Comments for Chapter 513 Intellectual and Developmental Disabilities Waiver Services

Effective Date: April 1, 2021

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1	9/18/20	I am an IDDW Coordinator with ACHC in Randolph Co. WV. Our Service Coordinators cover 4 counties: Tucker, Upshur, Barbour and Randolph. Randolph is one of the largest Counties in WV. When we go back to normal after COVID-19 safety issues, our Service Coordinators have extensive travel in order to facilitate IDT meetings and Home Visits. SC's often travel close to an hour one way, just to get to the member's home. Sometimes the SC has to have a 4-wheel drive vehicle to get to the members home, especially in the Winter months. Lowering rates for SC, limiting the dollar amount, is going to of necessity lower their ability to provide quality case management. Agencies will have to increase the caseload of each SC in order for the Agency to maintain viability. I can predict that Agency's will lose some very qualified, experienced professionals due to heavy caseloads. Even now our Agency has trouble finding people who want to work with IDDW once they find out the caseload amounts, they need to deal with. ACHC has provided many IDDW members services or years or decades. Also, keep in mind that many of our families, members, do not have the access to technology, such as computers, email, laptops. The families and members we work with have voiced to us that they feel that "choice" is being taken from them. They do not want; a new Service Coordinator, new BSP, nor to they want to choose self-direction with PPL. I personally agree with them that the right to choose is being taken or at the least restricted. Some of our members live in remote areas and in our area available agencies are limited. As a professional that has worked with the IDD population, I feel that this is the wrong direction. I feel that your	NO CHANGE – Conflict Free Case Management (CFCM) is being implemented due to the Code of Federal Regulations (CFR) (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This requirement cannot be waived and must be implemented. NO CHANGE - The two rates are an average of services billed in natural family homes and those billed in 24/7 Intensively Supported Settings (ISS) and group home settings. Caseload limits were removed to allow agencies to better align caseloads for their particular geographic region. The Bureau for Medical Services (BMS) will monitor the size of caseloads through retro reviews and advise the agency to decrease if it appears the caseloads are too large to handle the workload.

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		decisions are placing, our members, their families, Agencies and professionals under an extreme amount of stress and anxiety. We here at ACHC are committed to providing the best services we can to IDDW members. I hope that these proposals will be reconsidered.	
2	9/18/20	Comments concerning new SC rates changing. As a SC, for Appalachian Community Health Center, we service Waiver members in 4 counties: Randolph, Barbour, Tucker, and Upshur. Geographically, Randolph is the largest county in WV. We do not feel that a drop, in the billing rate for Service Coordinators, will be beneficial to the quality of service, that we are able to provide to our members. Service Coordinators are tasked with travel time, as well as the time spent in our members' homes, providing services, such as the monthly home visits. Such a rate decrease will likely be detrimental to Service Coordination, through an increased of caseloads, as well as a lower quality of service provided to our members. Thank you for your time, as well as allowing public comments on this matter.	CHANGE - BMS determined that the rates were not accurate and a revised application with the corrected rates has been posted to BMS website. The corrected rates are $200 per month for members living in natural family and Specialized Family Care (SFC) settings and $250 per month for members living in ISS and Group Home settings.
3	9/18/20	I would like to begin my comment with the understanding that I have listened, I know that utilization from 2019 was used in the calculation of the reimbursement rates for case management. I also understood that at one point it was presented at $200 per NF member and $250 ISS member and has now been reduced further to $150 per NF member and $200 per ISS member. The following is my concerns:	CHANGE - BMS determined that the rates were not accurate and a revised application with the corrected rates has been posted to BMS website. The corrected rates are $200 per month for members living in natural family and SFC settings and $250 per month for

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		1. The division between NF and ISS does not take into account the services received by that member. The members that attend day habilitation, supported employment, etc from NF settings require as much case management as those in ISS settings. There is a day visit that has to be completed bi-monthly and extra coordination between agencies. There are also the individuals with dual services that require extra coordination in the NF setting. Additionally, the utilization has been cut because budgets have been cut. We have no choice but to keep billing and services at a minimum. We are often almost restricted to 240 units so we can attempt to get other needed services within the budget. 2. The requirements for service coordination in 2019 does not have all the additional responsibilities and interactions between agencies as the CFCM structure is going to require. This position continues to get more and more responsibilities and requirements with stricter and stricter guidelines with no consideration for the case manager. If I am being completely honest, $50 a month per member is not worth dealing with the supported living agencies versus natural families. It is always something. In this position I feel I am consistently training other agency's staff on the requirements and responsibilities and doing so much hand holding just so I can get what I need to complete documents and requirements in the case management position. I created forms this week in an attempt to plead with RNs and BSPs to get just the basic DD5 requirements, so they know what exactly is needed and required. (The agency bucked it, and a week after the annual meeting, I still do not have any of their documentation for the meeting. These things occur all the time but is a perfect example. I am sure I will get their part the day the document is due	members living in ISS and Group Home settings.

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		and struggle to meet my deadlines and get complaints when authorizations are late. And yes, I have addressed it over and over with the agency leadership and in my interagency agreement.) 3. I have worked in this field since the beginning of 2008 in a service coordination/ case management position. I fully believe that the majority of caseloads for case managers are between 12-17 cases. Have you considered polling that information? What are the current caseloads of the SCs working in the field in 2019, 2020? The cap was 30 cases and honestly even at that limitation, the quality of care is questionable. That is more than one home visit a day and not counting day visits. Then you have your meetings, documentation requirements and responsibilities. This position keeps getting more and more stringent documentation requirements. I joke all the time that IDD waiver has more documentation than brain surgery. And don't you dare make a human mistake on a document or you will be doc requested and be required to have an entire meeting to correct a typo!	
4	9/21/20	To Whom it May Concern: I am writing with objections to certain aspects of the proposed IDDW Application. I am the Mother/guardian of a 20-year-old IDDW waiver participant that chooses to live at home in a family setting. My son has been a participant in the IDDW program since 2002. Per the proposed document (2020 IDDW Application), the program goals have been identified as providing person-centered services for people	NO CHANGE - This item has not changed from the previous application and thus is not open for public comment. Each person on the IDDW program can pursue the Exceptions Process if the person’s interdisciplinary team wishes to pursue services for which the cost will exceed the assigned budget amount.

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		with intellectual and/or developmental disabilities based on their needs in the least restricted environment as indicated by the following statements, “The goal of the IDDW program is to provide services through which qualifying individuals may receive person-centered services and supports in the least restrictive manner in the community. All individuals are assessed annually and assigned an individualized budget. All services purchased must be within the individualized assigned budget.” “The objective is to provide needed services to individuals with intellectual and/or developmental disabilities and to increase enrollment capacity in a systematic manner in order to reduce waiting lists for these services.” Given these stated goals, I am concerned about the following language in the application document: “Additional limits in the waiver include the individualized budget methodology and are as follows:(a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which an IDDW member's services are subject;” In particular, how the State of West Virginia intends to ensure that my son’s needs are meet in the least restricted environment in a setting of his choice when his Individualized Budgets is assigned by the UMC based on the limit of “historical expenditure/utilization patterns and, as applicable,	

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		the processes and methodologies that are used to determine the amount of the limit".	NO CHANGE – This section has not changed from the previous application and thus is not open for public comment.
		The reliance on historical expenditure/utilization patterns for determining his budget is problematic for a number of reasons, but most importantly because it does not capture my son's actual needs. Instead, it reflects the incapacity of the current provider delivery systems to provide the services he needs in the setting he has chosen.	
		For example, my son is 100% feeding tube dependent and needs to have nursing services to provide enteral feeding throughout the day. Under previous waiver applications, this was a waiver provided service. Under the current application, this service is only provided for waiver participants over 21. This is an unmet need in my son's current IPP in two ways; 1) an arbitrary age restriction; 2) lack of staff in our area to meet his needs.	NO CHANGE – This section has not changed from the previous application and thus is not open for public comment.
		Regarding the arbitrary age limit for Nursing Services, to meet this need, my son was referred for Nursing Services via Medicaid. Upon approval, we received notification that the existing Nursing providers were unable to staff the shifts required by my son because of nursing shortages. This continues to be an unmet need in my son's current IPP. Next year, when he turns 21, this will again become a waiver eligible service. Because he has not utilized this service in previous years (because a previous waiver application changed the age of eligibility for this service from any waiver participant to only waiver participants over 21) his utilization/expenditure pattern will not show any service delivery of this need.	NO CHANGE – This section has not changed from the previous application and thus is not open for public comment.

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		Consequently, his next year's budget will not reflect his actual need but instead demonstrate how reliance on a utilization/expenditure pattern model for Individual Budget limits is flawed and contradictory to the stated goal of meeting my son's needs in the least restricted environment. In his current budget, expenditures for nursing services are absent, which falsely suggests that he does not need these services. What this utilization/expenditure pattern actually reflects is the provider delivery system's incapacity to meet the needs of my son by establishing an arbitrary age limit for services regardless of need, and that needs are under reported or absence from utilization/expense pattern data because of incapacity of service providers to a Staff member (a nurse in this case) due to insufficient staffing across multiple scales within the state.	NO CHANGE – This section has not changed from the previous application and thus is not open for public comment.
		I argue that the use of utilization/expenditure patterns is methodologically flawed and does not represent the actual needs of IDDW participants, and thus should not be allowed. Instead, a needs-based methodology that is disconnected from costs/usage/expenditure patterns (similar to the Individual Education Planning (IEP) needs identification) is more appropriate for meeting the stated goals of providing needed services in the least restricted environment.	NO CHANGE – This section has not changed from the previous application and thus is not open for public comment.
5	9/24/20	I am the legal guardian/parent of a 19 yr old young man who has been on the waiver since he was 3 years old in Berkeley County. Over the years we have been fortunate to work with excellent SC/Direct Service agencies. Currently, the agency we work with is the best. My comment is regarding the recent requirement of conflict free case management through one agency and direct services through another agency. Though I understand the rationale for this change I feel that my freedom of choice is	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This requirement cannot be waived and must be implemented.

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		being infringed upon when I am required to add another agency to my son's care team in an effort to curtail agencies financial incentives over a person centered approach. However, I am not sure this can be accomplished when all an agency has to do is break apart these services, by opening another CM only agency and then transitioning current their client roster over, loop holing this requirement. Such the case has happened in our area. In addition, I have made my choice of agency very carefully, the other agencies in the area have not met a standard that I am comfortable with. I now must involve another one of these agencies who I feel is not competent into the decision making process of my son's budget, assessments, etc. What I would like is the freedom to choose to keep my CM and direct services with the same agency. Thank you for giving me the opportunity to voice my opinion in this matter.	
6	9/24/20	1.) Could an attached sheet be added identifying what human service degrees are acceptable when hiring Behavior Support Professional and Service Coordination jobs? 2) Could we get some clarification regarding the flat rate payments for Service Coordination? Why is there only a $50.00 increase for payment from natural supports/SFC to ISS/group home settings when a Service Coordinator is primarily more involved with an ISS setting at a rate that would justify a higher payment than just a $50 difference? What happens should there be pay back on a service a Service Coordinator provided during a month per an audit, does the company lose the entire payment	NO CHANGE – This item was not changed with this amendment and the current acceptable Human Services Field Degrees are defined in the current glossary. NO CHANGE - The two rates are an average of services billed in natural family homes and those billed in 24/7 ISS and group home settings.

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		for the month or is it prorated? Why was it determined that there would be a flat rate payment for Service Coordinators when they are required to provide a plethora of services to a client and each client's needs are different. If a Service Coordinator provides more services to a client that is more behaviorally and medically needy requiring more meetings, plan development, etc why couldn't the rate be adjusted to a higher amount for these clients?	
7	9/24/20	I work with providers with the waiver program. I would like to suggest to keep the SC and the residential staff, BSP, and RN be under the same service provider instead of the SC being a different provider. It makes it easier on the service provider that they are in the same agency for meeting and for communications. I have clients where it is already like this and it is always a mess trying to get the paper work from one agency to the other agency. There is always someone that does not come to the meeting that needs to be there from the other agency even though they know or they cannot be reach by phone for the meeting. If they are in the same agency they have always been there or can have a representative there.	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This requirement cannot be waived and must be implemented.
8	9/29/20	Doing all these changes and having the kids switch case provider is a mess the kids don't like change. When you change things up they lock up and refuse to talk or do their activities. We should have the choose if we want to switch or not	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This requirement cannot be waived and must be implemented.
9	9/29/20	We don't want to switch	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42

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			CFR 431.301 (c)(1)(vi). This requirement cannot be waived and must be implemented.
10	10/02/20	I am writing you this letter to speak to the current proposed rates for SC services being only $200 for at home consumers and $250 for consumers who live in a residential setting. This truly is not a livable rate for a qualified college grad. As the office manager for an independent service coordination agency I see our numbers in and out. These rates are not sustainable for businesses to operate with long term. In a Covid world where we are actually billing less units do to no face to face interactions with our consumers currently we still average more then your $200 per consumer average. One SC with a case load of 27 average units for just this month are 23 units per consumer. This is an average cost of $219 dollars per consumer at the current unit rate. We currently aren't able to pay the SC what they deserve based on their education, skill and time put in at the rates as it. And you will essentially be cutting those rates and requiring more SC time then what the current Covid world calls for. The governor has also stated that WV has a 90 million dollar surplus and I purpose the state of WV put that money where it needs to go and that is directly into health care works homes. These people have worked hard to get their educations and they word hard for our IDD Waiver consumers and they deserve a pay that reflects that.	NO CHANGE - Rates are based on claims data submissions for 2019 in both natural family homes and 24/7 ISS and Group Home settings. The resulting amounts are the average for both settings.
11	10/03/20	Regarding changes on Jan. 1, 2021 My sister has been with this company and had the same case manager and I am sure that she would want to continue with the same one . She does not do well with change	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This requirement cannot be waived and must be implemented.

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12	10/01/2020	To Whom it May Concern, Being a part of the waiver program has been a true blessing. My son, REDACTED, has been receiving most of his services thru one agency. I understand the need to not have a monopoly on services, but he is so disabled that taking him to four different agencies is a hardship on our family. It also causes a lot of stress and confusion for him. Hopefully, agencies will be permitted to keep at least two services per case to help lessen the stress on the individual and their families.	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This requirement cannot be waived and must be implemented.
13	10/09/2020	I would like to introduce myself. My name is REDACTED and I am a Family-Based Person Centered Support for the Potomac Highlands Guild in Petersburg, WV for my mentally and physically disabled daughter in our home daily. I would like to make some comments on two of the proposed amendments for the Intellectual/Developmental Disability Waiver (IDDW). My first comment is on the Conflict-Free Case Management. With our family as well as her Home-Based Person Center Support and Respite provider living in a very rural area of West Virginia, it's hard to have 2 different companies for our case management services. I think it should be our choice and the family and providers choice if they want the same of different companies. If everyone thinks that there in no conflict, then they should be able to continue using the same company. I know that her Home-Based Person Center Support and Respite provider would have to take a major pay cut if she switches companies. My daughter loves her service coordinator/case manager and would hate to lose her. She has really taken up with her service coordinator/case manager and looks forward to her phone calls and visits. My daughter doesn't like change and may have a difficult time adapting if she has to change companies. My second comment is on the service coordinator/case manager billing being set to a monthly rate. I agree this is better than set by units, but I don't think $150 for community consumers and $200 for residential consumers is enough. I know our service coordinator/case manager has to travel almost an hour one way when she comes to my client's house.	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This requirement cannot be waived and must be implemented.

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		So that's about 2 hours just traveling time for our monthly visit. That is not counting her time for the visit, any follow ups she does on the phone or computer, her documentation and whatever else she is required to do. I think they should get a higher monthly rate for their total time for each client. Thank you for allowing me to send my comments and I hope you consider my opinions.	NO CHANGE - BMS determined that the rates were not accurate and a revised application with the corrected rates has been posted to the BMS website. The corrected rates are $200 per month for members living in natural family and SFC settings and $250 per month for members living in ISS and Group Home settings. Rates are based on claims data submissions for 2019 in both natural family homes and 24/7 ISS and Group Home settings. The resulting amounts are the average for both settings.
14	10/09/2020	I would like to introduce myself. My name is REDACTED and I am a Contract Home-Based Person Centered Support and Respite Worker for the Potomac Highlands Guild in Petersburg, WV. I take care of a mentally and physically disabled in her home 6-8 hours a day. I would like to make some comments on two of the proposed amendments for the Intellectual/Developmental Disability Waiver (IDDW). My first comment is on the Conflict-Free Case Management. With both my client and I living in a a very rural area of West Virginia, it's hard to have 2 different companies for our case management services. I think it should be the family and providers choice if they want the same of different companies. If everyone thinks that there in no conflict, then they should be able to continue using the same company. For me, as a provider, if I switch to a different company, I will have to take a major pay cut. My client loves her service coordinator/case manager and would hate to lose her. She has really taken up with her service coordinator/case manager and	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This requirement cannot be waived and must be implemented. NO CHANGE - NO CHANGE – Conflict Free Case Management (CFCM) is being implemented due to the Code of Federal Regulations (CFR) (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This requirement cannot be waived and must be implemented.

