last paragraph of 501.8 notes "Termination of the Medicaid benefit itself (e.g., the Medicaid card} always requires a 13 day advance notice prior to the first of the month Medicaid stops." I understand this is not a change in policy, but this is an ongoing issue. Who receives .the notification? It has been my understanding that the case manager should, but I generally find out a member is no longer financially eligible when I check monthly and by that point it is generally too late. What would happen if that is the case and DHHR cannot backdate the approval? In my experience, the agency simply loses the money it spent on services.			A notice of discontinued financial eligibility is generated from the local DHHR offices. The person on the ADW program gets that notice. If there is a notice of discontinuation of medical eligibility, that notice comes from the UMC and the CM agency is notified.
137	10/13/15	**Scanned Document #141546** 6) Page 32 under 501.9.1.2, "If a person reports formal Personal Attendant services to assist with ADLs are not	**D**		24

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		needed, a request for closure must be submitted." I would imagine that the personal attendant should be providing at least some of the ADLs- However, is it still acceptable for the informal to provide assistance with personal care for those members that are more private?			
138	10/13/15	**Scanned Document #141546** 7) On page 32 under 501.9.2, " ... complete and sign a Medical Necessity Evaluation Request (MNER) form including ICD diagnosis code(s}". What if the physician only writes diagnoses and will not provide the codes? Will the MNER be rejected?			Yes, they will be rejected. ICD-10 codes are now required. Physicians should be very familiar with this.
139	10/13/15	**Scanned Document #141546** 8) Page 34 under 501.9.3, "A MNER form must be submitted to the UMC after being signed and dated by the person (or legal representative} and referent ... "What if the physician chooses not to complete the form? Is the individual's only option to either change physicians or lose their services? In more rural areas there are a limited number of physicians and not everyone can travel to go to a doctor.			This is a requirement of the program. Without a signed MNER, the person cannot be re-evaluated and could lose their slot. Their physician should be made aware of the outcome if the MNER is not completed.
140	10/13/15	**Scanned Document #141546** 9) On page 35 the last sentence under 501.9.3.1 A, "The Case Management Agency is responsible for sending the Notice of Approved Continued Medical Eligibility to the Personal Attendant Agency." Why? The Personal Attendant Agency has access to Care Connection, so why would the Case Manager need to forward the	**D**		64

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		documentation?			
141	10/13/15	**Scanned Document #141546** 10) Page 41 under 501.13 about halfway down the page, "It is the Case Manager's responsibility to send a copy of the Service Plan to the person and/or their legal representative (if applicable) within seven business days from the meeting." The timeframe to forward paperwork (for the CM) has been significantly decreased although the RN and member must be present when the plan has been developed. In addition to the stricter time frame there are also new training requirements (page 22), but there has been no reduction in caseload for the CM (page 44). The Case Managers have already seen an increase in paperwork since the introduction of the web portal. Also, I did not notice a timeframe for when the RN has to forward their paperwork.	**NC**		No specific issues to respond to.
142	10/13/15	**Scanned Document #141546** 11) Under the same section as #10, "When the person receiving ADW services has a change in needs, the Personal Attendant Log can be changed and attached to the current Service Plan to document any permanent Plan changes ... " I'm assuming the Service Plan Addendum no longer exists, is that accurate? If so, where would changes that are not related to the PAL be noted (e.g. changes in physician or informals)? Also, if a person has a major change that requires a new assessment to be completed, would a new Service Plan then have to be completed as well?	**NC**		Correct. The Service Plan Addendum no longer exists. The CM may make changes on the Service Plan sections below, by adding a line, dating and initialing the addition to the Service Plan for a Service Plan Update. Example of a service added below

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					with the CM's initials and date it was added below (highlighted in yellow is the addition and signature/date are in red). If a person had a major change, the CM could do a new assessment and new Service Plan. A training based on just the forms will be conducted in January.
143	10/13/15	**Scanned Document #141546** 12) On page 43 under 501.14, "ADW services not provided as scheduled on the Service Plan cannot be made up on a different day .. ln the Personal Options, services not provided as planned, may not be carried over into a new month." My first concern is whether "ADW services" is intended to mean the hours of service or the actual services provided. It is understood that a Personal Attendant cannot make up hours they miss. However, if by missing that day they also miss doing the members laundry, I'm assuming this can be moved to another day with documentation indicating why it was necessary, is that accurate? The other concern is the discrepancy between the traditional model and personal options. If one cannot make up services, why is the other permitted to do so?	NC		ADW services is referring to hours, not the actual service. For more information, please see Response 55.2

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144	10/13/15	**Scanned Document #141546** 13) Page 4S Under "K", "At a minimum, upload the following documents into the UMC web portal: Enrollment Request, MNER, Service Plans, Person-Centered Assessment, legal representative information, WV Personal Care Dual Services Request form (if applicable) and any other pertinent information." Should this to be taken to mean all legal representative information should be uploaded or just as it is received/if someone transfers? It would be quite time consuming to go back through all our files and upload everyone's documentation. Also, can Care Connection handle the documentation that we've been instructed to upload? In the past, I have attempted to upload a PDF version of a members Service Plan only to find it would not upload. After repeated attempts and no explanation or error message, I finally noticed that it was because the file was larger than Care Connection accepts. Will this be addressed? Finally the language "and any other pertinent information" seems rather subjective and lack of clarity tends to lead to issues.	NC		On rare occasions when a document is converted to PDF, it will make the document larger than 4 MB. Even when that happens, the document can be broken into separate pieces which are smaller than 4 MB. This allows for sizeable documents to be uploaded. The system generate an error message when the file won't upload, at the top of the page.
145	10/13/15	**Scanned Document #141546** 14) At the top of page 47, will there be training on the ADW Wellness Scale for the Personal Attendants? What weight will be given to the information provided? Those reporting are not medical professionals and their ability to report accurately may vary.	NC		There is no planned training for Personal Attendants on the Wellness Scale. For more information see Response 55.4
146	10/13/15	**Scanned Document #141546** 15) Page 47 in regard to Essential Errands and Community Activities: For those who live in a rural area	NC		If Essential Errands and/or community activities take place

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		and don't have access to a local grocery store or restaurants, many of them accessed those services when they went to doctor's appointments. Will those activities/errands still be accessible to them although they are not in the immediate area and the member will no longer be able to combine the travel since they will have to utilize NEMT for doctors' appointments?			on the same trip as the medical appointment, you must be very careful not to duplicate the mileage. They would have to be recorded separately and accurately. Providers may make policy around this issue to not allow both to occur on the same day to avoid duplicate billing if they choose.
147	10/13/15	**Scanned Document #141546** 16) On page 53 under 501.22 Payments and Payment Limitations, "Personal Attendant services may be provided on the day of admission and day of discharge." Won't Medicaid flag that billing as fraudulent since the hospital/nursing home would have billed as well?	**NC**		No, because it is now permitted in policy.
148	10/13/15	**Scanned Document #141546** 17) At the bottom of page 54 and top of page S5 under Dual Provision of ADW and Home Health Agency Services: "Home health agency services provided to the person on the ADW must be coordinated by the ADW Case Management Agency". Is that only if home health is providing assistance 'with bathing? The Case Manager frequently doesn't know home health is going to be	**D**		See 23.6

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		provided until after the fact and they do not have only control over the home health agency. How would the Case Manager "coordinate services" when home health RNs rarely stick to a schedule and instead generally call a client when they're in the area to see if they can stop by? Also, "Documentation of the referral from the person's attending physician must be maintained in the records of both the ADW provider agency and the home health agency." Why is the Case Management agency being held responsible for a referral made by a physician, frequently without the CMA being notified? What if the documentation is requested from the physician, but it is not provided?			
149	10/13/15	**Scanned Document #141546** 18) The last sentence on page 58, 501.32 B, "... the CM Agency must provide the receiving agency, at a minimum of three business days prior to the effective date of the transfer, a copy of the current Service Plan, Person-Centered Assessment, a copy of the Enrollment Confirmation and any other pertinent documentation. This will be done by ensuring the documents are uploaded in the UMC's web portal.' Currently it is not possible to access a member in the web portal until the day of their transfer. Does this mean that it will become possible to access their information in Care Connection 3 days prior to the transfer? If so, does that mean the current provide will lose the ability to access their information in Care Connection 3 days prior to the transfer?	**NC**		No, it is not possible to access the information prior to the transfer. The intent is to make sure the receiving agency has the needed information in a timely manner.
150	10/13/15	**Scanned Document #141546**	**D**		16