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		looks forward to her phone calls and visits. My client doesn't like change and may have a difficult time adapting if she has to change companies. My second comment is on the service coordinator/case manager billing being set to a monthly rate. I agree this is better than set by units, but I don't think $150 for community consumers and $200 for residential consumers is enough. I know our service coordinator/case manager has to travel almost an hour one way when she comes to my client's house. So that's about 2 hours just traveling time for our monthly visit. That is not counting her time for the visit, any follow ups she does on the phone or computer, her documentation and whatever else she is required to do. I think they should get a higher monthly rate for their total time for each client. Thank you for allowing me to send my comments and I hope you consider my opinions.	BMS determined that the rates were not accurate and a revised application with the corrected rates has been posted to BMS' website. The corrected rates are $200 per month for members living in natural family and SFC settings and $250 per month for members living in ISS and Group Home settings. Rates are based on claims data submissions for 2019 in both natural family homes and 24/7 ISS and Group Home settings. The resulting amounts are the average for both settings.
15	10/07/2020	• Start Date - The amendment states the 7/1/2020 date however the implentation of the CFCM does not have a start date. The KEPRO calls have documented this to be December with January anchors, but it was announced in one of these calls that that is a target date and may change. Agencies need this information for planning purposes. Please inform agencies the start date as soon as possible. • Roll Out - How will the PMPM rate roll out? This is a strong recommendation for the per member/per month rate to begin across the board for all IDDW members beginning at the same time. To run duel systems is problematic for clinicians, billing, authorizations and modifications, as well as tracking and monitoring.	CHANGE – The start date was moved to 4/1/2021. Member will need to have a separate case management agency on their anchor date. CHANGE – The PMPM rate will be in place on 4/1/2021 for every

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		• Roll Out - How will the CFCM roll out? Will this be with every Annual IPP beginning in December and we'll have the calendar year to get these completed?	member whether they have moved to CFCM or not.
		• Electronic Monitoring - This code has 4 sub-codes and each is targeted for increase each year over the next 5 years. There are 2 provider agencies listed who offer this service; yet Case Management is a mandated service and the rate in this proposal is insufficient and with no proposed increases. What has been the usage of Electronic Monitoring? Is it anticipated that this service will be used by more IDDW members? Agencies?	NO CHANGE – The member must choose to have separate case management agencies and separate service agencies by their anchor date, on or after 4/1/2021.
		• Electronic Monitoring - There is a requirement for CMs in this section: "The Case Manager conducts a home visit that includes a programmatic review of the system as well as a drill at 7 days of implementation, and again at 14 days, and at least quarterly thereafter. The drill will consist of testing the equipment and response time." This is a high level expectation from CMs and unreasonable. CMs do not have expertise in Electronic Monitoring systems. How will they be trained? What is expected to be their responsibility if the "testing" doesn't go well? Additionally, with CFCM, the CM is not an employee nor supervisor. What authority and responsibility does a CM in this situation? If there is something amiss with this electronic monitoring system, for the CM to document it on the home visit form doesn't seem adequate, yet what else can be done? I don't believe this should be a CM requirement/responsibility. If it is to continue to be, it should be spelled out in the CM section of the manual and with more detail of the expectation and training.	NO CHANGE – This has not changed from the current manual is not a section open for public comment. NO CHANGE – This has not changed from the current manual is not a section open for public comment.

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		• Case Management - In general the largest concern is he CM rate with no proposed increase throughout the 5 years. Case Management is a mandated IDDW service. The requirements for CMs continues to be of high quality (College Level) to include an additional requirement for state certification, yet the rate does not allow for a salary that matches the requirements, let alone be able to offer salary increases. Even with the extensive job duties outlined in the Waiver manual, the Case Manager's job duties do not meet the Wage and Hour definition of salaried/exempt, primarily because they do not supervise staff. Case Manager's are classified as hourly/non-exempt. This rate does not cover if any Case Manager works overtime hours. I'm using the Fair Labor Standards Act for this information: https://www.dol.gov/agencies/whd/fact-sheets/17a-overtime	CHANGE - Rates are based on claims data submissions for 2019 in both natural family homes and 24/7 ISS and Group Home settings. The resulting amounts are the average for both settings.
		• Case Management - The agency that is providing other Waiver services should have access in CareConnection even when an authorization is not in place. If this could even be a "read only" access. There are details that the provider agency should have and without access to the CareConnection is prohibitive.	NO CHANGE - Kepro's Careconnection® does allow the service agency to access some information regarding service authorizations but does not allow access to all information regarding purchase requests submitted by the Case Manager. The service agency may request this information from the Case Manager as needed. Information regarding the timely requests for service authorizations/modifications will be monitored by Kepro and performance issues will be

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		• Case Management/Rates - In the IDDW application that went out for public comment on March 5, 2020, there were two event codes for CM and the rates were: Year 1: $200/$250 Year 2: $204/$255 Year 3: $208/$260.10 Year 4: $212.24/$265.30 Year 5: $216.48/$270.61. These were reportedly based on usage prior to Covid when travel time was included and CMs traveled to and from IDDW member homes for home visits, to and from day hab visits and to and from many IDT meetings. If travel time is going to begin again, the rates in this current application should at minimum reflect the incremental increase that was proposed in March. expectation that are placed on CMs. I don't believe prior usage is a fair depiction of this rate.	addressed with the Case Management agency. Service providers are also to notify Kepro if they experience problems with obtaining service authorizations or modifications of authorizations. NO CHANGE - That draft was withdrawn and BMS is not accepting comments on an application that was withdrawn.
		• Case Management/WV IMS - The CMs are expected to enter incidents into WVIMS. With CFCM, the CMs are not employees of provider agencies for the same IDDW members. This is an impractical job requirement for the CM to be expected to obtain the incident report from the provider agency (which is most likely where the incident report is from) and in the timelines required. The agency providing the service should be the entity to enter the incident reports into WVIMS.	CHANGE – For members that receive services through the Traditional Service Option, the agency(s) delivering services to the member will be responsible for

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			reporting incidents to the IMS. For members that receive services through the Personal Options Service Option, the assigned Resource Consultant will be responsible for reporting incidents to the IMS. Prior to conducting the member's monthly home visit, the Case Manager will contact the Service Agency and/or Resource Consultant to determine if incidents have been reported since the previous monthly home visit. During the monthly home visit, the Case Manager will review the incident(s) with the member/legal representative and determine if the incident(s) require changes to the member's service plan. Critical Incidents, particularly those pertaining to a crisis or reports of alleged abuse, neglect or exploitation of the member are to be reported to the Case Manager by the service agency and Resource Consultant within 24 hours of the agency/Resource

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			Consultant being made aware of the critical incident.
		• Case Management/Crisis Response - The CMs are expected to be available "before, during and after" crises. This is an impractical expectation of the CM. As mentioned, the CMs are, in most cases, hourly employees (unless they have other job duties outside of case management. The rate is insufficient to pay overtime and to have CMs on call is an unfunded mandate.	CHANGE – The Case Manager is responsible for the development of the Crisis Plan which is to identify the entity/individual responsible for responding to each type of crisis reflected in the plan. i.e. residential service provider will be responsible for responding to crisis that occurs when residential services are being provided in the home or community.
		• Case Management/Home Visits - Monthly home visit requirement: Can this be revisited to allow for every other month and/or with phone call visits? During Covid-19, the CMs have been providing monthly phone calls for monitoring. This has allowed for adapting to higher caseloads. With the low rate for CMs, it'll be more likely for the CMs to have higher caseloads and keeping monthly phone contact may allow for this to be more manageable	NO CHANGE – This item was not changed with this amendment and was not a section open for public comment. Face to face Home Visits have been suspended due to the Covid-19 Pandemic and will not resume again until it is safe.
		• General - With CFCM affecting some of the new IDDW slot releases, we have seen extensive CM work that isn't funded. In some cases, the family ends up choosing another CM provider agency after there has been some CM work done on behalf of that member and it is not reimbursable. In some cases, we have seen that the IDDW individual is either an individual with Special Project funding, in an ICF/IID, or	NO CHANGE – BMS was not able to implement this change at this

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		even in a state facility. During this time, no IDDW funding can be billed, yet the onus is on the Case Manager to make arrangements for housing, complete a DSS-LA form, complete an intake process, etc. and the IDDW service provider agency either doesn't provide services or is getting the funding through the ICF rate or the Special Project funds in those situations. In these situations, the CM provider agency may not have any reimbursement for these services.	time but will review again with future amendments.
		• General - Will the state allow a period of two weeks after the end of a budget year (for ISS members) to allow the CM and IDDW provider agency to modify the ratios based on actual usage - in these cases not exceeded the authorized budget.	NO CHANGE – The current period is two weeks after the end of the budget period.
		• General/CFCM - The CFCM mandate that individuals cannot have the same provider agency as the service provider agency limits choice. There are individuals who have been on the IDDW program for 10, 20, and 30 years and have been highly satisfied with their choices of providers. These IDDW members should be allowed to be grandfathered in if that is their choice.	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This requirement cannot be waived and must be implemented. This comment was submitted twice.
		• Case Management - What would be considered an exception of conflict free CM by BMS?	NO CHANGE – The stakeholder group determined that a cultural and geographical exception may be granted by BMS. This comment was submitted twice.

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		• Group Home PCS - In regards to the max 12 hrs of 1:1 services, how will this effect clients currently living in a 1:1 setting?	NO CHANGE – Individuals living in 1:1 settings normally are approved for 24 hours of 1:1 services unless they can be unsupervised for short time periods. This comment was submitted twice.
		• Respite - Do respite staff have to use the EVV?	NO CHANGE – Only in-home respite providers must use EVV. This comment was submitted twice.
		• Behavior Support Professional – It list qualifications for a BSP II having a BCaBA if they are endorsed but it does not clarify if a BCaBA can be a BSP 1	NO CHANGE – This has not changed from the current manual is not a section open for public comment. This comment was submitted twice.
		• Behavior Support Professional - If there is only one BSP reimbursement why are there still two levels?	CHANGE – This has been corrected.. This comment was submitted twice.

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		• Licensed PCS - It specifically states that staff in a licensed residential home will have to use EVV. We had previously been told it would not be used for residential homes.	CHANGE – This was an error and has been changed. This comment was submitted twice. .
		• Rate for CM Services - Rates listed are inadequate to the responsibilities outlined in the manual.	NO CHANGE - Rates are based on claims data submissions for 2019 in both natural family homes and 24/7 ISS and Group Home settings. The resulting amounts are the average for both settings. This comment was submitted twice.
		• WV IMS - CMs are required to be available for crises 24 hours a day. This is unreasonable due to CMs being hourly employees mandated by the federal definitions. It is also required for CMs to enter incident reports, but this is not practical since CFCMs will not have access to reports from other provider agencies within the timelines. The timelines will not be met.	CHANGE – The Case Manager is responsible for the development of the Crisis Plan which is to identify the entity/individual responsible for responding to each type of crisis reflected in the plan. i.e. residential service provider will be responsible for responding to crisis that occurs when residential services are being provided in the home or community. This comment was submitted twice.
		• CM Utilization - Due to CFCM, agencies will be reliant on Case Managers that are not employed with an agency that is providing services. Very often, there are times throughout the course of an	NO CHANGE - At this time, Kepro's Careconnection® does not allow the service agency to request new service authorizations or

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		authorization when modifications need to be completed in a timely fashion so that services can be paid for. What recourse will an agency be able to take if a CM does not address a service modification in a timely fashion which results in an agency not getting paid for services rendered?	modify existing authorizations. Kepro and BMS will monitor the Case Manager's performance regarding the timely request for annual service authorizations based upon the members' anchor dates. Performance issues will be addressed with the Case Management agency. Service providers are also to notify Kepro if they experience problems with obtaining service authorizations or modifications of authorizations. This comment was submitted twice.
		• CM Utilization - At this time Care Connection can only be accessed by the assigned administrator of the CM agency regarding modifications or other budget issues. It is possible to review a budget if there is an authorization in place. However, if the service agency does not have an authorization number, they are totally reliant on the CM agency to update them on budget submissions and other budgetary issues. Is there a way that both the CM agency and the agency providing the direct services can be given access to the clients' budgets through Care Connection?	NO CHANGE - Kepro's Careconnection® does allow the service agency to access some information regarding service authorizations but does not allow access to all information regarding purchase requests submitted by the Case Manager. The service agency may request this information from the Case Manager as needed. Information

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		• Appendix C – Non-Medical Transportation - It is overly burdensome to require direct support staff to provide copies of vehicle insurance, sticker, registration, and driver's license. It costs agencies a lot of money in postage to inform staff when renewals are due for all four requirements. Additionally, it requires a lot of man hours to keep track of all these requirements. Allow agencies to develop an attestation form that requires drivers to abide and confirm to all WV driving laws which would include vehicle sticker, registration, insurance, and current license.	regarding the timely requests for service authorizations/modifications will be monitored by Kepro and performance issues will be addressed with the Case Management agency. Service providers are also to notify Kepro if they experience problems with obtaining service authorizations or modifications of authorizations. This comment was submitted twice. NO CHANGE – This has not changed from the current manual is not a section open for public comment. .
16	10/13/2020	We are the family of a child who qualifies for Waiver under the category of Intellectual/Developmental Disability. He is an 11 yr old child with severe Autism Spectrum Disorder, Apraxia, and Sensory Procession Disorder. We have been receiving services from his agency since he was 3 or 4 years old having started with Speech Therapy and later Occupational Therapy as well as Respite, safety, health, behavioral, and other services.	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This requirement cannot be waived and must be implemented.

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		As someone who is familiar with his issues, it is very common for the need for continuity and predictability in his daily life. Changes are particularly hard in an already challenging environment. While we understand that conflict of interest could become an issue, we can assure you that we have never seen anyone that would apply to. It is of utmost importance that communication between all areas be current and continual. It creates a hardship if we have to start all over and familiarize another agency with his needs/abilities/challenges. We have an excellent team that communicates well and has come to understand the unique needs of our family. Communication not only occurs within this agency but also along the lines of his academic environment where he attends a school for Special Needs. This helps to facilitate and make it easier to understand what is needed and to quickly attend to any problems that should arise. We have a highly trained staff that always strives to help him reach his full potential and to recognize when something is becoming a problem or a special need becomes apparent. Familiarity is highly required and receiving services from different agencies would be particularly cumbersome and, in our opinion, impede progress that is being achieved in the present situation.	
17	10/13/20	The WV Developmental Disabilities Council (WVDDC) appreciates the opportunity to provide comments on amendments being proposed by the Bureau for Medical Services (BMS) to the I/DD Home and Community-Based Services Waiver (IDDW) application. The Council is pleased to see the changes that were being proposed in the IDDW application out for comment in the spring were not included in this amendment. It is our understanding the BMS decided to renew the	

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		waiver application under which the State was already operating for another five-year period and make these amendments instead.	
		The State plans to rename the service currently called "service coordination" to "case management" and implement conflict-free case management, as required by the Federal government effective January 1, 2021. It appears case load limits have also been removed. Since the role of case manager will be the same as the role of service coordinator under the current system, the Council is concerned about what this will mean for those served by the program. What assurances will be in place to assure caseloads are reasonable and manageable?	NO CHANGE - The case load limits have been removed in the new application. BMS will monitor the size of caseloads through retro reviews and advise the agency to decrease if it appears the caseloads are too large to handle the workload.
		It is a positive step to see the BMS will be developing a certification process/case-management training which will be required of individuals seeking to provide case-management services who have a four-year degree in a human service field but are not licensed social workers.	NO CHANGE – Council agrees with proposed change.
		The Council has advocated for a change to a monthly fee rather than the billing of 15-minute units for case management services for more than a decade. We appreciate this change but are interested to know what safeguards will be in place to assure the appropriateness of the billing.	NO CHANGE – Council agrees with proposed change. Retro reviews will be the appropriate vehicle to assure the appropriateness of the billing.
		The Council has no opinion on the implementation of Electronic Visit Verification (EVV). It is a federal mandate.	NO CHANGE – Council expresses no opinion with proposed change.
		We are happy to see the addition of several services (Physical, Occupation, Speech, and Dietary therapies, along with Environmental	

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		Accessibility Adaptation for Home and Vehicle) to the self-directed option. This moves West Virginia in the direction of having a true self-directed program, although there are still several challenges to it. As mentioned earlier it is a relief to see the BMS did not include several of the ideas proposed in the earlier application which the Council strongly opposed. Those included things such as the prohibition on billing respite services while the caregiver works and moving therapy services from the Waiver to ESPDT or State Plan services. We are sorry to see other proposals made then that did not make it into this amendment, such as the restriction placed on the use of cameras in bedrooms and bathrooms. The Council also feels more can and should be done to encourage the competitive employment of people served by the program, including training requirements and higher compensation for individuals employed to assist in obtaining and supporting people in competitive employment settings.	NO CHANGE- Council agrees with proposed change. NO CHANGE – Appendix C currently states "The Case manager must ensure that there are no cameras present in member's bedroom or bathroom pursuant to 42 CFR Section 441.301 (c)(4)(111) which states that all HCBS settings must have the following qualifies of ensuring a member's rights of privacy, dignity and respect and freedom from coercion and restraint. If cameras are found to be present, the case manager must report this in the WVIMS system immediately as well as to Adult Protective Services Centralized Intake." CHANGE – Rate errors have been corrected. BMS does not propose

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		Finally, the rates listed for the five-year period are hard to understand. Some rates appear to have increased by a few cents from the previous application while others decreased. Some rates, for instance Job Development, begin and end at less than the published current rate. Is the BMS proposing a decrease in rates for some services? The Council continues to advocate for higher rates for those workers who are providing direct support services to increase the likelihood of attracting and retaining qualified individuals to the workforce and to demonstrate the work they do is valued. We thank you for this opportunity to provide comments on the proposed amendment, and we remain available to discuss any of these comments further.	any decrease in rates in this amendment. NO CHANGE – BMS agrees that the work of a person providing direct care services is valued and appreciates the comment.
18	10/14/2020	DHHR has offered a $338 per month/per member rate. This rate has now been dropped to $200 for the natural family and $250 for residential programs. This will require that the agencies take on more clients, providing less 1:1 attention to these larger caseloads just to keep their doors open. The average people in these positions at the agencies have strong qualifications and should be compensated appropriately without having to carry such large caseloads. The larger the caseload, the less quality attention can be given to those in our society that need more attention and direction. The average agency staff members will need case loads of between 45 and 50 clients in order to keep their job, therefore providing less person centered and more quantity centered services to stay afloat. The time required, per client includes at a minimum, home visits, Kepro assessments, IPPs, routine reviews, etc. At the quoted new	NO CHANGE - The two rates are an average of services billed in natural family homes and those billed in 24/7 ISS and group home settings.

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		rates more providers will be forced out of business, therefore, leaving an even bigger void in this critical need than there is now.	
19	10/14/20	Concerns were as follows: How would non-emergency medical transportation be used for work and supported employment since they do not go all the places that are needed and the limitation again on prevocational services to two years. In the category of Prevocational services two years of volunteer work has been added. We have members who are elderly who are actually paid and volunteer and the change in the routine could be detrimental for them. In the category of day habilitation, a statement about non-emergency medical transportation should be used but what if it is unavailable. Some member who attend PVTA is unavailable to pick them up at their current locations. Our individuals have employment contracts from Keyser to Wardensville for mowing contracts. How would this transportation occur? Regarding on-line case management training to be developed by BMS, we would like to ask for clarification if this will be required prior to January 1, 2021, for existing case managers, and if this will be added as an annual required training, as the current conflict-free service coordination.	CHANGE – The 2-year time limit for prevocational services has been removed. The provider agency may want to become a Non Emergency Medical Transportation (NEMT) provider to assist their members. NO CHANGE – All Case Managers who are Licensed Social Workers, Licensed Professional Counselor or Registered Nurses will be grand-fathered in. Any new case managers must complete the training within 6 months of employment.

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		There are several references to using a fingerprint-based check at a three-year interval – will this replace the current five-year requirement, and will there be an extension granted to have these completed for existing employees who are in-between intervals?	CHANGE – This error has been corrected.
		The policy for the minimum duties of a case manager include verifying financial eligibility during monthly home visits. Currently, service coordinators call a toll-free number to determine this, recording a tracking number to verify completion. As WV has several rural areas where mobile telephone reception is poor or non-existent, is the interpretation of "during" the visit to be viewed literally?	CHANGE – The case manager should verify financial eligibility prior or during the monthly home visit.
		Also in the case manager description is noted that they are to "monitor that service providers implement the instruction, behavioral, and service objectives in the IPP." This appears to overlap with services performed, in some areas, of the behavior support professional. Can this be clarified that the monitoring is to communicate concerns, or how the case manager is to alert and rectify if providers are found to have not followed the objectives of the IPP?	NO CHANGE – This section has not changed from the previous application and thus is not open for public comment.
		Within the case manager duties section regarding meeting every other month with the person at their facility-based day or prevocational programs is language that the purpose includes determining a transition out of a facility within two year time limits. This specification is not located within the services for day programs/prevocational services, and has previously been determined to not be required by CMS. We ask that this time-limit on day program/prevocational services be removed. The services are invaluable to members who may not ever fully transition to community settings from a day program, but benefit in stability of routines and predictability of support offered by these facilities.	CHANGE – The 2-year time limit for prevocational services has been removed.

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		The case manager section also stated that the case managers will be able to bill for services performed to assist an individual transition out of an ICF/IID facility or institution for mental disease on day one of these new services. During the opening of slots to clear the waitlist, agencies providing these case management services have not recouped billing, as this is not clearly noted in the current manual. Will there be retroactive billing available for agencies/providers who can clearly document what services have already been performed?	NO CHANGE – BMS was not able to implement this change at this time but will review again with future amendments.
		Through monthly and quarterly provider calls, the institution of Electronic Visit Verification (EVV) has been said to be applicable to residential agency staff only when providing transportation services to members, but the current direct care language in this application states that the EVV rules will be applied to these staff. We request that this clarification on when EVV is to be used added to round-the-clock services language.	CHANGE – This has been corrected.
		The proposed rate structures for years one through five include incremental increases for many services, yet case management is to remain at one set fee structure throughout the period. In the original case management unit rate proposed in March 2020, case management rates for family and agency were proposed at $200/month and $250/month per member, respectively, with incremental increases per member each year at approximately $4 and $5 each. The new application has no incremental increases for case management during the five-year period. It also has a proposed decrease of three cents per unit on the currently utilized purchasing system. In a state where case managers in much of the state will regularly spend an average of more than two hours of travel to and from visits and meetings for members, this continues to place an undue hardship on agencies to find, train, and retain qualified personnel. The agency requests the previously proposed incremental increases be placed into this application, and that no decrease in the current unit rate to serve	NO CHANGE – The draft application of March 2020 was withdrawn and BSM is not accepting comments on a withdrawn application.

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		members throughout this transition. Additionally, the agency requests clarification on how the transition will be timed, as the rollover to a new purchasing model in the middle of member budget years will be very difficult to calculate to ensure services are within a members allocated budget.	
20	10/14/20	• Implementation of Conflict Free Case Management requirements in accordance with the Code of Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(l)(vi.). ○ The choice should remain at a minimum for those who have a direct family parent or guardian. I feel that everyone should have the choice to hire whichever Case Manager they choose whether in agency or out of agency. • Added to the criteria for a case manager's credentials to include a 4-year degree in a human service field with certification from on-line case management training developed by the Bureau for Medical Services. ○ I welcome the Case Management training and think requiring a 4 year degree in the human service is a great idea for future Case Managers. However, current Case Managers that wouldn't meet the new qualifications should be grandfathered in. or - required supervision for a period of 3-5 years to gain experience for those that lack either years of experience or the field of study. • Implementation of Electronic Visit Verification (EVV) in accordance with the 21st Century CURES Act. The state will be in compliance by Jan. 1, 2021. unless there is a federal mandate extending that date. ○ It is my understanding that WV does not currently have a vendor to provide this service. If it goes in the application and	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This cannot be waived and must be implemented. NO CHANGE – All Case Managers who are Licensed Social Workers, Licensed Professional Counselor or Registered Nurses will be grand-fathered in. Other Case Managers currently employed can become certified through the on-line case management system. NO CHANGE – The State of WV recently awarded the contract for

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		we are not ready to provide it does that create more of a problem for the state?	an EVV Vendor and is working toward becoming compliant on 1/1/2021.
		• BSP provider qualifications. Four year degree in a human service field or a Board of Regents degree, completion of the WVAPBS facilitated 3 hour Overview of Positive Behavior Support or the WVUCED Positive Behavior Support Direct Care Overview, completion of an approved WVAPBS curriculum and one year of professional experience in the I/DD field. o I think these requirements are great. I think a human service degree should be required or other bachelors with 5 years of professional service in the I/DD field.	NO CHANGE – This section was not changed and was not open for public comment.
		• Exceptions o It is more reasonable to have the exception amount from the previous year become the following year's budget	NO CHANGE – This section was not changed and was not open for public comment.
		• Rates of Services: Case Management, Agency Family based PCS and Supported Employment o The rate pays for the position, but with this service being separate it doesn't pay for the support that the position needs. I fear that Case Managers will be overloaded with cases to make up the cost for the supported positions since CM is out of agency.	NO CHANGE - The two rates are an average of services billed in natural family homes and those billed in 24/7 ISS and group home settings.

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		• Case Management Duty- general ○ Case manager should be able to attend IEP as advocacy	NO CHANGE – This section was not changed and was not open for public comment. CMS does not allow IDDW services to be provided in a school setting.
21	10/14/2020	Hello, my name is REDACTED. My husband, REDACTED, and I have two, adult, children on the waiver program that have REDACTED. Chronologically, REDACTED is 25 and REDACTED will be 23 in January. The girls have been in a residential setting since 2016. We are writing today in regards to the proposed waiver changes. The change that gives us the most concern is that of service coordination needing to be from a different agency than the one providing the service. We reside in REDACTED and our children in REDACTED. We believe we are in an area that is greatly challenged due to the lack of agency availability. REDACTED and I are significantly apprehensive about this proposed change. We feel this may disrupt services for REDACTED and REDACTED, or at least, pin agency versus agency and cause chaos to the delivery of their services. We feel that our girls should be exempt to this change because of the remote area in which we live. Please consider this for clients such as our children. It challenging enough having to travel outside our area for speciality doctors and appointments. Or to shop at establishments other than a dollar store or Walmart. We are very limited in our choices, for anything, in our area, and would significantly appreciate 'a by' regarding this new, proposed change. To us, it seems counterintuitive to have agencies/businesses audit each other when they are in competition with one another to begin with. We do not feel this would reflect positive for either of our children. Please reconsider this change for those of us with limited options.	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This cannot be waived and must be implemented.

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22	10/14/2020	• Implementation of Conflict Free Case Management requirements in accordance with the Code of Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(l)(vi.). ○ I understand that this is a Federal mandate and likely unable to change but continue to believe that it limits choice for the people served on I/DD Waiver. It is hard on individuals who have had the same case manager for 20 years. Could the change just occur as each new slot is opened? As a provider we have grave concerns about the case managers who will be taking care of our budgets and the recourse if they don't do what is required and our agency is not paid. We have already experienced this and not been paid due to mistakes of an outside SC and are concerned about being able to continue to provide services if budgets are not completed in a timely manner. • Added to the criteria for a case manager's credentials to include a 4-year degree in a human service field with certification from on-line case management training developed by the Bureau for Medical Services. ○ I welcome the Case Management training, but I have grave concerns about limiting the ability to be a Case manager to those with a 4-year degree in a "human service" field. Will there be a grandfathering in for Case Managers with years of experience? I request required supervision for a period of time for those that lack either years of experience or the field of study. • Implementation of Electronic Visit Verification (EVV) in accordance with the 21st Century CURES Act. The state will be in compliance by Jan. 1, 2021. unless there is a federal mandate extending that date.	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This cannot be waived and must be implemented. NO CHANGE – All Case Managers who are Licensed Social Workers, Licensed Professional Counselor or Registered Nurses will be grand-fathered in. Other Case Managers currently employed can become certified through the on-line case management system. NO CHANGE – The State of WV recently awarded the contract for an EVV Vendor and is working

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		○ It is my understanding that WV does not currently have a vendor to provide this service. If it goes in the application and we are not ready to provide it does that create more of a problem for the state?	toward becoming compliant on 1/1/2021.
		• Added service of Home-Based Person-Centered Supports Personal Options to identify employees that do not live in the member's home. 7. Added a modifier to the Transportation Personal Options service to identify employees that do not live in the member's home. 8. Added four new self-directed extended professional services: Physical Therapy, Occupational Therapy, Speech Therapy and Dietary Therapy. 9. Added two new self-directed services - Environmental Accessibility Adaptation Home and Environmental Accessibility Adaptation Vehicle. ○ I do not necessarily see a way around it, but I am concerned that adding so many codes is going to complicate things for families who are self-directing services. Would it be easier to add to the things that can be purchased via goods and services rather than giving new codes?	NO CHANGE – Most of the new codes added are the self-directed codes and Public Partnerships, LLC (PPL) will manage those. The family will both a case manager and a resource consultant to assist them. CMS would not allow us to put Vehicle and Home Modifications under Participant Directed Goods and Services.
		• Budget methodology ○ The current budget methodology does not allow for a family to choose agency services and have the maximum amount of direct services and therefore it forces families to choose the self-directed option. This limits choice. It also has huge impact on families when they know they need help from a BSP, but are unable to give up direct services to access the other service. The personal options coordinator receives funds out a separate pot of funds which lowers the cost to Waiver, but does not truly lower costs for the state as a whole. Could Case Management, or other services come from this separate pot to	NO CHANGE - This item was not changed and is not open for public comment. A member can choose case management from one agency, Behavior Support Professional (BSP) from another agency and still self-direct. We do not know what a personal options

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		allow more for other services? WV has a budget surplus, yet people with I/DD who have documented need are getting fewer and fewer services. I fear that WV is setting the stage for a crisis of people with challenging behaviors and lack of skill development who later have aging parents who cannot provide care and no connection to agencies who might be willing/able to act more quickly for someone to whom they are connected than a complete stranger. Families often list someone on the crisis plan to take over if they are unable to provide care, but when the moment occurs, they are unable to handle the responsibility. • The state reserves capacity of 12 slots in years 1, 2, 3, 4 and 5. 6 slots are for adults and 6 slots are for children per court order. The 6 adult slots are for adults, 18 years of age and older, who have been on the wait list for at least one year and have been institutionalized for one at least one year in a state-owned mental institution (currently the William R. Sharpe, Jr. Hospital and the Mildred Mitchell-Bateman Hospital). The 6 children's slots are for individuals under age 21 who have been on the wait list for at least one year and have been institutionalized in an out-of-state facility for over one year ○ I'm not sure if this is realistic, but would these slots be able to be used for others at some point in the fiscal year if they were not needed for those targeted? • BSP provider qualifications. Four year degree in a human service field or a Board of Regents degree, completion of the WVAPBS facilitated 3 hour Overview of Positive Behavior Support or the WVUCED Positive Behavior Support Direct Care Overview, completion of an approved WVAPBS curriculum and one year of professional experience in the I/DD field.	coordinator is, but this person is not a case manager. NO CHANGE – This item was not changed and is not open for public comment; however, slots can be awarded after March 1 if not utilized by the targeted populations.

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		○ I understand that this isn't a proposed change, but I believe it should be. A Regents degree can focus on life experience of any kind and is not necessarily linked to a human service field. I request to consider allowing Regents and other non-human service degrees with additional experience. Often life is the best professor! • Exceptions ○ Exceptions are bulky and take a lot of service time. Thus far every person we serve that needed and exception last year needed one the following year. It would make more sense to have the exception amount from the previous year become the following year's budget or that the committee or pre-hearing conference group could make this recommendation on a case by case basis. • Rates of Services: Case Management, Agency Family based PCS and Supported Employment ○ CM- Case Management is a cornerstone of services in I/DD Waiver as well as a required service. It is also a very high turnover position. The rate pays for the position, but with this service being separate it doesn't pay for the support that the position needs. Someone has to monitor personnel records, payroll, billing, reception needs, not to mention buildings, lights, water, etc. I fear that agencies will cut corners and increase case loads to unreasonable rates to be able to make it and lead to reduced health and safety for waiver participants, slower budgets for provider agencies and increased turnover of case managers. Agency Family based PCS- Agency home based PCS pays $10.96 per hour. If family member gets $8.75 that barely covers the 15% overage for benefits let alone	NO CHANGE – This item was not changed and is not open for public comment. NO CHANGE – This item was not changed and is not open for public comment. . NO CHANGE - The two rates are an average of services billed in natural family homes and those billed in 24/7 ISS and group home settings.

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		any overhead for processing the billing, timesheets, training, personnel records, etc. Agencies are mandated to treat families as any other employee and provide the same training as any other employee. PPL gets a monthly payment to provide the overhead. Many of the agencies in my area have decided to stop providing this service already due to lack of reimbursement. The rate of this service limits participant choice. Supported Employment: I do not understand why the rate for Supported Employment is less than PCS. If any difference I believe it should be higher. Supported Employment allows for increased social circles and increased "normalization". It lessens dependency on the system and increases self-esteem. I believe this service need be the best direct care service out there to promote acceptance in our communities. In general, When you pay for a pinto, you get a Pinto. When you pay for a Cadillac you get a Cadillac. The people we serve deserve premium services. • Case Management Duty- general ○ Case manager should be able to attend IEP as advocacy to ensure getting entitlement services needed through the school system.	NO CHANGE – This section was not changed and was not open for public comment. CMS does not allow IDDW services to be provided in a school setting.
23	10/13/2020	I am writing to express concerns in a comment on the proposed IDDW five-year renewal application. Specifically I would like to address the proposed change to eliminate caseload limits for case management services. I am concerned that this change coupled with a monthly fee schedule potentially opens up the system for agencies to abuse this by taking on more clients for case management than they can comfortably serve. This could possibly negatively impact these vulnerable clients if	NO CHANGE - The case load limits have been removed in the new application. BMS will monitor the size of caseloads through retro reviews and advise the agency to decrease if it appears the caseloads are too large to handle the workload.

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		their case managers are too busy ensuring all the home visits are done on their large caseload so the agency can get reimbursed for this service rather than ensuring other necessary follow up & linkage that each client needs is provided. I realize the purpose of annual reviews & audits are to address these potential issues. However, this could still result in clients not receiving the level of service they require from a case manager for months before this is discovered during an annual review. Thank you for your time in reading and reviewing my comment.	
24	10/13/2020	1. On page 55, when describing every other month day habilitation visits by the case manager, it states "The purpose of these visits is to determine progress toward obtaining services and resources, assess achievement of training objectives, identifying unmet needs, and to determine progress toward transition out of a facility and into a community setting within 2-year time limit. The visit is documented on the Case Manager Home/Day Visit Form." What happens if sufficient progress is not made to transition them to a community setting within two years? Will this manual include a requirement to discharge individuals from day habilitation if they have not graduated to a community setting within two years? Many individuals will not be able to graduate to a community setting, so we recommend provisions be made to maintain these individuals in a day habilitation setting longer term.	CHANGE – The 2-year time limit for prevocational services has been removed.
		2. General questions Currently in the IMS any incident that requires first aid is considered a critical incident. If a Band-Aid is applied for a scratch, we must put it into the IMS system as a critical incident. Will the IMS definition of critical incident be aligned with the OHFLAC definition in the new manual?	NO CHANGE – BMS is working on a new system, however, the current system will remain in place until a new system is developed.

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		3. On page 195, it states "Incident reports must also be sent to OHFLAC by the IDDW provider agency if restraint is used." Does this include restraints that are part of a behavior plan or just those restraints that are unauthorized for emergency situations to protect the member or others from harm? We suggest only unauthorized restraints used in emergency situations be reported. Reporting all use of restraints would result in a significant increase in reports sent to OHFLAC.	NO CHANGE – This item was not changed with this amendment and is not open for public comment, the current requirements to report to the Office of Health Facilities Licensure and Certification (OHFLAC) remain. This comment was submitted twice.
		4. General Question. With case management becoming an independent service, direct service providers will need direct access to CareConnection© to ensure the Case Manager is requesting the correct authorizations. How will this be accommodated once independent case management goes into effect?	NO CHANGE - Kepro's Careconnection® does allow the service agency to access some information regarding service authorizations but does not allow access to all information regarding purchase requests submitted by the Case Manager. The service agency may request this information from the Case Manager as needed. Information regarding the timely requests for service authorizations/ modifications will be monitored by Kepro and performance issues will be addressed with the Case Management agency. Service

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		5. General Question. Our annual case management service provision averages $3,404 for residential clients, and $3,026 for a natural family with day treatment services. The application states the case management rates for residential clients will be $250/month (or only $3,000 annually) and natural family clients with or without day treatment will be $200/month (or only $2,400 annually). The only way for this service to be remotely viable is to have very large caseloads. With the services required of the Case Managers in this manual, including monthly visits to the member's home and bi-monthly visits to day habilitation services, a large caseload would be impossible in a rural state like West Virginia. Most importantly, service quality for the members will decline drastically. The amount of requirements and expectations of the case manager need to be reduced to allow for large caseloads or the monthly fee needs to be increased to allow for smaller caseloads and quality care. 6. What is the procedure for evaluating individuals that are currently receiving more than 12 hours of 1:1 service? What extenuating circumstances might support the need for more than 12 hours of 1:1 service? What form will be used for requesting more than 12 hours of 1:1 residential service for individuals that are currently in an Unlicensed Residential x 1 and need to continue that level of care?	providers are also to notify Kepro if they experience problems with obtaining service authorizations or modifications of authorizations. This comment was submitted twice. NO CHANGE - The two rates are an average of services billed in natural family homes and those billed in 24/7 ISS and group home settings. This comment was submitted twice. NO CHANGE – Individuals living in 1:1 settings normally are approved for 24 hours of 1:1 services unless they can be unsupervised for short time periods. Providers may submit a Direct Services Support Living Arrangement Assessment to request more than 12 hours of 1:1 service for those residing with roommates. This comment was submitted twice.