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		19) Medical transportation no longer appears to be a covered service. I understand that NEMT is available (at times). However, what if that does not meet the member's needs? I also understand the OA does not regulate MTM, but is there a guarantee that members who need someone to travel with them will be permitted such? If the other caregiver available is their Personal Attendant, can they travel with the client (via MTM) while they are working? If not, who will assist those that cannot ambulate, those with dementia, anyone who needs assistance toileting, etc.? As the draft indicates "Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered", it is concerning that this issue is not addressed. Thank you for taking the time to review my concerns and I look forward to your response.			
151	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 1) P 6. Program Description A person on the ADW must receive Personal Attendant Services on a monthly basis, unless temporarily in a nursing home, hospital, or other inpatient medical facility. Comment: If a person does not utilize their PA services monthly, will there be a problem? Some person may take a vacation or be hospitalized.	**NC**		The policy list's hospitalization as an acceptable reason for not receiving Personal Attendant services. Vacations are not an acceptable reason for not receiving Personal Care services for longer than 30 days. See Response 23.2
152	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final	**C**	This statement will be removed from the	

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		2) P 9, TMH WV Ensuring there is no duplication of planned Goods and Services purchases via the TMH program and the Participant Directed Goods and Services service via the Personal Options program, pre-transition and ongoing. Comment: ADW no longer has PDGS as an option, thus this statement is no longer relevant. Should be removed.		Take Me Home WV Section of the manual: Ensuring there is no duplication of planned Goods and Services purchases via the TMH program and the Participant Directed Goods and Services service via the Personal Options program, pre-transition and ongoing.	
153	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 3) Pg. 9 UMC provides a framework and a process for authorizing ADW services. Comment: Is this a necessary statement? The budgets are determined by the level of service needed. This statement may be more appropriate for TBI and IDD.	**NC**		Yes, BMS believes that this is a necessary statement. The UMC does provides a framework and process for authorizing the monthly ADW budgets.
154	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final	**C**	The policy was changed to: BMS	

Comments for Chapter 501 Aged and Disabled Waiver

Effective Date December 1, 2015

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		4) 501.1 BMS contracts with a Fiscal/ Employer Agent (F/EA) to administer the *Personal Options* Financial Management Services (FMS) program. Comment: Might want to state PO as a self-directed program not a FMS program.		contracts with a Fiscal/ Employer Agent (F/EA) to administer *Personal Options, the self-directed* program.	
155	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 5) Pg. 10 Any Case Manager working for a Case Management Agency that has self-referred a person receiving ADW services or influenced an ADW person's "Right to choose" (transfer) must not bill Case Management for the month this activity is conducted and will be referred to their professional licensing board for a violation of ethics Comment: Does Policy mean a) Any case manager within that agency will be at fault and subject to review if one CM is found to be self-referring? b) The specific CM who has self-referred within an agency c) Or is the agency at risk?			The individual Case Manager will be reviewed. If more than one Case Manager at a particular agency is found to be violating this policy, the entire agency could be at risk.
156	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 6) 501.1 Conflict of interest and self-referral are prohibited.			Training on Conflict Free Case Management may be provided by the OA and will be available

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		Comment: How will training be initiated and monitored?			on the Learning Management System. Or a provider may choose to develop their own training. It must include all the components of the OA training and be approved by the OA. It is a required training and will be reported annually in the OA's Continuing Certification system.
157	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 7) P10, 501.2 All direct access personnel will be prescreened for negative findings by way of an internet search of registries and licensure databases through the Department's designated website, WV Clearance for Access: Registry & Employment Screening (WV CARES). Comment: Does this include RCs? Will this include program representatives?	**NC**		This does not include Resource Coordinators or Program Representatives.
158	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 8) Pg. 10 501.2	**NC**		More detailed information will be provided at the WV Cares Training.

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		Negative findings that would disqualify an applicant in the WV CARES Rule: 1. State or federal health and social services program-related crimes; 2. Patient abuse or neglect; 3. Health care fraud; 4. Felony drug crimes; 5. Crimes against care-dependent or vulnerable individuals; 6. Felony crimes against the person; and 7. Felony crimes against property. Comment: These are very general. Is there a more descriptive list that also has infractions with time frames (i.e.10 years for drug infraction, etc.). If these are so broad and life long, many direct care staff may be excluded and cause issues for provider agencies.	C	Please note – Section 501.2.1.1 has been updated to include: 8. Sexual Offenses 9.Crimes against chastity, morality and decency: and 10.Crimes against public justice.	
159	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 9) 501.2.1.1, P12 If the review of the criminal history record information reveals a conviction of a disqualifying offense, the applicant will receive a fitness determination of “not eligible” and may not be employed, unless a variance has been requested or granted.	NC		This will be covered at the WV Cares training.

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		Comment: What will be considered a variance? Is this like a negotiated risk agreement? Can an employee who failed the prescreening but is applying for a variance, provide services? Will the state allow employees to work upon initiation of their background check?			
160	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 10) 501.2.1.1, P12 The hiring entity will receive written notice of the employment fitness determination. Although fitness determination is provided, no criminal history record information will be disseminated to the applicant or hiring entity. Comment: Will WVCARES make the final decision regarding employment fitness determination? Will agencies and F/EA receive the letter confirmation or will the participant, since they are the employer of record?	**NC**		This will be covered at the WV Cares training.
161	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 11) 501.2.1.3, P 13 The hiring entity will receive notification of any potential negative findings. The hiring entity is required to research each finding to determine whether or not the potential match is a negative finding for the employee. Comment: How will research be conducted? Will	**NC**		This will be covered at the WV Cares training.

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		agencies and the F/EA be responsible to research each finding?			
162	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 12) 501.2.1.3, P13 OSHA Comment: Is the ADW requiring OSHA training or Infectious Disease Control training as required in the TBI program?	C	501.3.4 (C) has been changed to: Universal Precautions training.	
163	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 13) 501.2.1.7, P14 CPR, First Aid, OSHA, Abuse/Neglect/Exploitation Identification, and HIPAA training must be kept current Comment: Could "kept current" have a more complete definition? Perhaps, if attendant is actively providing services, the training must be current in order to be paid.	NC		It is the expectation that any active employee keep all training current.
164	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 14) 501.3.4, P23 In addition, four hours of training focusing on enhancing direct care service delivery knowledge and skills must be provided annually. Specific on-the-job-training can be counted toward this	NC		On the job training can include either person specific or general training. Person-Specific Example: Training in the use of a lift. The

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		requirement. Comment: Person-specific or general allowed?			training could be specific to the participant and his/her lift. How to place the lift in the room (particularly if it is small), how to transfer the participant, and how to safely use the person's specific lift. The benefit of doing training in the home setting is that the RN see the worker demonstrate the new skills while being safely monitored. General Training: The training could be regarding lifts in general, safety while using all lifts and how to maneuver a lift in the correct manner. While it will make a difference if the person has a different setting or

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					type of lift, there is a great deal of general skills training that can be transferred from setting to setting.
165	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 15) Pg 23 Individuals providing Non-Medical Transportation Services must have a valid driver's license, proof of current vehicle insurance and registration. …..and checked annually thereafter. Comment: In PO should the participant maintain this or should the "Proof" be provided to the F/EA?	**NC**		The employer of record must verify the information is current and accurate, The F/EA should maintain the documents for monitoring purposes.
166	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 16) 501.3.5 For *Personal Options*, the Resource Consultant must report any incidents in the WV IMS within one business day of learning of the incident as well as notify the Case Manager. If the Case Manager becomes aware of an incident before the Resource Consultant, the agency must report it to the *Personal Options* Program Manager at the OA. The OA reviews each incident, investigates, and enters outcomes of the investigation within 14 calendar	**C**	501.4.1 will be changed to: For *Personal Options*, the Resource Consultant must report any incidents in the WV IMS within one business day of learning of the	

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		days of learning of the incident. Comment: When the CM becomes aware of an incident, shouldn't the PO F/EA be notified along with the PO Program Manager?		incident as well as notify the Case Manager, if applicable. If a Case Manager becomes aware of an incident before the Resource Consultant, the agency must enter it in the WV IMS and also report it to the *Personal Options* Program Manager at the OA and the Resource Consultant.	
167	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 17) 501.3.5, P24 Financial Eligibility. The applicant may choose a Case Management Agency upon application to the ADW program. The Case Management Agency will be notified by the UMC when chosen Comment: If the person is interested in ADW and would choose PO, would the OA PO Program	**NC**		At the application stage, the applicant receives the yellow DHS-2 form. The Case Manager, if chosen, will assist in the process. The OA PO Program Manager is not involved at this point. The UMC will

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		Manager be responsible for initiating DHS 2 forms for the potential participant? Could there be ADW education, using the ADW Program Brochure, that is initially sent to interested persons with a selection form? This process was mentioned in the application on pg. 50. "At the point of referral (receipt of the MNER by the UMC), the applicant is provided with an ADW Program Brochure that details services available to eligible individuals. The Brochure includes information about their right to choose between home and community based services and institutional services. A Consent Form is used to document the applicant's choice between home and community based services and institutional services. The ADW Program Brochure also informs the applicant of their right to choose between a Traditional Model and Personal Options Model of services. A Service Delivery Model Selection Form is used to document the applicant's choice between Traditional Model services and Personal Options services. Freedom of Choice of Provider forms is also included at this time. If the applicant chooses, they can select an ADW Case Management agency to assist them in establishing financial eligibility.			be providing all the information outlined in the comment at the medical evaluation visit. If the person if not financially eligible, the information would be irrelevant.
168	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 18) Pg. 25 If the applicant has been placed on the Managed	**NC**		There is no notified to the F/EA at this time. The selection will be entered into CareConnection©.