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		7. What are the required trainings for the waiver program as mandated by OHFLAC and BMS? For example, Direct Care Ethics and Positive Behavior Support are not listed anywhere in the application. Are these two trainings still required? Please list all required trainings that could lead to repayment if not kept current.	NO CHANGE – This section has not changed from the previous application and thus is not open for public comment. The specific training requirements are noted in the IDDW policy manual. This comment was submitted twice.
		8. If Positive Behavior Support (PBS) training is still required does this training continue to need to be completed by a trained BSP? Is there any consideration of having non-BSP staff being able to train with the services for BSP's being cut and the shortage of BSP's in the state?	NO CHANGE – This item was not changed with this amendment and is not open for public comment.
		9. BSP units state "768 units/120 hours per IPP year". 768 units equals 192 hours and not 120 hours. Which is correct?	CHANGE - This error has been corrected and the correct amount is 192 hours or 768 units. This comment was submitted twice.
		10. General – We are deeply concerned there is no clear process for direct service providers to quickly resolving problems obtaining authorizations through independent case managers. Without a quick process to resolve these disputes direct service providers will be required to make decisions about providing services with no assurance they'll be reimbursed. We believe there needs to be a clear and timely process for BMS to resolve these concerns and provide direction to service providers.	NO CHANGE - At this time, Kepro's Careconnection® does not allow the service agency to request new service authorizations or modify existing authorizations. Kepro and BMS will monitor the

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			Case Manager's performance regarding the timely request for annual service authorizations based upon the members' anchor dates. Performance issues will be addressed with the Case Management agency. Service providers are also to notify Kepro if they experience problems with obtaining service authorizations or modifications of authorizations. This comment was submitted twice.
		11. NPI and EVV – We were originally told the only staff that would be using NPI numbers and EVV are the staff billing Home-based PCS and Respite services, Case Management Services, and staff billing Mileage. The new application basically requires all employees working in direct care to use NPI numbers and EVV. Did this change? Can we have this clarified? We are deeply concerned that requiring each employee to bill services under individual NPI numbers will slow the billing and collections process to the point it will put some providers in financial jeopardy.	CHANGE – This error has been corrected, 24/7 staffing in residential settings will not be required to use EVV at this time. This comment was submitted twice.
		12. The finger-print based checks are 5 years with WVCARES and the application is requiring every three years. Can we keep the check at 5 years? There is a significant cost to re-fingerprint staff and many people will be out of compliance immediately with this change once the manual takes effect.	CHANGE – This has been changed to 5 years. This comment was submitted twice.
		13. Many services show incremental rate increases each year for 5 years. Will this actually occur?	

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		14. The application does not show a rate increase for case management. Is there a planned incremental rate increase for case management?	NO CHANGE – Yes, this will occur.
		15. On page 192, compared to the revised IDDW new budget methodology summary sheet dated October 1, 2019, for Adult Waiver Group Home and Individual Support Settings, the application indicates the base budget for these living arrangements have decreased. Is this correct?	NO CHANGE – No, not at this time. This comment was submitted twice.
		16. Why does Job Development have such a large decrease in their reimbursement rate $5.01 to $4.39?	CHANGE – Base rates have been updated to reflect most recent rates. This comment was submitted twice.
		17. What is the rate for Transportation-Trips? There is no rate listed .	CHANGE – This rate was an error and has been corrected. This comment was submitted twice.
		18. On page 160 of the application (service plan implementation and monitoring), this statement "Any concern related to the member's health and safety must be reported through the WV Incident Management	CHANGE – This error has been corrected and the rate remains unchanged at $8.31 per trip for agency owned mini-buses and

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		System" is cause for concern. This is very subjective on the case manager's part, and appears to put the onus on the case manager to enter incidents in IMS, which may often prevent timely submission into IMS. Should the provider not be alerted to the issue to ensure the correct information is provided? Who is responsible for entering information into IMS so there are not double entries made? With independent case management, should not the provider agency, where the incident occurred, be responsible for entering the incident into IMS instead of the case management agency? There are no clear guidelines as to who enters incidents so duplication could occur, or worse, no incident entered at all. The application states all providers are to enter incidents. There is going to be a minimum of two providers and could be many. Who is to enter incidents into IMS?	vans. This comment was submitted twice. CHANGE – For members that receive services through the Traditional Service Option, the agency(s) delivering services to the member will be responsible for reporting incidents to the IMS. For members that receive services through the Personal Options Service Option, the assigned Resource Consultant will be responsible for reporting incidents to the IMS. Prior to conducting the member's monthly home visit, the Case Manager will contact the Service Agency and/or Resource Consultant to determine if incidents have been reported since the previous monthly home visit. During the monthly home visit, the Case Manager will review the incident(s) with the member/legal representative and determine if the incident(s) require changes to the member's service plan. Critical Incidents, particularly those pertaining to a crisis or reports of alleged abuse, neglect or exploitation of the member are to

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		19. On page 196 (and other locations in this application) it states that all IPP's are entered electronically into the UMC's web based application system. Currently, only the annual IPP's and IPP's that indicate a change in services are required to be uploaded into CareConnection? Is this an accurate change going forward? 20. The application states on page 198 "The IDT and HRC must approve these (restrictive interventions) at least every six months. The Human Rights Committee reviews and approves all new restrictive interventions prior to implementation and annually thereafter." Is it six months or annually?	be reported to the Case Manager by the service agency and Resource Consultant within 24 hours of the agency/Resource Consultant being made aware of the critical incident. These comments were submitted twice. NO CHANGE – This section has not changed from the previous application and thus is not open for public comment. Policy requires upload of any documentation requested by BMS. This comment was submitted twice. CHANGE – This has been changed to "at least annually". This comment was submitted twice.
25	10/12/2020	We are REDACTED, guardians of REDACTED, and we are writing to strongly urge BMS not to make any changes to Service Coordination and other services until this pandemic is over for our country. We have been isolated for 7 months providing all daily care of REDACTED because the risk of having staff or anyone around her is too high to take a chance of her getting COVID 19. REDACTED is non-ambulatory with a history of respiratory issues. As her parents we are also compromised due to our age and other health issues. Our concerns with the changes in Service Coordination is: 1. We have already been through having SC services from one agency and direct care from another agency two other times and	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This cannot be waived and must be implemented.

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		REDACTED was not receiving what she needed. Had we not made the switch back to all service from one agency, REDACTED 's life would be in chaos. The SC could not get the other agency to provide services, communication was very poor, staff would refuse to follow SC efforts, paperwork was never on time back to SC, etc. 2. Separating SC and direct care limits REDACTED's service options in our area. REDACTED's program plan is complex and very scheduled because persons with TBI need that type program. 3. If we continue with the current agency for SC services, then I, as her parent, cannot continue to provide Family PCS through that same agency. Other agencies in our area do not want to provide Family PCS because they cannot cover their cost of providing that service. 4. As we have stated, we have not seen people face to face since March due to COVID-19. You are asking us to deliberately put REDACTED in harms way because that is what it would take to make any of these changes now. The current SC has not even been able to see REDACTED since March. Why would you think we would want a complete stranger (new SC) to come to our home and possibly infect her? The same applies with direct care providers. We have worked hard over the years with the SC to develop the type of working relationship with REDACTED and to know her program. That is so important because she will know her and her needs in case of emergencies with her parents.	NO CHANGE – If another qualified provider is not available in your area, then the member may qualify for a geographical exception. NO CHANGE – You will have to work for a different residential agency or use the self-directed option. NO CHANGE– Home Visits have been suspended due to the Covid-19 Pandemic and will not resume again until it is safe.

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		5. We rely on our current agency to coordinate services and stay within budget. When we had split agencies providing services it was a nightmare. The left hand did not know what the right hand was doing most of the time. Yearly we state on the DD-2 what agency we want services from. We have done that for as long as I can remember. If a consumer/parent/guardian state on that form they want services all from the same agency could that not be considered waive their right to get SC services separate from other direct services? It is ironic that the Federal government would be concerned about conflicts of interest for the IDD population and not their conflicts of interest. If some agencies have been abusing this, they should pay the penalty not the consumers. You have ways of tracking and monitoring this.	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This cannot be waived and must be implemented.
		6. REDACTED needs consistent and streamlined services. Changing the titles of CM and SC, QMRP's and BSP's is only causing confusion and added paperwork.	NO CHANGE – The title of Qualified Mental Retardation Specialist (QMRP) was removed 15 years ago.
		7. We are formally requesting a waiver or exception for REDACTED to continue to have her SC services through REDACTED. and direct care also from that same agency.	NO CHANGE – The only exceptions are geographical or cultural. You may check with your Case Manager and see if the member qualifies for either.
		8. REDACTED's yearly Kepro assessment is REDACTED and her yearly IPP is REDACTED. We must have an answer to #7 above by the REDACTED date so we can make plans for her next years services. We have been told that we have to decide by that	

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		date. We cannot jeopardize REDACTED's health or our health to meet and select a new SC or direct care staff. 9. We rely on DHHR and CMS to advocate for the people they serve in this state to the Federal government so they can have better and more services and options instead of less. 10. This past year has been the most challenging year of all the 35 years REDACTED has had IDD Waiver and these changes have just added to it.	NO CHANGE – The member must choose a separate SC agency and a separate Residential agency by 4/1/2021 or the member's anchor date. NO CHANGE – CMS is the federal government and funds this program, and BMS follows their rules and regulations. NO CHANGE – 2020 has been a challenging year.
26	10/11/2020	I would like to suggest that please let us keep one company who is serving our son. We are very happy with services provided by XXX. Having to choose multiple company and dealing with multiple company isn't very easy. We would prefer to keep one company XXXX for our son's title-19 services. They treat us very nicely. They are very helpful. So please let don't make us choose different companies for different reasons. Thank you so much.	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This cannot be waived and must be implemented.
27	10/15/2020	Throughout document under provider qualifications - The employee's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks which are checked initially every 3 years and the OIG which is checked monthly.	CHANGE – This has been changed to 5 years.

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		Replace with checked every 5 years Under every therapy service - Dietary, OT, PT, ST - If a person is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member. The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Person-Centered or Home-Based Person-Centered Support and In-Home or Out-of-Home Respite and Non-Medical Transportation. How will BMS ask for billing of services and what reporting criteria will be required monthly. Also need to track number of events or units and age of member. Who will verify vendor licensing and credentialing? PDGS List of Requirements How will RC/SB provide answers to the list of requirements. Also state UMC must pre-approve – should be clear that UMC approves the units and dollar amount while PPL approves the specific item or service. PDGS The Personal Options Vendor will only pay for work performed by a vendor that has a Business License and/or relevant skills for work to be performed.	NO CHANGE – Authorizations sent to PPL based on the member's spending plan will be tracked by what is billed monthly. PPL will verify the vendor licensing and credentials and BMS will verify through annual reviews. NO CHANGE – BMS ultimately approves the item/service being purchased.

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		"relevant skills" is vague and open to interpretation. Clarify language on "Personal Options" vendor
		
		• PDGS This service is used only after all other non-family funding sources have been exhausted.
		  ○ Who will verify this? Additional clarification needed – will the participant/family have to show other resources were attempted?
		
		• Personal Options Program Representative - Minor children under the age of 18 through their parent or legal representative must appoint a "Program Representative" to assist with the responsibilities of self-directing their services. The Program Representative cannot be the person's legal guardian. Adults without a legal guardian may choose to appoint a Program Representative to assist them.
		  ○ Current program allows the non-billing parent to act as the Program Representative. Will BMS plan to "grandfather" in any participants that do not have the capacity to act as the employer and allow the participant to continue to self-direct? Will BMS plan to inform participants going forward of this requirement?
		
		• Appendix E - monitor quality through monthly telephone contact and face-to-face contact with members at least every six months
		  ○ Personal Options IDD does not require face to face 6-month visits. Is the intention to re-instate 6-month visits for PPL Resource Consultants?
		
		• The dietary therapist may attend and participate in IDT meetings and the annual assessment of functioning...
			NO CHANGE – BMS ultimately approves the item/service being purchased.
			
			NO CHANGE – BMS ultimately approves the item/service being purchased.
			
			NO CHANGE - This item was not changed and is not open for public comment.
			
			CHANGE - This item has been updated to remove the face-to-face

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		○ If dietary therapist can attend and participate in IDT-who is responsible for credentialing records of DT RC or CM agency? • EAA ○ Will we only receive EAA referral after all funding sources are exhausted? Who will verify this and then submit EAA request and confirm this adaptation to the home has been completed?	contact by PPL Resource Consultants. NO CHANGE – The Traditional Provider verifies the credentials for their employees and PPL verifies credentials for the therapist chosen by the self-directing member. NO CHANGE – This service is to be used only after determining funding is not available through State Plan Medicaid (durable medical equipment, EPSDT, etc.), private insurance, or local/community charity groups.
28	10/15/2020	Our Case Management agency opened in 2019 based on the requirement of conflict free Case Management and the need for our services in the Eastern Panhandle. As you are aware, as a stand- alone agency, we only provide one service and do not have any other source of revenue to rely upon. With the proposed reimbursement rate of $200 per month for Natural Family members and $250 for members in the ISS and Group Home settings, we have a great concern these rates would not sustain the stand-alone business financially. With the proposed changes to the manual, the Case Managers responsibilities are not lessening, it seems to be increasing. More training	NO CHANGE - The rate is an average of services billed in natural family homes and those billed in 24/7 ISS and group home settings.

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		and the potential for an increase in their case load due to the low reimbursement rate that is being proposed. The explanation is the rate was pulled from units utilized however, was it taken into consideration the turn over in Case Managers due to the demands placed upon them and the lack of billing in their first few months as it takes a few months for a Case Manager to get "up to speed" if they are new to this field or fresh out of college? What about the services provided that are not reimbursed such as when an individual member is on hold? Case Managers are expected to still provide certain services without being reimbursed such as submitting the DD-12. The idea of a flat rate removes the individualization from the individuals we serve and makes it a "One Size Fits All" which is not conducive to the services of a Case Manager. While the individual served is required to have specific services, sometimes these services take additional time to complete when you factor in translation for non-English speaking families, research, demanding guardians, details of an IPP, etc. We fear the quality of services provided to the individuals will suffer with a flat rate mentality as the Case Manager will no longer have the units to fall back on for any additional services that may be required of them for their case load to satisfy the demands of the program or a demanding guardian. Taking all of this into consideration, we feel a fair rate would be as follows: $226.33 monthly for Natural Family without attending the Workshop $242.50 monthly for Natural Family with Workshop $282.91 for ISS without attending Workshop $299.08 for ISS with Workshop	

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		We strongly recommend increasing the Case Management rate proposed if BMS wants Conflict Free Case Management services. We feel it is the only way for the stand-alone providers to succeed.	
29	10/15/2020	I wanted to take this opportunity to comment on the new waiver manual and the changes that are being proposed. As a fairly new case manager I am still learning this process and the rules regarding independent case management. I want to start off by saying that I understand the need for some of these changes and I personally admire the accountability that is trying to be upheld with the implementation of these new procedures. I understand, like all job positions, that there are individuals that try their best to manipulate the system and get justification for work that is simply not being done. I condone those who persisted that these changes be implemented to allow for increased accountability in those individuals. I take a great deal of pride in the quality of care that I give to each of my consumers, whether that be natural families or supported living, and I strive to ensure that the larger agencies working with my consumers are doing their part in providing that care as well. That is what this position is designed to do; ADVOCATE. We are supposed to provide advocacy for those who are not able to do it themselves. The position of Case Manager, requires an individual to be an educated professional to qualify. However, these qualified professionals are not getting paid a professional's salary. I have a Bachelor's Degree and a Master's Degree. With my 13 cases; 11 natural families and 2 Supported Living at the rates proposed will bring in a reimbursement of $54,000.00 annually. This would be a good salary and I understand that an increase in caseloads would obviously bring in more money, but this amount of	NO CHANGE - The rates are an average of services billed in natural family homes and those billed in 24/7 ISS and group home settings.

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		money is before the agency takes out their percentage. The company I work for takes a 50% reimbursement rate to help keep the business running. This is a lower reimbursement percentage then the majority of the bigger business agencies in the area. This is a small business agency and they need this money to cover all of their business expenses. After taking that rate out I would be bringing home a pay of $27,000.00 annually before the taxes, mal-practice insurance costs, trainings, vehicle costs, travel expenses to consumer's homes, gas, etc. The amount allocated per family and/or supported living case is not taking in all of the considerations of the job position in my opinion. The travel alone to some of these locations can get very costly. I realize that some of the times to these locations will only be monthly, but there are additional KEPRO assessments, annuals, and 180-day meetings plus the home visits which consider a large amount of travel. The majority of the supported living cases require quarterly meetings also. Some of our families are out of county, so I personally am looking at 50 minutes to these homes one way. What incentive is there for me to continue in this line of work? What compensation is there for obtaining a higher education degree? As a substitute teacher, which is what I did before starting this position, the bring home pay was approximately $115.00 a day without the constant stress and large amount of paperwork that comes with this position. That is more in one day than what is brought in for an entire month of service and travel with a natural family. I personally decided to enter this line of work because of the flexibility it allows for my family and the opportunity to help bring a higher quality of life for those with special needs. This position is not designed to make an outrageous salary, and I am fine with that, but I do feel like it needs to be worth the time that case managers	

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		take away from their own personal families. Like I said before, I realize that the number of cases would need to be increased to make more money, and my personal case load is not very large, but the no cap on caseloads in my opinion is doomed for failure. This system is set up so individuals will inevitably be drastically increasing the quantity of cases they carry, but they will be sacrificing the quality of care. Who gets hurt here? The consumers! The exact ones we as case managers are supposed to be providing advocacy for. I've been in this position for a year and I have witnessed first-hand the apathy for these supported living individuals, and now case managers' loads are going to be so large to make more money that these individuals will not get all of the care they deserve. These pay rates leave no room for motivation and will make the quality of care decrease. The majority of people will inevitably have larger caseloads to make more money but the quality of care for people will decrease. I personally am not an advocate for that. I try to give the best level of service that I can provide and I feel like these changes are personally penalizing me. Thank you for your time.	
30	10/15/2020	While I see the benefits of CFCM and agree with the reasoning behind it, I have a problem with the implementation of it without exceptions to the rule, as there are always exceptions to the rule. There is in no way you can say that member's rights are not being violated and their freedom of choice not being taken when you are disallowing them to keep their current case manager because that case manager works for the same provider that provides their residential. Unfortunately, it is not only violating the member's rights, but it is violating Case Manager's rights as well and yes, we do have rights. I, for example, took my job in the fall	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). It cannot be waived and must be implemented.