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		Enrollment List (MEL), when a slot becomes available, the applicant and the Case Management Agency (if already chosen) will be notified by the UMC. Comment: If the person has chosen PO and there is no CM, how will the F/EA be notified?			The F/EA will be notified when the person is ready to enroll in the program.
169	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 19) 501.3.9 Approval If the applicant is determined medically eligible and a slot is available…. The notice will be sent by mail to the applicant. The Case Management Agency will also be notified, as will the TMH office, as applicable Comment: If the participant has chosen PO and not to have a CM, will the F/EA receive notice or will the notice go to the OA?	**NC**		The notification goes to the OA.
170	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 20) 501.4.1, P27 Re-Evaluation A MNER form must be submitted to the UMC after being signed and dated by the person (or legal representative) and referent (physician, Nurse Practitioner, Physician Asst.) …..The Case Manager must check the reevaluation line at the top of the form. A referent's signature is required annually and	**D**		6

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		must include the ICD diagnosis code(s) Comment: Do all re-evaluations requests (MNER) need to be signed by medical personnel? If there are no changes, can the request be initiated by the person? If all go through medical personnel the process will be much slower. For a PO participant, will the RC assist with this process if there is no CM?			For PO participants, the process remains the same as far as making sure the MNER is submitted.
171	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 21) Pg. 29 If the UMC makes the contact, a letter is sent to the person (or legal representative) and notification is sent to the Case Management Agency noting the date and time of the assessment. Comment: For a PO participant w/o a CM, will the F/EA be notified of the scheduled assessment?	**NC**		Yes, via CareConnection©.
172	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 22) 501.8, P30 If the person meets the medical eligibility criteria, a Notice of Approved Continued Medical Eligibility is sent to the person (or legal representative). The Case Management Agency, the TMH office, and Personal Options vendor will be notified. Comment: Language implies that CMs are required. Is that intended?	**C**	501.9.3.1 has been changed to: The Case Management Agency, if applicable, the TMH office, and *Personal Options* vendor will be notified.	

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173	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 23) Enrollment: Once an applicant has been determined both financially and medically eligible, the Case Manager, if applicable, must request Program Enrollment from the OA by completing an Enrollment Request Form. The OA will complete the Enrollment and provide a Confirmation Notice to the Case Management Agency and the Personal Attendant Agency. If the person chose Personal Options, the Personal Options Program Manager at the OA will be notified by the Case Management Agency, if applicable. Comment: This implies that the CM is usually involved in the request for enrollment. Will the OA handle this as they do now for persons choosing PO?	**NC**		It says 'if applicable". The OA will continue to enroll people who choose the *Personal Options.*
174	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 24) Pg. 33 The *Personal Options* Fiscal/Employer Agent is responsible for managing the receipt and distribution of individuals' participant-directed budget funds, processing and paying the Personal Attendants' payroll and reimbursements for transportation.	**NC**		

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		Comment: If the person in PO does not choose to have a CM should there be a statement that indicated that the F/EA would be responsible for CM duties such as assisting with eligibility, Assessment, Service Plan development, etc.?			It is the assumption that the person self-directing or their program representative would be responsible for this with the help of the Resource Coordinator. However, there may be other duties that will fall solely to the Resource Coordinator. BMS feels that it is clear throughout other sections of the manual that the F/EA will assist those who choose to self-direct in every facet of the program.
175	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 25) 501.9.2.1 For those choosing Personal Options, they may choose to use part of their budget to purchase an RN assessment, but it is not required. If they do not choose to have a nursing assessment, the	**NC**		If the question is, should an RC complete a Nursing

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		Resource Consultant will complete the Personal Options Assessments in conjunction with the Case Manager, if applicable, at the initial visit. Comment: Is it assumed that the RC will complete it in place of the "Personal Options Assessment?"			Assessment, the answer is no. If you are asking if the RC should complete the "Personal Options Assessment", the answer is they should assist the person in completing the document as needed.
176	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 26) 501.9.3 The Person-Centered Assessment (Section 1 and 2) must be completed at least every 6 months from the date of the initial Assessment and annually thereafter Comment: The statement indicates the need to complete the assessment every 6 months and annually. Does that mean it should be completed once or twice a year?	**NC**		The Assessment is to be completed twice per year and more often if there have been major changes.
177	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 27) 501.9.3 For those choosing Personal Options, if they do not have a Case Manager, the Resource Consultant is responsible for all duties related to the Service Plan. Comment: Would this assume the responsibilities	**D**		174

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		are for the "PO assessment" and the service plan?			
178	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 28) 501.9.3.1 Case management responsibilities also include the development of the Service Plan, the completion of the assessment, the ongoing monitoring of the provision of services included in the Service Plan, quality of services provided, monitoring continued eligibility, health, safety welfare, and advocacy. Comment: Could there be a statement included that "if a person chooses PO, the Resource Consultant will assume these CM responsibilities"?	**D**		174
179	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 29) 501.10 At a minimum, a monthly telephone contact and a home visit every six months must be conducted to ensure services are being provided and to identify any potential issues. Comment: Since these are case management responsibilities, are we to assume if in PO the RC would be responsible for the monthly call and the 6 month visit. Should this be stated in the F/EA section?	**D**		174
180	10/14/15	Title of Document: ADW Review 10- Title of Document: ADW Review PPL 10-15-14 Policy Manual Final	**D**		174

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		30) Pg. 36 Under CM responsibilities it states: "Specific activities to assure that needs are being met also include: A. Assure financial eligibility remains current. B. Submit the MNER in accordance with policy. Comment: Would this be a good place to state that the RC assumes these responsibilities if the person is in the PO program?			
181	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 31) 501.11.2, ADW services not provided as scheduled on the Service Plan cannot be made up on a different day. (Traditional Model) Any changes in scheduled services must be approved in advance by the RN in the traditional model. In the *Personal Options*, services not provided as planned, may not be carried over into a new month. Comment: Will PO participants be able to use budget authority in a given month and use their hours as they need them?	**NC**		Yes… PO participants will be able to use budget authority in a given month to use their hours as needed.
182	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 32) P37 All personal care needs as outlined on the Service Plan must take place before essential errands or	**NC**		No, that would not limit someone taking a bath at the end of the day. The point is to ensure the person's personal care needs

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		community activities can occur Comment: Does this statement limit someone from requesting a bath at the end of the day or before bed? Would this affect employer authority?			are not neglected.
183	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 33) If at any time a Personal Attendant is witnessed to be, or suspected of, performing any prohibited tasks, the RN or *Personal Options* vendor must be notified immediately Comment: Is this specific to paid time? How does this address a family member who may administer medication, etc. off the clock? Realistically, many participants may have a PA, especially a family member who does these activities as informal support.	**NC**		Any Personal Attendant, regardless of relationship to the recipient, must NOT perform prohibited tasks while providing Personal Attendant services. Personal Attendant Services specific to the participant are outlined on the Service Plan and PAL and the worker is to comply with the plan (within ADW policy guidelines as well).
184	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 34) Dual ADW and PC services Comment: Would the RC be expected to facilitate the Dual Service request and participate in the DS meeting as is practiced now if the person is in PO?	**NC**		Yes

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185	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 35) At a minimum, Case Management agencies must communicate in writing including accessible format as requested to each person (and/or their legal representative) receiving ADW services initially, upon admission to the agency (transfer) and annually the following Comment: May want to include PO and RC in this initial section.	**D** **D**		174 174
186	10/14/15	Title of Document: ADW Review PPL 10-15-14 Policy Manual Final 36) P38 Discontinuation of services Comment: Very nice and thorough description. Are we to assume that the F/EA RC will be responsible for duties when there is a discontinuation?	**D**		174
187	10/12/15	**Scanned Document #141934** I am writing in regards to the proposed changes for the Medicaid Waiver Manual. There are several changes that are in consideration that I oppose but I will only address what I consider the most important at this time. 1) Section 501.19: This will cause the most hardship on our clients. Many of our members live alone, no family close by or family members work or family members are aged and not well themselves. Our members count our homemakers to get them safely to their doctor's	**D**		16

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		appointments, assist them while they are there with toileting, hygiene and clothes removal. Our HM's accompany them in to the exam room and listen to what the doctor advises the member to do and reports back to me for documentation. If the doctor makes a referral the HM's assist in getting this done. This is much more than driving them to an appointment and dropping off and picking up later. Most of our HM's will report to the doctor any changes they have noticed with the member. Our members would not be on this program if they are able to perform their ADLs independently. Who will be responsible if they get injured riding on a transport bus and dropped off at a large facility like the Physician Office Center at Ruby Memorial Hospital and UHC. Our members get confused of which facility they are supposed to go, what then? It would be nice if before this decision is put in policy that someone would come out and meet our clients and ask themselves if this was their family or loved one would they still be making these changes.			
188	10/12/15	**Scanned Document #141934** 2) Section 501.3.3: I have a couple clients that this would affect due to circumstances beyond their control. They have had to be made guardian of a family member and has had to quit their job to be able to provide 24x7 total care to a family member. They may get compensated with a small salary being the caretaker/homemaker but this in no way is enough for what they do or give up. Again I would love to take someone out to the homes to meet these people that this affects.	**D**		1

Comments for Chapter 501 Aged and Disabled Waiver

Effective Date December 1, 2015

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
189	10/12/15	**Scanned Document #141934** 3) I have worked for the ADW program for the past 13 years and I have noticed with each policy change that it seems to be more about the paper work than the client. We want to keep our aged and disabled at home in the least restrictive setting but it appears that each policy change takes away more of their independence of making their own decision which is one of their rights. I have always taught my HM's to show respect to their clients by giving them some independence in their selection of how and when they want their care to be performed. Our clients have already lost so much with their mobility, etc. Thank you for your consideration into not making the new manual effective until listening and reading the letters our clients took time to write.			No specific comment .
190	9/22/15	**Scanned Document #140937** I have attached my comments to the areas that I feel will create the most havoc for our staff and members. 1) Of particular concern is the fact that the state appears to have eliminated any medical transportation of the member for medical appointments see page 51 501.19.	**D**		16
191	9/22/15	**Scanned Document #140937** 2)Secondly, 501.22 page 53 allows for PA (MH) services to be billed on the day of discharge from a facility but I do not see the option of the RN or CM billing to conduct a visit and to reassess member status to assure member needs have not changed.	**D**		14
192	9/22/15	**Scanned Document #140937** 3) Thirdly, page 23 Section at top, restricts court appointed guardians from being caregivers for the	**D**		1

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
		members.			
193	9/22/15	**Scanned Document #140937** 4) Page 6 middle of page, now states that PA services are mandatory-please refer to the CMS memo that contradicts this requirement-CMS stated as long as recipient received 1program benefit…Case Management is a given with traditional services. Thus 1 program benefit is satisfied.	**D**		23.3
194	9/22/15	**Scanned Document #140937** 5) Page 13 states provider agency will not receive the findings of the Fingerprint Background check…just if passed or failed…Our hiring criteria may be stricter than the State's (especially ion DUI's, shoplifting etc) now we will not have access to the criminal record details on applicant's. Again, who pays for the fingerprinting now?	**NC**		59 There will be more information at the WV CARES training.
195	9/22/15	**Scanned Document #140937** 6) Additionally, on page 13 it speaks of "direct on site supervision by hiring entity until an eligible fitness determination is made-in home supervised homemaker? What agency has staff to be able to accommodate this ridiculous mandate? The providers are already having difficulty obtaining homemakers, layering this ridiculous unrealistic impossible expectation on top of staffing demands will further impede ability to staff cases.	**D**		72
196	9/22/15	**Scanned Document #140937** 7) Now the MNER/medical forms can be signed by any listed entity not just an MD/DO now…Section 501.9.2 page 32 and later on at re-evaluation area. Page 5: The new forms need to be posted for public comment also. Providers need to be to review and comment on new	**D**		135

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		forms and proposed procedures for usage.			
197	9/22/15	**Scanned Document #140937** 8) Page 6: 4th paragraph is it now mandatory again that the member has to have a HM every month? Does not state that MM must utilize any specific number of hours. How does this comply with CMS requirements that only one service must be accepted by the member per month?	**D**		23.3
198	9/22/15	**Scanned Document #140937** 9) Page 10: 501.2 strong solicitation language. Who judges if the CM solicited a case? Are there parameters set forth to determine this?	**NC**		The OA will conduct an investigation and will render a decision based upon the information presented to them during the investigation.
199	9/22/15	**Scanned Document #140937** 10) Page 12: A new website that will be accessible to every provider agency. Prescreened now by entity that charges a fee? Prior to employment consideration...is there a provider fee to access? Who pays for the background fingerprint check if it becomes common property for every provider?	**D**		There will information on this at the WV CARES training.
200	9/22/15	**Scanned Document #140937** 11) Page 13: Is this state entering into a **joint employer role** with this manual section? Last sentence…"Provisional employees who have requested a variance do not have to sign a statement…what does that mean?? If positive findings are present…person is already working…yet positive results…fitness statement?? Where is that form? Employers need to see what is being proposed…People can tell you	**NC**		

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		anything…why is there any leeway here for non-signature? It appears the variance is signed after positive findings are rec'd…confusing policy here…			
201	9/22/15	**Scanned Document #140937** 12) What is the meaning of **"direct on-site supervision"** by the hiring entity??? An agency representative must be at the member home while the PA is working**??? Who pays for the supervisor?? Under what code?** This is ludicrous unrealistic expectation…..	**D**		72
202	9/22/15	**Scanned Document #140937** 13) The employer should have access to the findings of the background check. If the employer is paying for the background check then employer may have standards that are stricter than the state guidelines related to employment of repeat offenders…i.e. shoplifting, DUI charges with breathalyzer on vehicle…yet these people are allowed to be hired by the State Guideline..We do not routinely hire shoplifters or repeat DUI offenders. We hold our caregivers to a stricter employment guideline than the state.	**D**		59
203	9/22/15	**Scanned Document #140937** 14) Page 21: Self Audits…a new mandate with submitting self-audit forms to OPI? Based on what frequency? What percentage of files are to be reviewed? On what frequency? Where are the standards/policy for this new mandate/.	**NC**		This is not a change in policy. Self-audits have always gone to the Office of Program Integrity. Self-audits are only conducted when requested or if the provider finds an error that needs results in a

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					disallowance.
204	9/22/15	**Scanned Document #140937** 15) Page 23 at top: Court appointed legal guardians?? Does this mean a durable POA (, Medical Power of Attorney (If Incapacitated)) Cannot Be the Caregiver Now? This will impact 100's of current members…	**D**		1
205	9/22/15	**Scanned Document #140937** 16) Page 26 501.4.1 Policy that the RN or CM enter the data info into the IMS in ref to CM or designated RN immediately reviewing the info entered? If CM, RN or director is entering info into the IMS, then they are seeing the incident info in real time…confusing statement? What does designated RN mean?? Is the state fixing the IMS to allow one agency person to review all entries for the day??? How else will immediate review of incident entry be completed by the agency?? At bottom of page 26/top of 27…All IR must be reviewed and signed by the director…this previously said "director or designee" mandate of only director here conflicts with policy at first paragraph of this section on page 26.	**NC**		The policy requires the agency to submit the incident within one business day. Then, print the incident, place in an agency administrative file with director's signature and date indicating a review of the incident. Policy allows for a registered nurse, license social worker or counselor to conduct the follow up of the incident. It is up to the agency to designate a qualified professional that meets this criteria to

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					conduct the incident follow up and investigation. This process is not new.
206	9/22/15	**Scanned Document #140937** 17) Page 29 First Bullet: Does this infer that the CM is responsible for monitoring PA agency HM services??? If this is being revived into the CM duties then $71.10 month is an inadequate fee.. How will the CM obtain the info? Travel or faxing documents will result in increased costs to the CM agency?? How will this be reviewed when the state audits? What if CM does not do this PA agency POC day to day review?	**NC**		This is not a new policy. That is one of the purposes on the monthly contact by the Case Manager and should be documented in the Case Management file.
207	9/22/15	**Scanned Document #140937** 18) Page 32: "If a person reports formal Personal Attendant services to assist with ADLs are not needed, a request for closure must be submitted." Does this imply that if personal care needs are met by spouse or informal instead of PA that the MM is not entitled to the MW program? This is discriminatory and flys in direct conflict with person centered planning! I should be able to say who assists with my bathing and grooming and not be mandated by the state to have the PA do it. Nursing homes provide the latitude for others to assist with hygiene needs…How can waiver "legally" eliminate the person's choice of care provider?	**NC**		Informal supports are not excluded from providing bathing. For more information, see 105
208	9/22/15	**Scanned Document #140937**	**NC**		BMS does not advise