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		of 2017, not knowing anything about Conflict Free Case Management because I was new to Service Coordination in its entirety. I was a stay at home mom and then worked in the school system, but I had never worked for waiver or in any other SC capacities. Now, three years later, when I am finally getting into my stride and I know my consumers well, I know their families well, I am learning what they want in life, it is null and void essentially. I now am being told they don't have a choice and I don't have a choice; they need to be transferred somewhere else for case management or residential, even if they don't want to. I have had conversations with all my members and their guardians; I have sat in countless meetings with them discussing CFCM and that they will have to choose a new case manager and they all look at me and say, "We don't want a new Case Manager; we want to keep you." I then have to look them in the face and say, "Sorry, that isn't an option, unless you want to switch residential services." They don't want to switch those services either because they have relationships with their staff members; those staff members are now their friends. Some members and families have long standing relationships with their case managers; they have been in their lives for 10 plus years. These members are happy with their services they are currently being provided with. We work in the behavioral health field, any BSP or psychologist in their right mind would speak to the validity and importance of consistency with our members. Consistent people in their life that care about them is a game changer in this field of work; it sets the canvas for success. I would like to know the answer, without being redirected to a sentence in a manual or a code laid forth in some book, because all that tells me is that you don't know the answer, to how our members have freedom of choice when they can't choose to	

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		keep their current service coordinator/case manager? I think agencies, families, and members deserve an answer to that. What you are essentially saying is that they have the freedom to keep me as their case manager, I just have to go work somewhere else, well now you have violated my right to choose. I took this job because it is a Christian ran company; I chose this place of employment because it lines up with my values. I should have the right to choose which case management provider I want to work for, as should any case manager or any other staff member that provides services in the I/DD Waiver program. That aside, when you ask staff to leave their place of employment so a consumer can keep them on their team, you are asking these staff members to surrender any vacation pay they have saved up and earned, you are asking them to surrender their pay rate, as they may not start out at the same rate they are currently earning when they start at a new place; you are basically telling them they have to start over somewhere new if they want to continue to work with this individual in the waiver program. Some professional staff members have built up retirement and have insurance through their current company that they may not receive as an option if put into a situation where they have to choose to work for a different case management company in order to keep their existing and long standing working relationships with their members. This mandate is putting case managers in an awfully unbelievable and impossible situation when we have a member saying they want to keep us and their family is saying they want to keep us, but the only way is if we move jobs. We are trying to advocate for them and give them their freedom of choice but our hands are tied.	

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		The same goes for if they want to keep residential; this mandate requires case management and residential services to be provided by different agencies, but if an individual currently receives all services from the same agency, you are forcing their hand to make an impossible decision if they are happy with their services. So, if they choose to keep our company for case management then they need to find a new provider for residential. What if they are happy with their staff? Their staff is forced to go work for another company? Then all my concerns about benefits and vacation pay and pay rate come into play again. What if there are residents that live in the same home as roommates and one guardian wants to keep the company for residential services and one wants to keep the company for case management? What do you do then when their freedom of choice goes against Waiver policy because members in homes can't have residential services provided by different companies? Will you once again violate their rights or will there be an "exception?" You can't possibly mandate where they live and who they live with when the whole point of this program is to pursue independence and community integration for these members. Once again, there are always exceptions to the rule. In every document I have read while researching this regulation and researching other states that have already transitioned to this, I keep reading the words, 'possible conflict', because of possible conflicts. There is always going to be a possibility for conflicts of interest no matter what guidelines you put in place. There are indeed exceptions to the rule and there need to be concessions made for those circumstances. One option laid out in the Colorado implementation plan was that an agency can provide both case management and direct services to the same individual, as long as there is a robust, informed consent, opt-out option. I am unsure	

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		of the response to this option, but I am sure it was shot down; but I would like to know why it was shut down. Why is this not an option? Please understand that I do realize there have been issues with companies pushing their services on consumers or this would not even be a discussion; I am in total agreement that that is unacceptable. But to make a blanket generalization that all companies are the same because of another company's mistake is wrong. It feels as if you are saying to the directors of the companies that because no one has integrity or the moral character to make the right decision and do the right thing when it comes to freedom of choice, we are going to slap your wrist and remove the problem all together. I can assure you, like stated earlier, you will never remove the possibility of conflict completely and I think it would be a better solution to put in a system of accountability from an outside source that could hold companies accountability for ethically communicating to all their members that they are free to leave their company at any time. It offends me personally because I have sat in countless meetings where I have communicated to my members and their guardians their right to leave and choose another agency, whether that be for residential or case management. I am not just talking about in meetings where other members of the agency are present; I am talking about private conversations I have had with them to ensure their member is taken care of. I can show you countless documentation where I have encouraged members to look into other residential services that may suit them better and fit with their needs better; I have encouraged that in case management as well, which is also documented, where I have encouraged them to consider another case manager that could provide for	

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		them better. My boss has always been aware of these conversations and encouraged them! Her heart has always been about meeting the member's needs and providing the best care for them even if that means transitioning them to another company. The idea that no one is capable of that integrity is absurd and offensive. I don't know what it would look like to have an outside body hold the agencies accountable and protect the consumer's freedom of choice but I'm sure it can be done. There can be phone calls made to these guardians and members from someone other than the case manager to make sure they are aware of their rights to choose any agency at any time (maybe someone from KEPRO or BMS themselves). Maybe the exception would be that there has to be at least one service on the team provided by another agency so there is at least one voice outside of that agency, in case of any conflict, that could provide advocation as well. Maybe the answer would be to require any member that has both residential services and case management provided by same company to have an advocate on the team as well. I believe there are effective ways around this without telling consumers who they can't have, which is essentially what CFCM is suggesting when they can't maintain their current providers they are happy with otherwise. I understand all of this has probably been laid before you and all of this has been heard by other states who have been practicing CFCM for years now, so I don't foresee any change as a result of these comments, but I do thank you for hearing our hearts and giving us a chance to express our opinions and frustrations. It would be way easier to do this job if feelings weren't involved and our hearts didn't end	

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		up connecting to our families in a professional capacity. I truly do want what is best for them. Another issue I have with the amendments is the rate reimbursement. This is not going to work for many companies to pay their case managers a fair and competitive salary. Most case managers do way more than the minimum laid out in the waiver manual, as they should if they are really trying to provide the best quality of life for their members. To lump all members together as needing the same amount of time, care, and attention is foreign to me and unrealistic. I have some members that can get by with the current minimum of 240 units (which is what these new rates are basically based on), but then I have a couple members that require way more time and attention than that, one of which is a natural family, which brings into question the discrepancy between the natural family rates and the ISS rates. In a perfect world with ideal situations, those rates would be sufficient and the discrepancy would make sense. But this is not a perfect world and if you would look at these cases individually, you would see that. I have a consumer that I burn through 500-600 units a year on and he is natural family. You may ask how is that possible? Well he is natural family because he lives in his own home and does not require 24/7 care. His mom went into a nursing home 2 and a half years ago and hasn't returned home and there is no foreseeable date for her returning home. His mom and him are both limited guardian and had no desire to move him to an ISS that required 24 hour supervision. He provides his own natural support for himself, but that means he relies heavily on me and his BSP to intervene on his behalf. We are very much involved in every detail of his life as he needs this support and guidance	

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		and has built a trust with us, which isn't something he dishes out willingly to just anyone. We had to earn that trust. That being said, because I help him with essentially everything he needs to get accomplished and he has no other natural supports to help him, I burn through a lot of units. The $200 reimbursement rate will not cover his needs. I guess our level of care is supposed to go down in order to stay within the 240 unit zone which almost equals the 200 dollar a month reimbursement rate. Not to mention, to make a decent living, we will need to take on quite a heavy case load and when the amount of people you take on goes up, there is no arguing that their level of care will go down. In a perfect world, with perfect staff, involved and caring guardians who are also advocating and don't just think it's the case managers job alone, a conducive team who are all working diligently to provide the level of care members deserve, and a cooperative member who never goes into crisis because rate reimbursement won't allow for the extra hours that are required in a crisis, this plan might work. Anyone would agree that those dynamics are not going to all line up seamlessly and effortlessly ever. There are too many moving pieces and changing dynamics and unique situations in this program to slap a flat rate on case management as every individual's needs differ and as they should! We are not cookie cutter agencies and these are not cookie cutter individuals. Not to mention, CFCM will throw a wrench in the dynamic of a conducive team working diligently and seamlessly together as we have seen this dynamic already implode as we transitioned a member to another residential provider and I was his Service Coordinator. In a perfect world, everyone would do their job. Program managers, RN's, BSP's would call back or email back and the case manager would have open lines of communication, but that was not	NO CHANGE - The two rates are an average of services billed in natural family homes and those billed in 24/7 ISS and group home settings.

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		our experience as we made countless attempts of trying to acquire required documentation, get the status of staffing for a member, and ensure care was being properly implemented. I was doing work the agency should have been doing just to make sure that the member was taken care of. Communication between teams is not always as easy as it sounds, depending on what agency you are working with. Case management actually will become more demanding with CFCM in place as we will be working diligently to juggle multiple teams and keep lines of communication open which will mean more hours put into the job for each individual. Those rates also don't even begin to cover mileage. I live in Beckley, WV and travel to Summersville, Craigsville, Oak Hill, Fayetteville, and at one point in time was traveling to Lewisburg. Obviously, in order for me to make a decent salary, I will need to take on more consumers and who knows where they will live. These rates can't possibly compensate for the travel and if you work for a company that can't provide mileage, we are putting mileage on our cars and essentially not getting paid for it. Most companies can't afford to provide a company car for all of their case managers and, as you probably know, business mileage can no longer be written off on taxes unless you are considered self-employed as of two years ago, so this will be a loss as well for case managers who are trying to make a decent living. My last point of concern, and I do apologize for how lengthy this is, is a question regarding stakeholders. I would like to know if there is a legislator on the stakeholders team. I'm sure there is, but if not, there definitely needs to be a legislator on the stakeholder team. Once again, thank you for listening to my concerns and giving us the opportunity to	

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		express our opinions. I'm sorry this was so long, but I didn't know how else to thoroughly express my concerns without laying out some details pertinent to this amendment. Thank you for taking the time to read this.	NO CHANGE – We were not able to find a legislator to participate on the CFCM team.
31	10/15/2020	As is usual with government regulatory agencies,instead of punishing offending providers, they change rules. Does that remind anyone of re -arranging chairs on the TITANIC????? When I showed the changes to several family members who are also social workers, , They were stunned!!! What a waste of money and time spent building relationships with other resources . REMEMBER THE TITANIC !!!!!!	NO CHANGE – Commenter was not clear on specifics.
32	10/15/20	My name is REDACTED. I deal with East Ridge Health in Martinsburg WV for assistance with my Autistic son. Please do not force me to deal with three agencies regarding my sons Title 19 assistance. Kepro and East Ridge are doing a great job. East Ridge has been wonderful with the financial paperwork and their workers work well with my son. Currently two agencies works great. Please do not force services from East Ridge to be divided. They are serving the community exceptional well. Thank you	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). It cannot be waived and must be implemented.
33	10/15/2020	I have worked in the Waiver filed for the last 6 years. One thing I've learned is change in Waiver is inevitable. Some of the changes I have experienced have been positive changes and some have negatively affected the clients I serve. It is my professional opinion the changes purposed by CMS to mandate Conflict Free Case Management will negatively affect the Waiver Participants. I think this is the exact opposite	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). It cannot be waived and must be implemented.

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		of Freedom of Choice. I understand the reason CMS would like to implement this requirement to prevent focus being on the agency financial gain and keep the best interest on the participant. I believe this situation has accrued but as the exception not the rule. I believe the clients interest is usually top priority. My experience is based in a very large agency with most Interdisciplinary Teams consisting of professionals from several entities such as DHHR, WV Advocate, Personal Care, natural supports that are Guardians and HCS's. In my opinion with the abundance of protection this adds it ensures the Participants needs and rights are being considered and that one agency is not benefiting or being considered a priority above participant needs. As I mentioned I work for a large agency serving over one hundred clients which less than 3% have a single agency influence only. I am asking CMS and BMS to consider requiring outside entities to be on every IDT to ensure appropriate intentions. We are supposed to provide client specific service and work as a team to do so. When you take a trusted team member from these clients it is a rights restriction, it is extremely detrimental to all parties involved. I do not believe it should be mandatory that the Case Manger not be affiliated with any other services , but to continue to be the Participants choice for the member and their IDT. Secondly, I would like to make a commit on the monthly fee for Case Management. I am not opposed to the monthly fee I think it will allow for more focus on the service being provided and less time spent writing notes for the services provided. I do oppose the rate its self. Again coming from a large agency we provide services for an equal amount of clients in an ISS setting and those in a Natural Family setting. It is in my experience	NO CHANGE - The rates are an average of services billed in natural family homes and those billed in 24/7 ISS and group home settings

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		the ISS clients require closer to $350 a month to provide all the services necessary. With so many Families choosing to drop BSP's from the IDT to keep their current Case Manager results in additional work for the Case Manager. The maladaptive behaviors still need to be addressed, resources explored, adaptive equipment researched to suite the client's needs. I believe the rate for a Natural family will require no less than $250 a month. Thank you for taking time to read my opinion and I hope you consider the points I've made.	
34	10/15/2020	Regarding on-line case management training to be developed by BMS, we would like to ask for clarification if this will be required prior to January 1, 2021, for existing case managers, and if this will be added as an annual required training, as the current conflict-free service coordination. There are several references to using a fingerprint-based check at a three-year interval – will this replace the current five-year requirement, and will there be an extension granted to have these completed for existing employees who are in-between intervals? The policy for the minimum duties of a case manager include verifying financial eligibility during monthly home visits. Currently, service coordinators call a toll-free number to determine this, recording a tracking number to verify completion. As WV has several rural areas where mobile telephone reception is poor or non-existent, is the interpretation of "during" the visit to be viewed literally? Also in the case manager description is noted that they are to "monitor that service providers implement the instruction, behavioral, and service objectives in the IPP." This appears to overlap with services performed, in	NO CHANGE - The training will be available prior to the 4/1/2021 implementation date. CHANGE – This error has been corrected. NO CHANGE – This item was open for public comment, but a change will be made to "prior to or during a monthly home visit" in policy.

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		some areas, of the behavior support professional. Can this be clarified that the monitoring is to communicate concerns, or how the case manager is to alert and rectify if providers are found to have not followed the objectives of the IPP?	NO CHANGE – This item was not open for public comment.
		Within the case manager duties section regarding meeting every other month with the person at their facility-based day or prevocational programs is language that the purpose includes determining a transition out of a facility within two year time limits. This specification is not located within the services for day programs/prevocational services, and has previously been determined to not be required by CMS. We ask that this time-limit on day program/prevocational services be removed. The services are invaluable to members who may not ever fully transition to community settings from a day program, but benefit in stability of routines and predictability of support offered by these facilities.	CHANGE – The 2-year time limit for prevocational services has been removed.
		The case manager section also stated that the case managers will be able to bill for services performed to assist an individual transition out of an ICF/IID facility or institution for mental disease on day one of these new services. During the opening of slots to clear the waitlist, agencies providing these case management services have not recouped billing, as this is not clearly noted in the current manual. Will there be retroactive billing available for agencies/providers who can clearly document what services have already been performed?	NO CHANGE – BMS was not able to implement this change at this time but will review again with future amendments.
		Through monthly and quarterly provider calls, the institution of Electronic Visit Verification (EVV) has been said to be applicable to residential agency staff only when providing transportation services to members, but the current direct care language in this application states that the EVV rules will be applied to these staff. We request that this clarification on when EVV is to be used added to round-the-clock services language.	

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		The proposed rate structures for years one through five include incremental increases for many services, yet case management is to remain at one set fee structure throughout the period. In the original case management unit rate proposed in March 2020, case management rates for family and agency were proposed at $200/month and $250/month per member, respectively, with incremental increases per member each year at approximately $4 and $5 each. The new application has no incremental increases for case management during the five-year period. It also has a proposed decrease of three cents per unit on the currently utilized purchasing system. In a state where case managers in much of the state will regularly spend an average of more than two hours of travel to and from visits and meetings for members, this continues to place an undue hardship on agencies to find, train, and retain qualified personnel. The agency requests the previously proposed incremental increases be placed into this application, and that no decrease in the current unit rate to serve members throughout this transition. Additionally, the agency requests clarification on how the transition will be timed, as the rollover to a new purchasing model in the middle of member budget years will be very difficult to calculate to ensure services are within a members allocated budget.	CHANGE – This was an error and has been changed. NO CHANGE - That draft was withdrawn and BMS is not accepting comments on an application that was withdrawn. The two rates are an average of services billed in natural family homes and those billed in 24/7 ISS and group home settings.
35	10/15/2020	Thank you for the opportunity to comment on the proposed changes. I want to briefly give you some information on my background. My daughter, REDACTED is 30 years old and was diagnosed with autism at age 4. At that time autism was not easily recognized. In fact, there was no autism program in REDACTED County at that time. Myself and another mother advocated for and was successful in starting the autism program in REDACTED County. I hope my comments will be helpful in your decision-making process.	

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		I have concerns about the proposed changes. I believe that the change to the unlimited case load is not a good decision. It is impossible for the case manager to offer the same level of care to their clients, when they will need to increase of number of clients to generate the same income. There are only 24 hours in a day and that means sacrifices will need to be made by the client. Next, I want to address your concerns about the possible conflict because the case manager and the Day-Hab are under the same employment. I feel that every client should be able to choose the best Day-Hab and case manager for them, even if they are under the same employment. In addition to this, I believe that the anxiety placed on the client should be of great concern. These clients, including my daughter do not adjust to change well. I cannot imagine the potential emotional stress they may experience. Changes in their day center, direct care, nursing, job coaches, friends. I am very new to the waiver program, so I am sure there are even more changes that I am not aware of. I cannot stress how profound these changes can affect their well-being. I know personally how change in their life can be overwhelming. Please consider how very important this is. If you feel very strongly about the potential conflict, then at least, consider grandfathering the current clients. I hope you will consider my comments.	NC - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). It cannot be waived and must be implemented.
36	10/14/2020	1. Application page 2: Added four new self-directed extended professional services: Physical Therapy, Occupational Therapy, Speech Therapy and Dietary Therapy. Comments: a. What is the purpose of offering these as self-directed services? The application specifies the monetary equivalent cannot be rolled over into any other service. b. How does this work?	NO CHANGE – These codes have been added to assist with CFCM. Partnerships, LLC (PPL) will manage those. The family will have both a case manager and a resource consultant to assist them.