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		19) Page 34: Is the state gong to provide a list of common ICD codes to providers or are providers going to have to purchase the current ICD coding book?			providers on what diagnosis codes to bill. There are several conversion tools available on the internet. These may be used these to convert the ICD-9 codes previously used to ICD-10 codes. Here's a list of the conversion tools that were shared with providers at the fall workshop: Code Conversion Tools: http://www.icd10data.com/ http://www.icd10codesearch.com/ https://www.aapc.com/icd-10/codes/ http://www.lussierlab.org/Web-Tools/index.html

Comments for Chapter 501 Aged and Disabled Waiver

Effective Date December 1, 2015

Comment Number	Date Comment Received	Comment	Status Result C = Change NC = No Change D = Duplicate	Action for Change Status	Reasoning for No Change Status and FAQs
209	9/22/15	**Scanned Document #140937** 20) Page 36: The case management agency is responsible for sending the Notice of Approved Continued Medical Eligibility to the Personal Attendant Agency. 501.9.3.1 The notifications are in care connection now, why does this manual not indicate the use of care connection as the portal for forms generation/access? RN and CM both pull their own form off of care con now. It is now policy that CM no longer has to provide the HMA with forms.	**D**		64
210	9/22/15	**Scanned Document #140937** 21) Page 41 3rd paragraph at bottom: The Service Plan mist include a risk plan, services(s) plan (service, amount, frequency, and duration) and resource plan with referral source. What does "and a resource plan with the referral source" mean? Referral source as in friend, neighbor, hospital, DR, other agency??? What if the person does not desire that entity to be involved in ongoing services? What if it was a out of state rehab facility or someone who has passed away??	**NC**		The new Service Plan has separated each area of the plan to simplify it. Here is where the CM documents below resources needed by the recipient. Example: Resources Needed: A Food Bank Referral Source: Helping Hands Food Pantry This is for a formal resource that the recipient needs.
211	9/22/15	**Scanned Document #140937** 22) Page 43 501.14 3rd paragraph: ADW services not provided as scheduled on the Service Plan cannot be made up on a different day. This change restricts the	**D**		78

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		person from having any latitude with their person centered planning needs…For example, if there is a death in the family, informals are present and the person opts to have no service for Mo/Tu/We (normal POC/SP hours) but now needs help pm SA/SU due to laundry, care needs assistance and shopping needs. This change now prohibits the person from choosing to use informals during grieving and then use waiver hours on a Sa/Su that were not original POC/Sp schedule??? This "flexibility" has always been a waiver option to allow the persons needs to be met as life changes occur. In effect, again, there is not a person centered planning option available the person, many components of this new manual show a complete lack of disregard to the lives of people and how needs change from day to day. The practice of Case Management helps to avoid duplication and provision of unnecessary services, and to ensure a balance of services. The Case Manager takes an active role in service delivery; although services are not provided directly by the Case Management Agency, the Case Manager serves as an advocate and coordinator of care for the person receiving ADW…How can case management do their job if the policy in this manual restricts any member choice of self-care determination???			
212	9/22/15	**Scanned Document #140937** 23) Page 45-Inem K is mandatory now to upload the service plan and assessment into care con??? Page 45 Item W- New accountability parameter for CM. Lack of member services this concern requires documentation in	**NC**		It is the Case Manager's responsibility to monitor the delivery of services. That is

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		the incident management system by CM if service delivery concerns. Lack of services documentation was not required previously…Where is the mandate for the homemaker agency to report to the care manager that the member is not receiving staffing??? How is the CM to learn of this problem? Many members do not call CM. HMAG do not notify CM if days without services…CM cannot control another provider agency.			one of the reasons for the monthly call.
213	9/22/15	**Scanned Document #140937** 24) Page 47 Personal attendant services can be provided on the day of admissions and day or discharge from a nursing home, hospital, or other inpatient medical facility. Does this also include the billing permission authorization for the case manager and RN to do home visits and reassess the member status?	**D**		79
214	9/22/15	**Scanned Document #140937** 25) Page 48: Person's wellness response on the ADW Wellness Scale (located on the log) Wellness scale usage…How will one obtain this info from a confused person? Arbitrary data, and in direct conflict with item K on this page with PA not to make any medical judgements…10 point system too confusion for people. A question of; Good, Fair, or Poor much easier question option with absolute direction then for PA to call RN supervisor if a poor response if received/.	**D**		7
215	9/22/15	**Scanned Document #140937** 26) Page 49: 501.18.2 One unit Nursing Services per month can be utilized for review of the Personal Attendant Log(s) to assure services were provided as planned, signed and dated by the Personal Attendant and	**D**		5

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		the person receiving the services, certifying the reported information is complete and accurate. State has continually increased demands on the RN supervisor with review of the PA logs due to compliance with federal false claims Act and state guidelines. Yet, state now has decreased billing reimbursement to 1 unit month!!! The fact is that nursing home eligible people have increased needs, have split shifts, 7 day week PA services and required multiple PA's to assure that their care needs are met. Some people may have 4-5 PA logs every 15/16 days. Expecting an RN to review and sign off on 4-8 logs per member in one month and only be reimbursed for 1 unit is a great injustice. RN's are an expensive, critically justified mandate for this medically based program. Only 1 unit = 15 minutes per month is an inadequate amount of time for RN to review the PA log. The verification of duties as completed by PA, checking PA/person initials, the signatures, travel time, area of travel, mileage consistency and ordered tasks as initialed by the PA are all tedious time demands. If there are multiple PA's in home==then each PA log has to be verified. The RN is saddled with verifying that services are compliant with federal false claims act—Time available to be billed should not be restricted to a mere 15 minutes for this important mandatory legal duty.			
216	9/22/15	**Scanned Document #140937** 27) **Pages 6 & 47 no medical transportation by Medicaid waiver program.** While community activities are a nice option, the more critical need for a waiver, nursing home eligible person is medical transportation.	**D**		16

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		The person needs to be able to have easy immediate access to critical transportation to medical appts. Not to have to be sitting on a van for hours while people are picked up and dropped off at multiple locations. The person with oxygen, congestive heart failure and in a wheelchair may be further medically comprised with hours of sitting. What about the diabetic who has to eat regularly and do insulin checks sitting for hours on a van? The incontinent person sitting in a wet pull-up for hours as there is no body to assist with hygiene care? People are left sitting in wheelchair in front of apartment complex to be assisted by some good Samaritan to get into their apartment. The person who lives in Pocahontas County and has to ride the van to Morgantown –3.5 hours each way then have treatment and ride back? Who assists with food, toileting and med needs/. There was an event with person discharged Sunday PM, had Dr. apt on Monday PM for new prescriptions and MD orders…no family, no taxi, no bus, MTM inaccessible as 5 business day notice needed and area too rural for other transportation access…this lady did not get to the Dr. as no HM available per HM agency staffing the case. Issues with the fact that a MTM is not assisting with toileting needs, MTM does not take the person into the hospital—the blind man in a wheelchair with no family, was dropped off at UHC, by MTM, sit in wheelchair until someone from hospital realized he obviously needed assistance to push his WC throughout the hospital (he was blind) to Dr. office, lab, etc.. MTM cancelled an apt from a remote area in Upsjur to Morgantown pain clinic			

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		due to no other appts in area for that day—(Name) lost out on getting pain pump inserted as no other transportation option. Dialysis people who are weakened from treatment will be at a higher risk for injury/falls due to weakened states post dialysis, now the PA can assist with meal prep, transfer into how then bed, chair, etc. Who helps if only MTM is doing transportation? How can this be a person centered program if the very basic need of medical transportation is being ignored and prohibited for someone wo has no informal support system? It appears that his program, a nursing home alternative, now prohibits any medical transportation for people who are frail, elderly and have a myriad of medical needs and diagnoses. The option of MTM is not a user friendly resource for every person. The person centered approach of this program is being completely ignored related to the critical medical transportation need of our members. How can any medically based program justify transportation for member to travel to purchase alcohol, cigarettes, or to go to a gambling facility as permitted community activities but then prohibit medical transportation?			
217	9/22/15	**Scanned Document #140937** 28) Page 52 Activities that are incidental to the delivery of Personal Attendant Services are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is. This sentence here means what? Very confusing	NC		It means, if there is anyone else including the participant, that can perform the incidental services such as cleaning, transportation, that