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		c. The application later notes the therapy providers will need to have CPR/FA cards on file. This is not currently a requirement. Is this a typo or a new rule? d. The application also states fingerprints will be checked. This is not currently a requirement. Typo or new rule? Just curious as to the rationale. 2. Application page 2: Added two new self-directed services - Environmental Accessibility Adaptation Home and Environmental Accessibility Adaptation Vehicle. Comments: a. Purpose of adding this as a self-directed service? b. The SC agency does not take a "cut" and will probably have to greatly assist with the paperwork anyway (similar to Goods & Services). It seems the prior request to make EAA and G&S accessible to all participants resulted in making EAA a self-directed service (which seems to serve no function), while G&S stays with "self-directed" services. Again, just curious as to the rationale. 3. Application page 33: The chart indicates 5964 unduplicated participants for each of the 5 years of the manual. However, page 6 states, "The objective is to provide needed services to individuals with intellectual and/or developmental disabilities and to increase enrollment capacity in a systematic manner in order to reduce waiting lists for these services." Is there no plan to add additional slots during the 5-year period for the manual? Or does this mean new slots will only be released when a current slot is no longer used (due to opting off the program, death, etc.)?	NO CHANGE – Most of the new codes added are the self-directed codes and Public Partnerships, LLC (PPL) will manage those. The family will have both a case manager and a resource consultant to assist them. CMS would not allow Vehicle and Home Modifications under Participant Directed Goods and Services. NO CHANGE – This item was not open for public comment, but at this time, there are no plans to open up additional slots.

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		4. Application page 54: The Case Manager must, at a minimum, perform the following activities listed below: • Assist the person who receives services and/or legal representative with re-determination of financial eligibility as required at the DHHR office in the county where the person who receives services lives. • Verify financial eligibility during monthly home visits. Comments: Assisting someone in a 24-hour residential setting when a family member is not involved is understandable. Generally, if a family member is involved it is unnecessary and sometimes impossible due to the disconnect between DHHR and agencies. This may just stand out to me as the majority of people we work with are in a natural family setting. Why is it necessary to verify financial eligibility monthly? If it is for the benefit of the agency, it is an unnecessary step. If a member is not financially eligible, claims stop being paid, so that is a good indicator the individual is not financially eligible. I'm just not sure why this is required. It seems like busywork, particularly when the form identified in the current manual has been deemed non-existent and every county DHHR sends whatever form they choose as an indicator of financial eligibility. If this serves a purpose, there has to be a better way.	NO CHANGE – This item was not open for public comment. Case managers assist with ensuring co
		5. Application page 56: Agency must have either a current WV Behavioral Health License issued by the WVDHHR Office of Health Facility Licensure and Certification (OHFLAC) or a certification as a Case Management Agency by the Bureau for Medical Services. Comments: I disagree with the requirement. Everyone providing case management should be required to have a behavioral health license, or no one should be required to have a behavioral health license for that service. Will OHFLAC continue to review service coordination/case management services as part of their reviews of an agency with a	NO CHANGE – BMS appreciates the comment. OHFLAC cannot license an agency that only provides case management services, thus, BMS created the certification process to expand

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		behavioral health license? I think this is aimed more toward the providers of 24-hour residential settings. Historically, OHFLAC has tried to apply these guidelines to natural family settings though it does not work well. Disclaimer: I have not yet had an OHFLAC review with the most current OHFLAC administration and revised regulations. The application references OHFLAC throughout, as well as asserting the importance of the case management service. As such, it seems conflicting for a case management only agency not to be required to have a behavioral health license if that has been determined to be a standard of quality. Additionally, Appendix H (p 224) states, "The primary means of monitoring the quality of IDDW services is through provider reviews conducted by the Office of Health Facility Licensing and Certification (OHFLAC) and the UMC." 6. Application page 56: Case management services must be provided by an individual fully licensed (this does not include provisional or temporary license) in West Virginia as a social worker, counselor or registered nurse or may be an individual with a four year degree (BA or BS) in a human service field and certification in the on-line case management training developed by BMS. Comment: Thank you for your consideration of not requiring case managers to have a social work license. It would be impossible to keep the positions filled. Some may remember having a social work license was a requirement for a service coordinator in the late 90s, and for whatever reason, that was eliminated, yet 20 years later, it is being revisited. The social work board does not seem to be in favor of providing leeway with provisional licensing, though it seems Adult Protective Services overrides that somehow. How will this work for those already employed? For new hires, I would recommend not making this required at the start of employment. Rationale: From a quality perspective, new hires have a lot	case management only agencies which are truly independent. NO CHANGE – BMS appreciates the comment. All Case Managers who are Licensed Social Workers, Licensed Professional Counselor or Registered Nurses will be grand-fathered in. Other Case Managers

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		thrown at them. It would be best to get some limited experience (3 months) and then complete the certification. From a business standpoint, it is annoying (and costly) to pay people to attend orientation for them to not be heard from again once the new hire paperwork/training is over. 7. Application page 56: Agency behavioral health license is verified biennially by the Office of Health Agency staff's credentials are verified initially and annually with exception of the state and federal fingerprint-based checks which are checked every 3 years and the OIG which is checked monthly. Comments: Is this a typo? Every 3 years for fingerprints? 3 years is noted in different sections of the application. 8. Application page 85: Goods & Services List Comment: Thank you for providing a more comprehensive list of items that are not allowed. 9. Application page 105: The maximum annual units of Family PCS services for an adult over age 18 living in a natural family/Specialized Family Care home setting cannot exceed 11,680 15-minute units per IPP year. This is in combination with the following direct support services: All other PCS services, LPN, Crisis Intervention and Electronic Monitoring. All direct care services cannot exceed an average of 12 hours/day on days when Facility-Based Day Habilitation, Job Development, Pre-Vocational, and/or Supported Employment services are provided. Comment: How loosely are you defining “average?” \\	currently employed can become certified through the on-line case management system. CHANGE – This error has been corrected. NO CHANGE – BMS appreciates the comment.

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		10. Application page 175: Notes that PPL "links with all mandatory reporting systems." Comment: Depending on the resource coordinator, PPL is still often resistant to completing incident reports, so this often falls to the service coordinator to complete since it is mandatory. Except for PPL. 11. Page 191: Discusses incident reports. Comments: I don't know if the application is the place for it. More likely the policy manual. Policy will need to specifically outline whose responsibility it is to complete an incident report if WV is to maintain compliance with federal requirements. It is currently challenging when multiple providers are involved, and I anticipate this will only continue as CFCM is rolled out. I don't think this can be left to an interagency agreement. As noted in my previous comment, there are issues with PPL and incident reporting. Additionally, this section of the application states that all providers of IDDW services need to have a behavioral health license, which contradicts other sections of the application. This section discusses the function of the IDDW agency as it relates to OHFLAC and incident reporting. So, is a case management only agency an IDDW agency? Will they have to report, investigate, etc. when an incident occurs? What is their relationship with OHFLAC if they are not required to have e behavioral health license? Are there repercussions for not following guidelines, provided they are required to do so? For failing to follow regulations, I face a potential loss of license or receipt of a provisional license, etc. It sounds as if a case management only agency doesn't have to obtain the license, follow the guidelines, complete the OHFLAC review, etc. I am curious as to how this works.	NO CHANGE – 12 hours is 12 hours. CHANGE – For members that receive services through the Traditional Service Option, the agency(s) delivering services to the member will be responsible for reporting incidents to the IMS. For members that receive services through the Personal Options Service Option, the assigned Resource Consultant will be responsible for reporting incidents to the IMS. Prior to conducting the member's monthly home visit, the Case Manager will contact the Service Agency and/or Resource Consultant to determine if incidents have been reported since the previous monthly home visit. During the monthly home visit, the Case Manager will review the incident(s) with the member/legal representative and determine if the incident(s) require changes to the member's service plan. Critical

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		12. Application page 245. Appendix J: It appears there will be two new service codes for SC (case management). One for natural family and one for residential. For year 1, the table lists an average of 6 units (events) per code. Shouldn't it be 12 (one per month)? I do see there are regular units listed also, so this appears to be why the events were decreased to 6. I am curious as to how this was calculated. Also, are there typos in some o the other tables? It appears that "15 minutes" should be an event in some cases. The rate for service coordination is listed incorrectly in at least one of the tables. (I'd say this is because the format of this application is hard to follow). I'm trying to determine where the $200/$250 rates came from. For most natural family settings, I think that is accurate, except in the case of a crisis. I will say we have recently seen a noticeable increase in calls related to PPL, with families wanting us (as SC) to follow up with PPL on their behalf as opposed to self-directing, which seems to defeat the purpose. I know the response is likely the person is not ready to self-direct and should look at traditional. That is not usually a feasible answer as most people need to "self-direct" so they can maximize their budget. For residential settings: those usually require a lot more work, in part due to the CFCM requirement. We have gotten a taste of how this will work with the new slots, as well as some residential cases due to reported issues with another provider. On the one hand, I can appreciate the need for CFCM. Regardless, it still requires a lot more steps (TIME) to complete	Incidents, particularly those pertaining to a crisis or reports of alleged abuse, neglect or exploitation of the member are to be reported to the Case Manager by the service agency and Resource Consultant within 24 hours of the agency/Resource Consultant being made aware of the critical incident. CHANGE – This has been changed to 3 events as this application is effective 4/1/2021 and only 3 months are left in the fiscal year. The rest of the year from July 2020 to March 2021 will be billed at the old 15 minute rate. NO CHANGE - The two rates are an average of services billed in natural family homes and those

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		something than if all services were in house. I don't have a lot of cases to see what our prior averages would be with this, but it still seems the $250 is more of a break-even amount. 13. If service coordination/case management will be an event code, what will the documentation look like if payment is tied to the home visit? I understand the importance of documentation but hope simplifying it will be considered, particularly if caseloads will have no limit. I have completed case management via other programs before and I really like the idea of an ongoing monthly entry system.	billed in 24/7 ISS and group home settings. NC -The Case Manager will be required to use EVV and must check in and out at the home visit. That will trigger the monthly code to be paid through the claims payer system.
37	10/14/2020	I have been in many Assessments and none of them have went over this information in a fashion that actually provides decent information to families. Usually this lands on the CM to relay to families instead of it coming from the UMC. Maybe there should be an extended training to SSF? Or maybe this should be more of a CM role as CFCM is implemented (billable time prior to services beginning for new IDDW slots or transfers). What is an example of an approved exception by BMS? This would be helpful as a baseline for CMs. For example, is an approved exception that there is only one provider in a specific WV county?	NO CHANGE – This section has not changed from the previous application and thus is not open for public comment. All comments submitted by this commenter were submitted twice, and as such are only addressed in this document once. NC – There can be a geographical exception (no other case management agency or residential agency in the area) or a cultural exception (Member requires a language interpreter and there is only one agency that has an interpreter available).

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		Assist with procurement of all services that are appropriate and necessary for each person who receives services within and beyond the scope of the IDDW program including annual medical and other evaluations as applicable to the person who receives services • An example of what this pertains to would be useful information for new CMs and/or those who do not keep current on policies.	NO CHANGE – This section has not changed from the previous application and thus is not open for public comment.
		Upload the ISP, the Demographic/cover sheet, and signature page into the UMC web portal within 14 calendar days of the IDT meeting. IDDW services will not be reviewed for authorization until the required documentation is attached in the UMC's web portal. • Why is this still in here? CMs are required to upload FULL IPPs to gain authorizations. This makes it seem as though only these 3 items are reviewed and/or needed.	CHANGE – Changed to "IPP".
		Comply with reporting requirements of the WV IMS for persons on their caseload • What is this going to look like with CFCM? Typically CMs only input IR into IMS that are directly related to the agency that the residential services are provided through. With CFCM, CMs will be inputting IR into IMS for individuals that gain all other services via a different agency. How will this be completed?	CHANGE – For members that receive services through the Traditional Service Option, the agency(s) delivering services to the member will be responsible for reporting incidents to the IMS. For members that receive services through the Personal Options Service Option, the assigned Resource Consultant will be responsible for reporting incidents to the IMS. Prior to conducting the member's monthly home visit, the Case Manager will contact the Service Agency and/or Resource Consultant to determine if incidents have been reported since the

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			previous monthly home visit. During the monthly home visit, the Case Manager will review the incident(s) with the member/legal representative and determine if the incident(s) require changes to the member's service plan. Critical Incidents, particularly those pertaining to a crisis or reports of alleged abuse, neglect or exploitation of the member are to be reported to the Case Manager by the service agency and Resource Consultant within 24 hours of the agency/Resource Consultant being made aware of the critical incident.
		Personally meet at least every other month with the person who receives services and their Direct Support Professionals at the Facility-Based Day or Prevocational program (if applicable). The purpose of these visits is to • I thought this 2 year time limit was lifted? From experience, not all CMs know the differences between the service delivery models, especially with high turnover rates. Maybe PPL or UMC could provide training or additional supports to CMs surrounding participant-directed services?	CHANGE – The 2-year time limit for prevocational services has been removed. This specific comment was submitted twice.

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		Present proposed restrictive measures to the IDDW provider agency's Human Rights Committee (HRC) if no other professional is presenting the same information. • Same idea applies here as IR. Does the CFCM attend other agencies HRC meetings to present information? Or does the CFCM add the discussion or restrictive measures to their agencies HRC meeting even though all that is provided there is CM? The case management activities completed prior to member's discharge from the facility may be billed on the first day of the member's return to the community when they are enrolled in the IDDW program. • This does not help CMs. CMs do all the work when it comes to linking with families, guardians, other agencies, UMC, PPL, BMS, and etc. CMs are responsible in making sure that these individuals have taken care of everything prior to becoming 'Active'. HOURS go into this process, especially those coming from ICF or hospital placements. This needs to all be billable time for CMs. If CMs did not do this, WHO WOULD? If CMs cannot bill for this time, then maybe this should be considered some other entities responsibility The maximum units of Transportation: Trips cannot exceed 2 one-way trips per day. • This has been debated for some time. One-way trip means from point A to point B. However, even in recent fair hearings, a trip has been described as ROUND trip - from point A to point B back to point A (there may be multiple stops in between - point C, D, and so on) but one trip is ROUND trip. However, this states a trip is 2 one-way trips per day. Clarification must be noted prior to finalizing this waiver.	NO CHANGE – Providers are expected to train staff in line with state and federal requirements. NO CHANGE – This item was not changed with this amendment. The case management agency will work collaboratively with the residential provider to ensure all providers are up to date on approved restrictive measures. NO CHANGE – BMS was not able to implement this change at this time but will review again with future amendments.

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		The primary mechanism for involving stakeholders in the Waiver's quality improvement initiative is the IDDW Quality Improvement Advisory (QIA) Council. The Council strives for a minimum of fifteen (15) members comprised of at least five (5) current or former program participants (or family/legal representatives), IDDW agency staff, advocates and other interested stakeholders. The Council serves as a forum for people and the public to raise program issues and concerns affecting the quality of IDDW services and to make recommendations to BMS. • I have been on the IDDW QIA Council since October 2019. Our quarterly meeting was today and REDACTED. We have never discussed policy or policy changes. Leadership comes from BMS rep, REDACTED, who engages conversations and requires group participation. Revision of who facilitates these meetings and what these are to be about should be considered. QIA Council could be an AMAZING contributor to the IDDW program, if given the time that it deserves and the attention it requires. The IDDW QIA is designed to: 1) Collect the data necessary to provide evidence that all CMS assurances and sub-assurances are consistently being met and 2) ensure the active involvement of stakeholders in the quality improvement process. The primary sources of discovery include provider reviews, incident management reports and people/legal representative complaints/grievances, administrative reports, oversight of delegated administrative functions, and stakeholder input. • Again, this is a brilliant concept! And much needed. But this is not what happens in these meetings. Information is presented. Maybe I'm missing something? The Council provides the UMC and BMS feedback and guidance regarding quality improvement initiatives. In partnership with the UMC and BMS, the Council reviews and analyzes data, identifies trends and	NO CHANGE – This item was not changed with this amendment. This language aligns with current policy as well. The provider agency may want to become a Non Emergency Medical Transportation (NEMT) provider to assist their members. NO CHANGE – This item was not changed with this amendment. The Quality Improvement Advisory Council is in place to advise BMS and is comprised of stakeholders that nominate and vote on leadership to facilitate the meetings for the duration of their term.

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		priorities, and develops the annual Quality Management Plan in which specific quality improvement goals and objectives are established. • We talked a lot about CFCM in 2019 and presented lots of ideas and plans - have not seen implementation of any of it. This rate will inadvertently increase CM caseloads; therefore, decreasing likelihood of valuable time placed into each individual who receives services. For instance, if one CM has even 30 people on his/her caseload that's 30 HVs/month. With this rate, caseloads will have to be over 30 unless agencies want to pay CMs next to nothing to work. CM is the ONLY service that is required on the IDDW program yet it gets the least support.	NO CHANGE – BMS appreciates the comment.
		Appendix J – BSP is listed at 11.22 per unit. • Every service in IDDW is getting increases (BSP is just an example) while CM suffers. Not sure how this benefits the individuals being served. Or increases health & safety factors since the CM is responsible for IR, HRC meetings, HVs, DHVs, IPPs, and all other services that relate to the health and safety of the individuals on IDDW program. Appendix J - Service Coordination G9002 U3 is listed as a 15 minute unit. • Is this a mistake? Appendix J - Skilled Nursing by a Licensed Practical Nurse T1003 U3 is listed at 11.47 per unit.	NO CHANGE - The two rates are an average of services billed in natural family homes and those billed in 24/7 ISS and group home settings. The case load limits have been removed in the new application. BMS will monitor the size of caseloads through retro reviews and advise the agency to decrease if it appears the caseloads are too large to handle the workload.