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		wording. Does this infer that all PC assistance with ADLs, IADLs, travel or all of these areas have to be met by other entities listed before PA can assist? Yet on page 32: "If a person reports formal Personal Attendant services to assists with ADLs are not needed, a request for closure must be submitted." Of this very same manual it states that if the PA is not doing these services/meeting these very same needs then the case must be closed??? What policy are we to follow? Contradictory information.			should be accessed first before using Medicaid dollars. There is an assumption that anyone on the ADW program needs Personal Attendant services to assist with ADLs or they wouldn't need to be on the program.
218	9/22/15	**Scanned Document #140937** 29) Page 53: 501.22 2nd paragraph: What about RN home visit to reassess the member status prior to or on the day of discharge? The RN has to first reassess the member to assure that the needs can be met safely by the PA. Especially after a lengthy stay or if significant change in status.	**D**		14 and 17
219	9/22/15	**Scanned Document #140937** 30) Has the state followed the joint rule making review policy for this policy manual? Where was proposed policy posted previously?	**D**		85.2
220	10/13/15	**Scanned Document #141735** To Whom It May Concern, I am a Provisional License Social Worker/Case Manager at Central WV Aging Services,Inc. in Sutton, WV. I am writing in regards to the some of the changes I have read in the Draft Aged and Disabled Waiver Manual. I know the state believes it is saving money by requiring	**D**		16

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		people to utilize the services of the MTM Transportation Program. However, I believe it will create great hardship for many people who are receiving services through the Age and Disabled Waiver. The majority of my clients do not have a support groups; if they do have family, the family members live too far away to help or they work and cannot take time off without the risk of losing their jobs. Our homemakers are the only assistance that many of my clients have. It will be detrimental to the clients, mentally and physically. I am will provide you with just a few examples. **Example One:** (Summarized for the log) Client's transportation had been scheduled through the MTM Transportation Program. totally blind, a severe diabetic and cannot be left alone. The driver picked him UP. took him to doctors office and left. My client was not able to get to the room when the nurse called his name. The driver was One and a half hours late picking up from the office, due to being on other runs. When the driver brought home, he sat him in a chair at the front door, sat the wheel chair in the yard and left. **Example two**: (Summarized for the log)Client that has to attend dialysis three times a week. legally blind, has a right leg prosthesis, severe arthritis, limited use of right arm due to a malfunctioned A/V Graft, incontinence, severe diabetic and becomes disoriented when sugar levels are too low, severe anxiety and depression. Due to physical and mental health issues, unable to drive, ambulate, transfer and dress without assistance, has to have assistance with personal hygiene when goes to the restroom, sugar levels have to be checked often. needs			

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		assistance with all ADL/IADL's. gets sick after dialysis treatment and has to have the assistance of homemaker at appointments. Due to severe anxiety, does not trust new people easily, does nor handle change well and worries about things a lot. MTM does not provide an assistant to help. What would client do during the appointments? The worry about the proposed changes is already causing added stress and anxiety attacks. How is this good for the client? **Example three:** (Summarized for Log) Client has no family; never had children and spouse has passed away. has a difficult time hearing and cannot ambulate without supervision and use of ambulation devices. unable to drive and does not own a car. is a diabetic and has occasional spells of confusion when sugar levels drop. has severe anxiety and panic attacks and trust just very few people. Her homemaker acts as ears at appointments. What will happen if does not have an assistant? **Example four.** (Summarized for Log) Client has been diagnosed with dementia, has periods of confusion, incontinence, is a fall risk due to physical health issues and has to have homemaker with to provide assistance and guidance. cannot go to the doctor by self, because does not understand what doctors are saying. informal support family members work and cannot take off work to take to appointments and cannot ride the senior van because lives too far out, they refuse to pick up and again gets confused and they do not provide an assistant. **Example five:** (Summarized for Log) client is a quadriplegic who has been paralyzed for eighteen years as a result of a spinal cord injury. Spouse works a full			

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		time job to pay the bills and buy food. Therefore, is not always able to take to appointments. They rely on the assistance of the homemaker. MTM Transportation, will nor provide assistance needed to transport client. **Example six**; (Summarized for Log) client has no family members other than father) who lives too far away and due to bad health and age, is unable to provide assistance to the client. Client had a stroke which left with extensive disabilities. Has spells of confusion and frequent dizzy spells which increase fall risk. Has to use a wheelchair most of the time) attempts to use a walker when has assistance. is a diabetic has to monitor levels closely. The stoke has caused vision problems that cannot be corrected. Hs no one except homemaker to assist him. **Example seven:** (Summarized for Log) client has no family and friends are not able to provide transportation because of their own disabilities. does not have a good support system. has a bad back and knees, is a diabetic. has problems with depression, anxiety and has periods of confusion due to memory loss. has to use a wheel chair, cane when able and a walker.cannot go periods of time without supervision and assistance. **Example eight**: (Summarized for Log) client is a paraplegic and wheelchair bound. The only family members has work full time and are unable to take leave from work to transport to the doctor. is not able to ride the Senior Citizens Van because they won't provide an assistant and lives too far out. requires assistance with all ADL/IADL's; is a one person assist all the time. cannot be taken and left alone. These are just eight out of my			

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		seventy-one clients. All my clients are on the Aged and Disabled Waiver Program because they meet medical and financial eligibility. Many have Alzheimer's, dementia, anxiety, depression, paralyzed, stokes, diabetics, physical disabilities that cause complications with ambulation and transferring, blindness and many other health issues. They cannot be left alone due to physical and mental needs. They depend on the homemaker services to assist them. They trust the homemaker because they know they will be there. The Braxton County and Gilmer County Senior Citizens Vans cannot provide transportation to all clients. They cannot transport every client to their doctors appointment because they have schedules they follow. They do not allow assistants to ride the vans with clients. Therefore, clients that are totally blind, legally blind, are wheel chair bound, has dementia, incontinent, has to use assistive devices and one person assist, cannot ride the van. MTM Transportation Program does not provide an assistant to stay with and help the client What are they supposed to do about getting around? What about going to the bathroom or if they have problems with being incontinent? What if their sugar levels drop low or go to high? What if they fall during ambulation or fall out of their wheel chair? What happens when they get lost or something bad happens to them? Who would be legally responsible for them? My clients are scared and upset. The proposed changes are causing increased depression, anxiety and panic attacks with my clients. I am concerned about the safety and well-being of my clients. They cannot be left alone and require assistance with			

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		ADL/IADL's, even when being transported to and from doctor appointments and while at doctor s appointments. MTM Transportation does not provide the assistance needed. It will cause hardship to the clients, mentally and physically.			
221	10/13/15	**Scanned Document #142836** Below are my comments about the manual. Someone else covered some of the things I had questions about, so I did not add them to mine. 1) Page 10 - 501.2 Why are the RN's services referred to as Skilled Nursing when they are not permitted to perform skilled nursing services? This could be confusing with other agencies duties, such as home health or hospice.	**NC**		RNs may provide skilled nursing services as outlined in the manual.
222	10/13/15	**Scanned Document #142836** 2) Page 45 - J. Will it now be the Case Manager's duty to submit requests for Dual Services? W. "Follows up on all service delivery concerns within two business days and documents in the WV IMS." This needs clarification.	**NC**		J. Yes W. Any time a Case Manager is aware of any gaps in services or concern with services delivered, they must follow up and document their finding in the WV IMS.
223	10/13/15	**Scanned Document #142836** 3) Page 46 - 501.17.2 PA Responsibilities-Incidental services may not exceed the amount of time used for hands-on personal care assistance. In other words, you have to use the same amount of time or less for IADLs that you do for ADLs. How can this time be estimated or	**D**		13

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		documented? Also, this could drastically cut hours that the member can receive per day.			
224	10/13/15	**Scanned Document #142836** 4) The PA is to complete a Wellness Scale on the PA Log. However, the policy states on page 48 the PAs may not make judgments or give medical advice. A Wellness Scale is a judgment, especially for those members who have a diagnosis of dementia or related illness.	**D**		7
225	10/13/15	**Scanned Document #142836** 5) Page 49 - 501.18.2 Only one unit can be billed for the RN checking Personal Attendant Logs. This is not enough time if you bill more than once a month or have more than one Log per pay period, for example, a member has a split shift with two Logs.	**D**		5
226	10/13/15	**Scanned Document #142836** 6) Page S2 - Mileage. 300 miles per month-Prior authorization required. Is this done annually in the billing system?	**NC**		The 300 monthly cap does not have to be prior authorized. Edits have been placed with Molina that will not allow more than 300 miles per month, per person without prior authorization.
227	10/13/15	**Scanned Document #142836** 7) The limit of 300 miles per month is not reasonable. For member's who live in remote areas and have doctor appointments in Morgantown or Charleston for example, one trip can use all of the mileage allowed. There should be an allowance for more mileage to be used in these	**D**		No waiver mileage may be billed for medical transportation. That must be done through the NEMT program

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		instances.			and there is no limit on mileage.
228	10/13/15	**Scanned Document #142836** 8) Using MTM for transport is not feasible for all members. Some members are not mentally able to go to an appointment by themselves. They wouldn't know where to go or what to do if just dropped off. Others have incontinent episodes and would not have the opportunity to get cleaned up if they had to ride on the van for hours, even if the PA is allowed to go with them.	**D**		16
229	10/13/15	**Scanned Document #142836** 9) Client stated that would not be able to use MTM transport due to episodes of incontinence. Even if someone were with him, would not be able to get cleaned up or change his clothes. has a diagnosis of CP and seizure disorder, which would prohibit from being safely transported on a van.	**D**		16
230	10/13/15	**Scanned Document #142836** 10) Client stated that went through a very trying time to get transportation set up. Because of weight, only goes to doctor appointments and cannot ride on the MTM vans. Has no family that can take so PA must take Stated that if must rely on MTM transportation, would again be housebound.	**D**		16
231	10/13/15	**Scanned Document #142836** 11) Client has been very vocal about transportation issues and has called BoSS about concerns. Goes to the VA Hospital in Clarksburg for shots in his eyes, which are vital to vision. Under the new policy, MTM cannot transport to these appointments. It is approximately 103	**D**		16

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		miles one way from Ravenswood to Clarksburg to the VA Hospital. One trip would use most of the 300 miles allotted under the new policy. Has no family who can transport so how would client get to appointments? This scenario is true for other VA members as well.			
234	10/13/15	**Scanned Document #142836** 12) If there is going to be a limit on the mileage per month, do we still need to limit trips to one per week for errands and community activities? If that is so, then why not tell the member they can have one day per week for these things and let them pick the day they want to go each week without specifying it on the POC? The PA can document the day on the POC and this could be easily checked by the RN. That way the member has control over what days they go out and would allow them to go out on the day they feel the best. let the policy makers ask themselves if they go to the store or pharmacy the same day every week and would want to make a six-month plan for doing their errands.	**D**		69
235	10/13/15	**Scanned Document #142836** 13) Page 54 - 501.25 Home health services must be coordinated by the CM and "documentation of the referral from the person's attending physician must be maintained in the person's records of both the ADW provider agency and the home health agency". This needs clarification. In general, CMs do not request home health services for members and often do not know this service has begun. How are we expected to know this need? This is something that is assessed by the HM RN or the member's physician. Are CMs expected to get a copy of	**D**		See 23.6

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		the referral from the person's physician, and are they willing to share this with us? Also, we are not responsible for home health agencies' records, so why is this included in our manual?			
236	10/13/15	**Scanned Document #142836** #14) This assessment and Service Plan procedure is certainly NOT person-centered. When I explain "person centered" to my clients as a reason for choosing specific days, etc., the comment always is that making them choose specific days for specific tasks is basically putting them "in a box". Some members get very upset. Most very reluctantly choose a day, with the assurance that the days can vary as long as there is documentation in the comment section to justify the change. Their suggestion is if they are allowed a certain number of hours per day, let the PA do what is needed on that day and initial on the POC that they've done it.	**NC**		Delivery of services may not be left to the discretion of the Personal Attendant. See Response 69.
237	10/13/15	**Scanned Document #142836** #15) I understand that I must follow the guidelines for the ADW Program. I do not have a problem with following rules. However, this policy manual is not within the guidelines of my ethical responsibilities as a social worker. It is my job to ensure the members have access to the services they need with less and less resources. There is no one who is more person-centered than a social worker who works to make sure people have their rights. To mandate what a person must do on certain days is not person-centered. It forces them to make decisions and plans that they do not wish to make. It is impossible for a person to decide which day to take	**D**		Simply document the reason for any change in the planned services.

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		their bath when they do not know how they are going to feel when they wake up the next day, let alone in a few weeks. They also have no way of knowing when they are going to have an incontinence episode and therefore will be need an extra bath or laundry done. If that happens on an off day, there would have to be a comment made for an extra bath, possibly an extra bed change and laundry. That leaves more for the RN to look for with less time to check the Plan of Care, and more for the State monitor to assess.			
238	10/13/15	**Scanned Document #142836** #16) Whatever policy is set, care must be given to ensure that ALL BoSS employees and monitors are trained in the same manner!! It is impossible to implement a policy properly and survive a monitor when BoSS representatives and each of the monitors give different answers about procedures. There must be consistency between those who run and monitor this program. When this does not happen, agencies are asked to pay back funds for doing the things they were told to do. This very unfair because when all is said and done, the members have received the care they needed. They certainly do not care whether or not a Plan of Care says PRN.	**NC**		Special care is taken at BoSS to be in constant contact with BMS to ensure that BoSS is following through on BMS's mandates. Before final letters and reports are sent to providers, BoSS meets with BMS and OPI to discuss and review those reports. BoSS conducts inter-rater reliability training with their nurse monitors. BoSS also does mock reviews with all nurse monitors and Nursing

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					Director to ensure that all score consistently the same. If there is inconsistency, then it is discussed and BMS consulted.
239	10/13/15	**Scanned Document #141629** 1) Eliminating medical transportation through the program will drastically effect the members of this programs and leave them at risk for falls, inability to toilet, and present them (those with dementia/memory problems) from understanding doctor's orders and what is done at office visits. Members of the A&D waiver are on the program because they require assistance with walking, transferring, toileting, meeting basic needs, prepared meals, sitting up food, doing shopping, and going to medical appointments. Many get confused and need reminders to take medicine/go to appointments a tasks. Many members of the program do not have support systems-family, friends or neighbors- to help with meetings needs or going where they need to go.	**D**		16
240	10/13/15	**Scanned Document #141629** 2) People who are on dialysis will have major difficulty getting treatments.	**D**		16
241	10/13/15	**Scanned Document #141629** 3) The suggestion that case be closed if they do not receive any services in a month conflicts with the 180	**D**		Likewise, people on the Managed Enrollment List are

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		day rule and is unreasonable. There are various reasons someone may not have services. With the program having a wait list they should not be closed so easily and then have to wait months to get back in.			waiting for services, while others have access and don't use it.
242	10/13/15	**Scanned Document #141629** 4) Pg. 32 says if someone states they do not need assistance with ADLs then they should be closed so waiver writers of policy need to realize that people who are new to program are after at first uneasy about a stranger helping them to bathe. Once they have a homemaker they are comfortable with they may allow this to be done. Some members prefer a relative/spouse help with bathing and other personal care tasks. We need to remember that the state approved people for the program based on their conditions and functional needs not the agency staff.	**D**		24
243	10/13/15	**Scanned Document #141629** 5) Policy mentions throughout the Person-centered approach but nothing in it is Person-Centered. Instead it is punitive and does not reflect the needs of the population being served.	**NC**		BMS feels that the approved CMS application and the manual do reflect the Person-Centered approach.
244	10/13/15	**Scanned Document #141629** 6) Case management agency cannot coordinate home health services. Doctor's order this directly from HH agencies, there is no need for this anyways. Only service that can be a duplication is bathing assistance and HH agencies stop this (because they have a shortage of	**D**		235

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		staff) as soon as PC or waiver services are started.			
245	10/2015	TAKE ME HOME, WEST VIRGINIA (TMH) OVERVIEW – Section on TMH Personal Options Need to remove "Participant Directed" from 3rd bullet.	C	**TAKE ME HOME, WEST VIRGINIA (TMH) OVERVIEW – Section on TMH Personal Options** 3rd bullet now reads: Scheduling of an enrollment meeting within 14 days from referral to address the development of the Initial Aged and Disabled Waiver Service Plan and Spending Plan	
246	10/2015	501.1 Bureau for Medical Services (BMS) Contractual Relationships Need to update second sentence in opening paragraph to clarify it is for both Traditional and Personal Options.	C	**501.1 Bureau for Medical Services (BMS) Contractual Relationships** Second sentence in opening paragraph now reads: The OA acts as an agent of BMS and	

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				administers the operation of the ADW Program, both Traditional and Personal Options.	
247	10/2015	501.2.3.3 Initial/Continuing Certification of Provider Agencies Sentence in first paragraph needs to be removed that reads: Once this process has been completed, the BMS fiscal agent will assign a provider number.	C	**501.2.3.3 Initial/Continuing Certification of Provider Agencies** The following sentence in first paragraph was removed: Once this process has been completed, the BMS fiscal agent will assign a provider number.	
248	10/2015	501.2.3.3 Initial/Continuing Certification of Provider Agencies The following sentence that reads as follows needs to be moved from the second paragraph and added to the end of the first paragraph: Medicaid services cannot be provided from an office location that has not been certified by the OA.	C	**501.2.3.3 Initial/Continuing Certification of Provider Agencies** The following sentence was moved from the second paragraph to the end	