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		• Another example of increase in cost of other services besides CM. Doesn't make sense. Appendix J – Year 3 lists Service Coordination G9002 U3 as 15 minute unit. Appendix J – Year 4 indicates Skilled Nursing RN as 17.28 per event. • This must be a mistake. It's listed as 15 minute in all other years. Appendix J – Year 5 Service Coordination G9002 U3 is listed as a 15 minute unit. • I'm starting to think this is a sign LOL	NO CHANGE – Case management is not set for an increase at this time. NO CHANGE – This has been changed to 3 events as this application is effective 4/1/2021 and only 3 months are left in the fiscal year. The rest of the year from July 2020 to March 2021 will be billed at the old 15 minute rate. CHANGE – This has been removed. CHANGE – This has been changed to unit. CHANGE – This item has been removed.
38	10/14/2020	Please find the attached comments, concerns and suggestions concerning the proposed IDDW amendment for the Center for Service	

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		Coordination. We are a Conflict Free, Case Management only, provider for the Title XIX IDD Waiver program located in the Eastern Panhandle. The Center for Service Coordination was formed in 2019 with the understanding our program was introducing the conflict free component. Our intent was to develop an agency that would truly stand-alone while working with neighboring providers for those we serve. We have no desire to introduce additional services, only to provide quality Case Management. Although we fully support the concepts and direction our program is headed, we note genuine concern with the proposed reimbursement rate. It is questionable whether an agency that stands alone in Case Management delivery will be financially viable without sacrificing quality services. In review of the Amendment to the IDDW application. Reimbursement Rate Proposed Reimbursement Rate: $200 per month for members living in natural family and SFC settings and $250 per month for members living in ISS and Group Home settings Old Rate: 9.70 per unit Comment: During a policy clarification call it was noted the $200 or $250 rate was based off actual usage. That would be an annual equivalent of 247 units NF / 309 units ISS at the current 9.70 rate. Contributing factors that must be considered when basing off actual usage.	NO CHANGE - The rate is an average of services billed in natural family homes and those billed in 24/7 ISS and group home settings. BMS will monitor the size of caseloads through retro reviews and advise the agency to decrease if it appears the caseloads are too large to handle the workload.

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		• High turnover rates: o Good providers move on – top two reasons given 1. rate of pay, 2. billing demand. o the number one complaint from parents is turnover in Case Management. • Training Period o With the proper training and oversight, it takes approximately 3 months to acclimate a successful Case Manager to position responsibilities. o During the introductory period, productivity is low • A High percentage of new providers do not make it o The documentation component is the number one reason Case Managers fail. Solid Performer Service Coordinators that provide good services, captured most of their billing and know their clients utilized 280 units minimally for NF and 350 units minimally for ISS. I feel these numbers are conservative, but realistic. Translation: That would be a monthly equivalent of $226.33 for NF and $282.91 for ISS minimally. Concerns of the proposal: 1. The demands being placed on Case Managers continue to grow and the skill level necessary to successfully navigate the system requires a true professional. a. I see no relief of Case Management expectations in the proposal	

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		2. Compensation needs to support quality providers. The proposed rate would fall short, especially in the Eastern Panhandle where we compete with DC, VA, and MD. a) At the current proposal rate, it would require a caseload of 26-28 members in order to pay a quality provider an attractive rate. b) Since expectations have not lessened 26 members or above would place unrealistic demands on a provider. c) A reasonable full-time case load has always been and should always continue to be 17-20 members. 3. I am concerned demands of Registration Coordinators will increase. With no unit reimbursement for service provided, the demands could escalate quickly. Although most are legitimate, the corrections are often minor, easy to fix but time consuming due to the slow response times once corrections are submitted for review. 4. I am concerned about client equality of service. A demanding guardian can dominate a Case Managers attention with no defined cut off point. In the past we could lean on units approved. I have seen in the ICF setting where one guardian can dominate the providers attention to the point other members suffer. 5. The monthly-fee waters down the concept of person-centered supports. One-size-fits all should not be a waiver concept. 6. Providing services without restitution. Case Managers are required to provide services when a member is on hold without compensation. The actual job of a Case Manager is to provide guidance and aid the member in recovering from a situation.	

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		Suggestions 1. Case Managers complete a document (similar to the DD-9) which outlines the need for Case Management services. Based off that document a negotiated monthly rate per member could be sought. For instance, a member who lives in the natural family setting who attends a workshop requires more attention than one who attends middle school. The current proposal reimburses at the same flat rate. Or, if flat rates need to be maintained Increase the rate to a 280-unit equivalent for Natural Family no workshop: $226.33 monthly Increase the rate to a 300-unit equivalent for Natural Family with Workshop: $242.50 monthly Increase the rate to a 350-unit equivalent for ISS no workshop: $282.91 monthly. Increase the rate to a 370- unit equivalent for ISS with workshop: $299.08 monthly. Or, Keep the current pay for service method. It does not operate outside the conflict free model. 2. Place a true time limit on Kepro's required response time. As it stands, we are asked to be patient and understand they are working on it.	

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		3. When a member is placed on hold, the Case Management code should remain active throughout. With the proposed monthly rate system, possibly a reduced monthly fee. Conclusion: I would strongly recommend adjusting the Case Management rate. If waiver does not financially support stand-alone services, we will be left with large providers only. If we do not pay for skilled providers, we will retain none. We will continually hire, train, and watch talent move to neighboring programs. Thank you for any consideration given my words.	
39	10/15/2020	I do want to add to my comment that I do see the benefit of CFCM and I wish it had been implemented from the very beginning to not cause this chaos in the midst of the transitions, let alone in the midst of a pandemic that experts are saying will not be behind us until further into 2021. I think moving forward it is a policy that will protect consumers rights and I don't argue that. I do think the right thing to do with the new slots is to implement the CFCM. I didn't want my previous comment to come across that I am completely against it because I am not and I think it's a wise move for all consumers. I just would like to see some concessions made for the consumers that already have an agency providing both case management and residential services and are happy. I also am curious to know if there are any other states that have not come into compliance with CFCM. Thank you!	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). It cannot be waived and must be implemented. Most other states have come into compliance since this federal rule went into effect in 2014. WV was warned by CMS the last time we had a renewal in 2015 that we must implement CFCM in the 2020 renewal.

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40	10/15/2020	• Implementation of Conflict Free Case Management requirements in accordance with the Code of Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(l)(vi.). o While considered a "CMS mandate", ODI asserts this to be reversable. Not long ago, another "CMS mandate" to close/defund all Day Hab facilities and Sheltered Workshops was issued. As of 2020, this has not occurred nor will it occur as it was apparent through public outcry to discontinue this course. The option to have one agency provide some level of service and then another to provide others, is and always has been, an essential tenet of the ID/D Waiver program. WV has failed to enforce this fundamental provision by allowing some agencies to tell members/families "its all or nothing". Thus, coercing the consumer to believe they have no choice. The core belief behind self-advocacy is to encourage decision making; good or bad. Since the inception of WV's system of community support, the goal has been to expect and respect self-advocacy for those we serve. Person-Centered Support is just that, person centered. The seven guiding principles are: individuality, independence, privacy, partnership, choice, dignity, respect and rights. For those consumers who have chosen to receive dual services since the inception of the program, to now be forced to have another Case Manager is contrary to the philosophy of both Self Advocacy and Person-Centered Support.	NC - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This cannot be waived and must be implemented.

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		ODI strongly recommends those who are currently being served by the ID/D Waiver program be given the option, via a Grandfather clause, to maintain their chosen Case Manager even if it involves the same direct service agency. Only those who enter the program after Jan. 1, 2021 would be required to have split service provision. Although, ODI maintains this still limits choice, it would not render the devastating effect as some who have happily chosen consistent Case Management services for 30+ years.	NO CHANGE – There is the possibility of a geographic or cultural exception, but those are the only exceptions CMS will allow.
41	10/15/2020	I am responding to #2 of the Waiver changes. My husband & I became Specialized Care Providers in 1986. We got our first placement child, REDACTED, in 08/1986, a four year old girl with multiple physical and mental disabilities. As a Registered Nurse I felt capable in caring for her needs. She lived with us for 14 years! At age 18 she transferred to an ISS setting & lived another 3 years. 9 months after getting RS a 12 year old boy, REDACTED, was also placed in our home. He also had multiple physical and mental disabilities. He lived with us for 7 years and moved to another SCP home when home and career situation changed. But we continued to have him every other weekend in respite. During the first 4 years they had 6 different Case Managers! During that time, I made all of their multiple medical appointments and facilitated all of their school needs. Our last Case Manager was absolutely hands down the best. She was taking care of problems that would arise with either child. Mostly these problems were with regards to new wheel-chairs, special equipment needed, arrange RESPITE which we did not have for the first 2 years & made arrangements that both children could join us on a 6 week trip to the West Coast including a visit to Mexico & to Disney Land. It was a once in	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). It cannot be waived and must be implemented.

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		a lifetime vacation pulling a trailer and sharing it with RS & GC and our own 3 children. Once out foster children moved on, we continued to provide respite for other individuals for total of 26 years. Why am I telling you this? Because Families bought into the idea of Independent Case Management years ago. Families & Guardians could choose a Case Management Agency that they trusted and depended on to perform this important function. Now, Families are being told to suck it up & choose some other agency to do this important job when they already chose the Case Management Agency and are pleased with the services that they have now. I feel like we are regressing back to those early days where Case Management was hit or miss. Independent Case Management should mean just that: Independent whether the Case Management it is within the agency that also is now responsible for their living situation or not.	
42	10/14/2020	1. Implementation of Conflict Free Case Management requirements in accordance with the Code of Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(l)(vi.) A) I do not see where there would be a conflict between case management and the services the client would receive at the same agency. I see it as the complete opposite and think by having the case management and service at the same agency as a benefit. B) My family has always been with the same agency. Anytime we need any type of service, we have always been able to express this to the Service Coordinator (SC) and be directed or assisted with these services.	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi).It cannot be waived and must be implemented.

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		C) Collaboration between the SC and other services at the same agency will be more difficult by moving the case management to a totally different agency. D) By having a totally different agency doing the case management will be more difficult for clients/families who have worked with the same SC for years. The SC knows the clients/families and their needs. Why change something that is working? E) Some clients do not do well with change. By having a totally different agency doing the case management, will disrupt the clients' world. F) By having a totally different agency doing the case management is going to make accessing files and information for the SC more difficult and not as readily available. G) The current SC keeps abreast with the Utilization Report and services are adjusted if needed. By having a totally different agency, this is not going to be kept current and may possibly make the client's budget not be utilized appropriately. 2. Added to the criteria for a case manager's credentials to include a 4-year degree in a human service field with certification from on-line case management training developed by the Bureau for Medical Services. I agree that this is a good change. 3. Changed case management billing to a monthly fee rather than a 15 minute unit.	NO CHANGE – BMS appreciates the comment.

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		I agree that this a good change. The 15 minute units seemed more confusing to calculate.	NO CHANGE – BMS appreciates the comment.
		4. Changed title of "Service Coordination" service to "Case Management". Okay with this change.	NO CHANGE – BMS appreciates the comment.
		5. Implementation of Electronic Visit Verification (EVV) in accordance with the 21st Century CURES Act. The state will be in compliance by Jan. 1, 2021. unless there is a federal mandate extending that date. No comment.	NO CHANGE – BMS appreciates the comment.
		6. Added service of Home-Based Person-Centered Supports Personal Options to identify employees that do not live in the member's home. No comment.	NO CHANGE – BMS appreciates the comment.
		7. Added a modifier to the Transportation Personal Options service to identify employees that do not live in the member's home. No comment.	NO CHANGE – BMS appreciates the comment.
		8. Added four new self-directed extended professional services: Physical Therapy, Occupational Therapy, Speech Therapy and Dietary Therapy. No comment.	NO CHANGE – BMS appreciates the comment.

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		9. Added two new self-directed services - Environmental Accessibility Adaptation Home and Environmental Accessibility Adaptation Vehicle. No comment.	NO CHANGE – BMS appreciates the comment.
43	10/15/2020	1. Utilization is required to be included in the plan, however with PPL services, the resource consultant can only give us the dollar amount spent rather than units used. Part of this problem is because they can reallocate money for different services. This is not reflected in the plan anywhere. If funds purchased for miles are reallocated to PCS services through personal options, this does not show in the plan and it looks like they are using miles since that is what was purchased. 2. BSPs are required to travel to complete behavior assessments, hands on training with staff in the person's home, and sometimes to attend meetings. Travel time should be billable for these required services. In turn, BSPs should also be able to bill for more services completed over the phone than only crisis response. 3. PPL services are allocated each month and if the services are not used, they are not able to be rolled over to the next month. They should be able to be carried from month to month, or at least a portion of them, to remain person centered regarding each person's individual needs. This is how it is set up with traditional waiver. 4. It would be beneficial to have two separate codes for LPN direct and indirect to keep track of utilization and tracking the need for direct LPN particularly. 5. LPNs should be giving medications rather than AMAPs for the safety of the people we serve.	NO CHANGE – This section was not changed and thus is not open for public comment. NO CHANGE – This section was not changed and thus is not open for public comment. NO CHANGE – This section was not changed and thus this item was not open for public comment. NO CHANGE – This section was not changed and thus this item was not open for public comment. NO CHANGE – This item was not open for public comment.

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		6. On page 152 in Appendix D-1 it is checked that the responsibility for service plan development is the case manager. On page 153 Appendix D-1 b in service plan development safeguards that Entities and/or individuals that have responsibility for service plan development MAY provide other direct wavier services to the participant, but in the specifications for this is says states that all case management provided will be conflict free. This happens again on page 160 Appendix D-2 b. Not sure if this is a typo or if reading it wrong.	CHANGE – Appendix D-1 b has been updated.
		7. IPPs are to be reviewed annually and at least every 180 days. This would be better to state the months since if the Annual meeting is on January 3rd then the 6-month meeting would be due by July 1st. Then the next Annual would be due December 28th rather than January when it is due. Since there are 5 extra days in each year and 6 in a leap year, the 180 days rule pushes the start dates back each time. Even if the Annual would be held late in the month, the 180-day rule is not appropriate as there are 365 days in a year instead of 360.	NO CHANGE – This section was not changed and thus this item was not open for public comment.
		8. BSPs are unable to bill for phone calls to staff. They are also unable to bill for travel. This seems very contradictive because it limits the ability to contact individual/staff, assess behaviors, monitor effectiveness of programing and implementation of programing, provide support during behavior incidents, etc.	NO CHANGE – This section was not changed and thus this item was not open for public comment.
		9. Credentialing opportunities for BSPs is VERY limited. The class is not offered routinely, which limits the ability to hire new BSPs if/when necessary.	NO CHANGE – This section was not changed and thus this item was not open for public comment.

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		10. The draft states LPN services are available for individuals 21 or older. What happens if an individual chose to leave home/school at age 18 to reside in an ISS or attend a day program?	NO CHANGE – This section was not changed and thus this item was not open for public comment.
		11. "The state will not continue to support 1:1 staffing based solely on personal preference due to cost constraints. Individuals will be given time to transition to other settings. Allowances will be made for members who can substantiate the need for 1:1 service." How is this person centered? How does it support independent living for the individuals?	NO CHANGE – This section was not changed and thus this item was not open for public comment.
		12. What services will be available to an individual who needs additional prevocational training after 2 years before entering job development or supported employment?	CHANGE – The 2-year time limit for prevocational services has been removed.
		13. The draft states individuals enrolled in the public-school system do not have access to prevocational services. How does this support normalization?	NO CHANGE – This section was not changed and thus this item was not open for public comment.
		14. The draft manual states" transportation to/from job sites may be included in supported employment services when other forms of transportation are unavailable or inaccessible." What if this is not the most person-centered approach?	NO CHANGE – This section was not changed and thus this item was not open for public comment.
		15. What additional training do DSPs providing Supported Employment require? The Draft manual states, "must have documented training in addition to the standard training requirements if they don't have experience in the implementation of supported employment plans of instruction."	NO CHANGE – This section was not changed and thus this item was not open for public comment.

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		16. The manual states it will not allow for direct care billing in the hospital setting. This is not person-centered as we find most hospitals are reluctant to care for our Individuals and are not equipped to assist them with their basic needs due to their I/DD diagnosis. 17. Reimbursement for SC services ($200 Natural Family, $250 ISS) would be better suited at a ($250 Natural Family, $300 ISS) rates. These higher rates will allow for a better person-centered approach for the Individuals. The fear is some SC agencies will provide a bare minimum service instead of a holistic service truly serving the needs of the I/DD waiver community. 18. The manual refers to a licensed dietician and Registered Dietician but WV uses Registered Dietician only.	NO CHANGE – The section was not changed and thus this item is not open for public comment at this time. NO CHANGE - The rate is an average of services billed in natural family homes and those billed in 24/7 ISS and group home settings. NO CHANGE – This section has not changed from the previous application and thus is not open for public comment.
44	10/15/2020	My name is REDACTED and I am on SS Disability. While I can only make so much a month, it would be great to get the pay periods within the month itself. Having us get paid on the 15th and 30th of every month instead of having some of the pay from the last month into the current month. This would be easier to take care of the monies within the month and keep track of it for the SS department. Thank you for your time.	NO CHANGE – This section was not changed and thus this item is not open for public comment.
45	10/15/2020	I wanted to speak to the new amendment being proposed for IDDW. As a SC for IDDW, I am more than a little concerned about the removal of the cap of how many participants I can serve. This in conjunction with the flat rate for natural setting and iss setting look like they will likely significantly increase our caseloads. Increasing caseloads will decrease the quality of	NO CHANGE - The rate is an average of services billed in natural family homes and those billed in 24/7 ISS and group home settings.

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		service we are able to provide. I also imagine, per some the the provider call QA's that address increased doc requests, that increased caseloads would increase provider errors due to sheer volume of work. This would create a greater back log for kepro, increase people getting out of compliance, etc. As for the the flat rate, I understand the thought. But I don't think the amount will suffice for many clients. I for one have a number of PRS that go to FDBH but live in natural family settings. These participants require monthly hv's as well as bi-monthly dayhab visits, and quite a bit of additional work that some of the other clients (including those in ISS) require. Please reconsider these things in this amendment for the well-being of everyone in the waiver program. Thank you for you time and consideration in this matter.	
46	10/15/2020	I would like to have consideration provided to the case management fee for services. Currently our agency covers 8 counties as allowed by the program, however we only provide services in 4 at this time but am a newer agency and growing. If transportation is not considered, I will be removing a couple of counties from my coverage due to they are too remote from my agency and would cost too much time to travel for meetings and visits. When services are a flat rate for service, case management agencies are going to be more reluctant to travel outside of their base county to provide services. This will ultimately reduce the choice of providers in some	NO CHANGE - The rate is an average of services billed in natural family homes and those billed in 24/7 ISS and group home settings.