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				of the first paragraph: Medicaid services cannot be provided from an office location that has not been certified by the OA.	
249	10/2015	501.2.3.4 Provider Reviews Section: Agency Continuing Certification Reviews Third bullet need to add 'of the date of report'.	C	**501.2.3.4 Provider Reviews** Third bullet now reads: Terminate the provider's participation as an ADW provider if all issues are not resolved within 60 calendar days of the date of the report.	
250	10/2015	501.3.2 Case Management Initial and Annual Training Requirements * statement updated for clarity.	C	**501.3.2 Case Management Initial and Annual Training Requirements** Updated * statement	

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				to read: * Providers may use training modules provided by the OA for these mandatory trainings or develop their own with the same components that must be approved by the OA.	
251	10/2015	Section 501.3.4 Personal Attendant Initial Training Requirements * statement updated for clarity.	C	**Section 501.3.4 Personal Attendant Initial Training Requirements** Updated * statement to read: * Providers may use training modules provided by the OA for these mandatory trainings or develop their own with the same components and that must be approved by the OA.	
252	10/2015	501.3.7 Registered Nurse Training Requirements	C	**501.3.7 Registered Nurse Training**	

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		* statement updated for clarity.		**Requirements** Updated * statement to read: * Providers may use training modules provided by the OA for these mandatory trainings or develop their own with the same components that must be approved by the OA.	
253	10/2015	501.4.1 Reporting Requirements, Incident Management Documentation and Investigation Procedures Last paragraph updated for clarity	C	**501.4.1 Reporting Requirements, Incident Management Documentation and Investigation Procedures** Last paragraph now reads: Due to the seriousness of reporting suspected abuse/neglect/exploitation, any staff,	

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				Traditional or Personal Options, that fails to report or consistently fails to meet the timelines for reporting may put their agency at risk of losing their ADW provider status or contractual relationship.	
254	10/2015	501.9.2.1 Results of Initial Medical Evaluation Need to add sentence for clarity to section A. Approval at the end of the 1st paragraph and the 3rd paragraph: If the applicant chose Personal Options, the OA will be notified	C	**501.9.2.1 Results of Initial Medical Evaluation** Added to the end of the 1st and 3rd paragraph: If the applicant chose *Personal Options*, the OA will be notified.	
255	10/2015	501.19.1 Non-Medical Transportation Services **Personal Options Model Procedure Code:** A0160 U3 needs to be corrected to: A0160 U4 **Prior Authorization:** Yes needs to be corrected to:	C	**501.19.1 Non-Medical Transportation Services** Now reads:	

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		Over 300 units (Provided that criteria has been met and approved by the OA.)		**Personal Options Model Procedure Code:** A0160 U4 **Prior Authorization:** Over 300 units (Provided that criteria has been met and approved by the OA.)	
256	10/2015	501.24 DUAL PROVISION OF ADW AND PERSONAL CARE (PC) SERVICES Letter E - Need to add the statement: For Personal Options, the meeting must include the F/EA and the participant	C	**501.24 DUAL PROVISION OF ADW AND PERSONAL CARE (PC) SERVICES** Added at the end of Letter E: For *Personal Options,* the meeting must include the F/EA and the participant.	
257	10/2015	**501.24** Dual Provision of ADW and Personal Care (PC) Services Letter G - Needs to be updated to read:	C	**501.24 DUAL PROVISION OF ADW AND PERSONAL**	

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		In the Traditional Model, the ADW Case Manager is responsible for the coordination of the two services. For those using *Personal Options*, initiation of Personal Care services is the responsibility of the Resource Coordinator. Coordination of the two services is the responsibility of the Personal Care RN		**CARE (PC) SERVICES** **Letter G.** Now reads: In the Traditional Model, the ADW Case Manager is responsible for the coordination of the two services. For those using *Personal Options*, initiation of Personal Care services is the responsibility of the Resource Coordinator. Coordination of the two services is the responsibility of the Personal Care RN	
258	10/2015	**501.29 RIGHTS AND RESPONSIBILITIES** **Need to add to 1st paragraph:** or Resource Consultants, as applicable,	C	**501.29 Rights And Responsibilities** Opening of 1st paragraph now reads:	

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				At a minimum, Case Management agencies or Resource Consultants, as applicable, must communicate in writing including accessible format as requested to each person (and/or their legal representative) receiving ADW services initially, upon admission to the agency (transfer) and annually the following	
259	10/2015	**Glossary –Budget Authority** **Need to correct term from annual budget to monthly budget**	C	Term now reads: **Budget Authority**: People choosing *Personal Options*, the Self-Directed Model for services, have choice in the types and amounts of services , wage rates	

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				(allowed by BMS) and of their employee's to meet their needs and are within their monthly budget approved by the UMC.	
260	10/2015	**Section 501.34 Discontinuation of Services** Need to add an additional reason for discontinuing services if the person can no longer be maintained safely in the community due to their declining health.	**C**	Bullet F was added to read: The person can no longer be safely maintained in the community.	
261	10/2015	**Section 501.2 Provider Agency Certification** **Need to replace this Paragraph on Conflict of Interest:** Conflicts of interest and self-referral are prohibited. Conflict of interest is when the Case Manager, who represents the person receiving ADW services, has competing interests (the same provider agency), takes action on behalf of the person or influences the person's "Right to choose." This action is a benefit to the Case Manager and the provider agency. Therefore, it is a conflict of interest. Failure to abide by Conflict of Interest policy will result in the loss of provider certification for a period	**C**	Section on **Conflicts of Interest** now reads: Conflicts of interest are prohibited. A conflict of interest is when the Case Manager who represents the person who receives services ("person") has competing interests due to affiliation with a	

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		of one year and all current people being served will be transferred to other Case Management agencies. Any Case Manager working for a Case Management Agency that has self-referred a person receiving ADW services or influenced an ADW person's "Right to choose" (transfer) must not bill Case Management for the month this activity is conducted and will be referred to their professional licensing board for a violation of ethics.		provider agency, combined with some other action. "Affiliated" means has either an employment, contractual or other relationship with a provider agency such that the Case Manager receives financial gain or potential financial gain or job security when the provider agency receives business serving ADW clients. A Case Manager representing the person and being affiliated with a provider agency is not by itself a conflict. However, if a Case Manager affiliated with a provider agency takes action on	

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				behalf of the person they represent to obtain services for the person from the company(s) with which the Case Manager is affiliated, or influences the Freedom of Choice of the person by steering them towards receiving services from the company(s) with which the Case Manager is affiliated, then a conflict of interest occurs. Case Managers must always ensure any affiliation with a provider agency does not influence their actions with regard to seeking services for the person they represent. Failure to	

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				abide by this Conflict of Interest policy will result in the loss of provider ADW certification for the provider involved in the conflict of interest for a period of one year and all current people being served by the suspended provider will be transferred to other Service Coordination agencies. Additionally, any Case Manager who takes improper action described above will be referred to their professional licensing board for a potential violation of ethics and must not bill Case Management for the month this activity	

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				occurred. This is considered influencing an ADW person's "Right to Choose (transfer)." BMS notes that whether any action is taken would be within the sole discretion of the particular licensing board and depend upon its specific ethical rules). Reports of failure to abide by this Conflict of Interest policy will be investigated by the OA and the results of this investigation will be reported to BMS for review and possible action.	
262	10/2015	**Section 501.2 Provider Agency Certification** Need to add Paragraph to address Liability	C	Added paragraph at the end of Section 501.2 that reads: The hourly wage of agency staff	

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				employed by an ADW provider is determined solely by the agency that employs the staff person. Agency providers must at all times comply with all local, state, and federal wage and hour employment laws and regulations, including, but not limited to, the West Virginia Wage and Hour Act, Fair Labor Standards Act (FLSA) and Internal Revenue Service (IRS) laws and regulations. ADW providers are solely responsible for making their own determination as to whether an individual performing work for the agency is an	

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				employee or independent contractor under applicable state and federal laws and regulations. Provider agencies should not interpret this as an opportunity to misclassify workers as independent contractors. Provider agencies are solely responsible for any liability resulting from misclassification of workers. BMS reserves the right to dis-enroll any ADW provider which is found to have misclassified employees by the U.S. Department of Labor, IRS, or any other applicable state or federal	

Comments for Chapter 501 Aged and Disabled Waiver

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				agency. All agency staff hired by an ADW provider must meet the requirements listed in the applicable Agency Staff Qualifications in Section 501.3 and its subparts.	