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		counties. I know the smaller more remote counties often already have limited service providers. We have cases that can take 50 minutes to reach the home to do a visit at this time, so that is almost two hours of time just in travel alone. The more travel involved in the case the more it will reduce the pay for the service coordination if a lot of service is needed as well. I have recently also accepted 4 cases in Wyoming County, which are all natural families but also attend day habilitation which require a day visit. These cases will require more travel time. Finally, please consider the amount of work it takes for us to get other provider agencies to do the right things and provide us with the appropriate documentation. We have be handed so much more responsibility as case managers, but it feels like we are not valued.	
47	10/13/2020	Disability Rights of West Virginia (DRWV) is the federally mandated protection and advocacy (P&A) system for the state of West Virginia. As the P&A, DRWV has a heightened interest in all settings in which individuals with disabilities receive services, including settings where individuals receive home and community-based services. DRWV has reviewed the proposed amendments to Application for the Intellectual Developmental Disabilities Waiver and submits the following comments. Purpose of Amendment (page 2): "*Changed case management billing to a monthly fee rather than a 15 minute unit.*" There is a concern that the quality of case management services will be decrease for the member by moving to a per member/per month rate. There is a concern that the case management agency	NO CHANGE – BMS appreciates the comment. Kepro and BMS will monitor the Case Manager's performance and performance issues will be addressed with the Case Management agency.

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		will bill the monthly rate without providing the individualized services that the member needs. Appendix C: Participant Services C-1/C-3: Service Specification/Other Service (page 92): "*The maximum annual units of Crisis Intervention Services cannot exceed 1,344 15-minute units (336 hours) per individual's IPP year. A unit is one hour.*" Please clarify if a unit is 15-minutes or 1 hour for Crisis Intervention services. Appendix G: Participant Safeguards Appendix G-1: Response to Critical Events or Incidents: (page 192) "*Any incident involving a person utilizing IDDW services must be reported to the UMC by entering the incident into the WVIMS within 24 hours of learning of the incident.*"; (page 196) "*Providers are expected to follow guidelines in reporting incidents into the IMS within 48 hours of detection.*" DRWV requests that the timeframe on page 196 be changed to adhere to the designated 24-hour requirement. In the current IDD Waiver Manual, on page 27, it outlines that the Service Coordination provider must notify the UMC whenever a Service Coordinator's caseload exceeds 30 individuals. DRWV is concerned that the Application no longer indicates there is a cap on the number of clients a Case Manager can have on their	CHANGE – A unit is 15 minutes and language has been updated. CHANGE – Language has been updated to reflect the 24-hour requirement. NO CHANGE - The case load limits have been removed in the new application. BMS will monitor the size of caseloads through retro reviews and advise the agency to decrease if it appears the caseloads are too large to handle the workload.

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		caseload. There is a concern that this change will decrease the individualized services that clients need. Thank you for considering DRWV's comments.	
48	09/25/2020	The people at Healthways are wonderful.	NO CHANGE – BMS appreciates the comment.
49	09/29/2020	I am against the reduction in mileage.	NO CHANGE – This item was not open for public comment and was not changed with this amendment.
50	09/30/2020	Conflict Free Management Initially I would like to state that we feel that forcing individuals and their families to separate services goes against Families choice. Our State has already implemented this conflict free by sharing consumers with other Providers- Case management and Service, PPL and recognizing choice for the others. Other state representatives have used this format to reflect the Federal mandate and we should consider it too. If we really want to reflect choice. Case Management Reference pages 54-55 includes the minimum list of Case Management duties. As one can see this extensive list contains required duties that vary in their roles and responsibilities. Community based and ISS consumers' needs are based on the individual needs therefore	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). It cannot be waived and must be implemented. This comment was submitted twice. NO CHANGE - The rate is an average of services billed in natural family homes and those billed in 24/7 ISS and group home settings. This comment was submitted twice.

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		designating a fee based on where they live is not reflective of the services that may be provided and reimbursed at one rate. $200 for Natural Families and $250. for ISS consumers is not always reflective of the work that is provided. It is our concern that the quality of services will be affected and those less responsible agencies will provide lower quality services. We feel the PMPM is easier to plan, lessens documentation requirements but the rate is not enough to cover the expense and some agencies will need to discontinue this service hurting our consumers and their families. Case Manager Home visit requirements continue to be monthly for all consumers. We feel these are necessary for Health and Safety. If the rate is not changed then we need to evaluate other cost effective options such as the teams need to be able to decide the need for monthly or other designation(Quarterly) based on the consumer need in a family or SFC setting. If health and safety issues are noted and of a concern or other face to face needs identified, monthly visits will be provided and mandated. If there are no issues or concerns, then the team may designate based on need.	

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		This will assist in covering costs and the meeting the rate coverage of natural Families and SFC setting. All ISS consumers will have monthly visits. Case Management Agency Requirements of Case manager- must have a degree in social science field—Have excluded- or years of experience in the field. Would like to have this included again. Also stated on-line training required but not specified what this will include as well as length of training. No statement of Grandfathering in for those with many years' experience or licensure. Case Manager There is no mention of lifting the Case load numbers above 30. Case management programs will never be able to meet the financial costs of services, staffing and other expenses if the caseloads remain 30 and under. However, the cost of providing these services may result in increasing the caseloads so high that the quality will be effected.	NO CHANGE – All Case Managers who are Licensed Social Workers, Licensed Professional Counselor or Registered Nurses will be grand-fathered in. Other Case Managers currently employed can become certified through the on-line case management system. This comment was submitted twice. NO CHANGE - The two rates are an average of services billed in natural family homes and those billed in 24/7 ISS and group home settings.

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		Dietary, SLP, PT and OT Adding these codes to Personal options is a concern for us in that coordinating one or all of these options will add to some family's feelings of being overwhelmed in their ability to self-direct. Would Families be able to use this budgeted Services/PPL – to switch over to services to respite and miles. It does not clarify this information. If not with PPL, these services need to be clarified as to who is responsible a Service Provider or a Case Managers agency- to be a pass through agency? We feel the CM agency should not be responsible.	NO CHANGE – These codes have been added so as to allow self-direction and conflict free services. The member who is self-directing will have a Case Manager and a Resource Consultant to assist them in the process. This comment was submitted twice.
		Individual Budgets The budget methodology pushes families to PPL and limits their choice. Historically, with the decrease in the budgets, families have chosen PPL to ensure their accessing more dollars to come their way. This has decreased their accessing support and training options for the consumers, the development of habilitation plans and community involvement. This has changed the program significantly and our consumers are sometimes suffering when they are not accessing BSP, Supported employment, RN and other necessary options. Choice is driven by budget.	NO CHANGE – This item was not open for public comment. This comment was submitted twice.

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		Exception Process The exception process is lengthy and somewhat inconsistent in what is approved as well as the required documentation. Also if the exception is approved one year, why does the next year's budget not include the previous years approved amount. Why does the exception process each year especially since the Case Manager rate is so limiting?	NO CHANGE – This item was not open for public comment. This comment was submitted twice.
		EAA – PPL Just add the EAA- Vehicle and Home adaptions services to the Goods and Services list.	NO CHANGE - CMS would not Vehicle and Home Modifications under Participant Directed Goods and Services. This comment was submitted twice.
		Staff Review A 100% review of all staff is excessive especially for large agencies.	NO CHANGE – This item was not open for public comment. This comment was submitted twice.
		Waiver Year 1,2,3,4,5 SC/CM's have not had a rate increase in many years. Most of the state's programs have reported to BMS and DHHR that we have been experiencing a loss in the provision of these services. The new PMPM	NO CHANGE - The two rates are an average of services billed in

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		rate of $200 and $250. does not speak to this need and after much review we find that it keeps us at the rate of previous reimbursement. If PMPM begins across the board in January and subsequent Conflict Free Case management results in the required transitioning of consumers to another provider for Case management, the services needed to cover the transition—7-day meeting, 30-day meeting and other transition requirements exceed this rate. As well as the need to get to know them throughout the reminder months.	natural family homes and those billed in 24/7 ISS and group home settings. This comment was submitted twice.
		There is no explanation how the PMPM is paid. Does it come out of the consumer's budget or off the top? If so this lessens choices.	NO CHANGE – The two rates are an average of services billed in natural family homes and those billed in 24/7 ISS and group home settings. This comment was submitted twice.
		It is our concern that the required duties that reflect quality of care may not be offered to meet the costs from some programs and it is our concern that the consumers will be affected. In order to provide effective quality services by quality staff we will need to have a better PMPM rate.	NO CHANGE – PPL is paid through an administrative fee and does not come out of the member's budget at all. This comment was submitted twice.
		This rate should also include a yearly cost of living or growth rate.	NO CHANGE - The rate is an average of services billed in natural family homes and those billed in

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			24/7 ISS and group home settings. BMS appreciates the comment. This comment was submitted twice.
51	10/08/2020	We have been informed that changes have to be made concerning how services can be obtained for Developmentally Disabled individuals on WV Waiver . While I understand the reasoning that a conflict of interest could potentially occur with some situations, we feel this change is very detrimental to a situation such as ours. We obtain services for a severely disabled nonverbal child that requires time and history to understand the needs and the best way to work with issues that arise. We have a team in place that not only works for the greatest benefit or outcome from using carefully coordinated communication but all staff and services providers are highly trained and communicate constantly to share problems/needs for this child. It takes lots of time to gain experience with what works and what does not for areas that affect his progress. Consistency is of utmost importance and it is a great hardship to have to start all over to build relationships and trust for a child on the autism spectrum who also suffers from apraxia and sensory processing disorder. We need someone who understands his unique issues and who is familiar with his environment in the world and in his academic setting. Forcing us to choose services from different agencies causes great hardship and difficulty in understanding what each service is providing and/or lacking. We would respectfully ask you to reconsider the decision and allow us to obtain services that best benefit our child and not further impede his development. It is a difficult life so we ask that you please do not make it more complicated and	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). It cannot be waived and must be implemented.

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		cumbersome. If you have questions or need further information, I would be more than happy to discuss anything with you.	
52	10/08/2020	I would like to ask that you don't lower the amount of 1:1 ratio of care. My daughter requires 100% total care in eating, toileting, getting out of bed, getting in bed, even covering herself with a blanket. I think when you have a 1:2 ratio during the day, one of the clients gets overlooked with their needs. Plus staff cannot even go out for groceries with a 1:2. They become basically home bound at that point.	NO CHANGE – This section has not changed from the previous application and thus is not open for public comment.
53	10/09/2020	I have comments as a professional staff with an IDDW agency who actively shares case management with other agencies. Who will be responsible if/when a case manager with an outside agency (or an independent case manager) fails to complete assigned tasks on behalf of an IDDW member?	NO CHANGE - Kepro and BMS will monitor the Case Manager's performance regarding the timely request for annual service authorizations based upon the members' anchor dates. Performance issues will be addressed with the Case Management agency. Service providers are also to notify Kepro if they experience problems with obtaining service authorizations or modifications of authorizations.
54	10/12/2020	CONCERN LISTED FIRST: In Appendix J-2-d (estimate factor) it reflects that the current Service Coordinator unit rate is only used during the first (or current fiscal year) year implementation budget. Does this mean that the SC to Case Management transition will be completed during the period December	NO CHANGE – This is to close out the Service Coordinator/Case Management units code.

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		2020 to June 2021, rather than during the previously stated period between December 2020 and December 2021, at each individual's anchor date? CROSS SECTIONAL ISSUES: Page 54, bullet 17 states, {CM} Will uploads the ISP, Demogrphic/cover sheet and signature page into the UMC web portal …. While on page 159 the upload designates the IPP to be uploaded. Page 193, Block 1, paragraph 5 states, Each provider … required to be licensed Behavior Health Center …. (should this specify the exception for CM only providers) Page 246, Estimate Factor, waiver year 1. It looks like the participant numbers and associated costs for FBDH and Pre-Voc have been switched (when compared to the following budget years). GENERAL COMMENTS: Page 9, section E; I believe that there may need to be a further description of what "willing and qualified to furnish waiver services …." How far may a member have to travel to access a service is only one actual provider is available in their immediate geographic area. (in a few counties there may be more than one provider, but due to roads one provide is in the actual area and other providers are more than 30 – 45 minutes away. This could cause over an hour of travel time if an agency requires the member attend IDT meeting in person in the "office".	CHANGE – Language updated - IPP is required to be uploaded. CHANGE – Language added to address case management only agencies. CHANGE – This error has been corrected. NO CHANGE – Geographical exceptions may be granted.

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		Page 58, box 2 states the maximum annual units of FBDH cannot exceed 6240 units/1560 hours …. and on Page 68, box 1 state the maximum annual units of Pre-Voc cannot exceed 6240 units/1560 hours – does this imply that if FBDH and Pre-Voc are used during the same day that the individual may receive more than a total of 6 hours average a day since it does not state for either service that the 6240 units/1560 hours annually are not used in combination together during any day? The way it is currently left, more than six hours per day could be used just to provide FBDH and Pre-Voc.	CHANGE – Language has been updated to include "in combination".
		Page 68, box 1 states, "People may access this service for up to two years before transitioning to Job Development or Supported Employment services. This is an issue that may negatively affect those with more severe disabilities or those with more aggressive, anti-social behaviors. I believe that a transition should be expected if using Pre-Voc, but do not think that a general time period should be provided for a program that promotes person centered planning in developing supports.	CHANGE – The 2-year time limit for prevocational services has been removed.
		Page 70, block 2 states Supported Employment cannot exceed … (average 8 hours/weekday) …. Once again this reflects that a person with disabilities may not or should not work weekend hours, which is becoming more prevalent than not. I believe it should state, "average 8 hours/day up to 5 days per week".	CHANGE – This was not open for public comment, but BMS agrees to this revision of language.
		Page 74, boxes 4 & 6. The way it is stated, the <u>Dietician cannot be a contracted staff</u>, both places only state, "Agency staff …." Also, in previous versions, it is always stated, "If the dietician is not agency staff, but is contracted by the IDDW provider to provide services in their	NO CHANGE – Under the self-direction option, the extended professional staff is not contracted but is either paid directly or through

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		specialty and is also enrolled as a WV Medicaid provider, either individually or as part of a group, then the Dietician only need to be licensed to practice in the State of WV." Will this stipulation still be part of the Manual? Page 77, box 4 leaves out the words "or contracted" for OT service. Also, in previous versions, it is always stated, "If the OT is not agency staff, but is contracted by the IDDW provider to provide services in their specialty and is also enrolled as a WV Medicaid provider, either individually or as part of a group, then the Dietician only need to be licensed to practice in the State of WV." Will this stipulation still be part of the Manual? Page 79, box 4 leaves out the words "or contracted" for PT service. Also, in previous versions, it is always stated, "If the PT is not agency staff, but is contracted by the IDDW provider to provide services in their specialty and is also enrolled as a WV Medicaid provider, either individually or as part of a group, then the Dietician only need to be licensed to practice in the State of WV." Will this stipulation still be part of the Manual?	their employer and must be an enrolled Medicaid provider and licensed in the state of WV. NO CHANGE – Under the self-direction option, the extended professional staff is not contracted but is either paid directly or through their employer and must be an enrolled Medicaid provider and licensed in the state of WV. NO CHANGE – Under the self-direction option, the extended professional staff is not contracted but is either paid directly or through their employer and must be an enrolled Medicaid provider and licensed in the state of WV.

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		Page 82, box 2 leaves out the words "or contracted" for Speech service. Also, in previous versions, it is always stated, "If the Speech Therapist is not agency staff, but is contracted by the IDDW provider to provide services in their specialty and is also enrolled as a WV Medicaid provider, either individually or as part of a group, then the Dietician only need to be licensed to practice in the State of WV." Will this stipulation still be part of the Manual? The reason these items are confusing is that in the term "contracted" appears in some places for one type of service but not consistent for all of the extended services. Page 113, General comment for transportation. Since most transportation is already used with another service which must be subject to EVV, is there a reason to have to validate travel support services? Page 126, General comment for 1:1 approval above 12 hours/day is that I hope the program does not begin to force individuals to move from local communities just to satisfy state budgetary issues in the provision of services.	NO CHANGE – Under the self-direction option, the extended professional staff is not contracted but is either paid directly or through their employer and must be an enrolled Medicaid provider and licensed in the state of WV. CHANGE – EVV was removed from the transportation code. NO CHANGE – Individuals living in 1:1 settings normally are approved for 24 hours of 1:1 services unless they can be unsupervised for short time periods. Providers may submit a Direct Services Support Living Arrangement Assessment to request more than 12 hours of 1:1 service for those residing with roommates.

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		Page 154, General comment for CM exceptions only being for geographical or cultural. Will a definitive definition or specific guide be provided to further assist the consistency of implementing exceptions only based on “geographical or cultural’ issues. Page 184. Statement. I believe that the State has overinflated the availability of independent advocacy available to participants. Although there are agencies who can provide the service, each one does not guarantee the availability of advocacy support if the participants issue does not meet the agencies’ screening protocol(s). These agencies’ protocols do not always reflect, through their denial, a participant’s need for assistive advocacy.	NO CHANGE – The stakeholder group determined that a cultural and geographical exception may be granted by BMS. These will be further defined in the policy manual. NO CHANGE – BMS appreciates the comments.
55	10/14/2020	I reviewed the changes to this application. I was curious why ALL services increase each year except for Service Coordination. Every single service goes up except for SC each year. BMS required the SC to do WAAAAAY more than what used to be required. We are required to follow on all budgets, addendums, IPP’s, exceptions, DSSLA’s, home visits, day hab visits and link and refer to all resources such as family support application, PPL PDG&S to name a few that have their own processes. Don’t forget about notes for EVERY service including 3 min phone calls and talking with Kepro and team members to get the 8th addendum you have put in for a budget to get denied because the zip code of the waiver member is wrong on careconnection. There is NO way that SC/CM can do a meaningful job with them requiring more and cutting our rates. Plus it is not what we	NO CHANGE – Conflict Free Case Management (CFCM) is being implemented due to the Code of Federal Regulations (CFR) (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This requirement cannot be waived and must be implemented. The two rates are an average of services billed in natural family homes and those billed in 24/7 ISS and group home settings.

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		agreed to when Pat presented it. This is going to cause agencies to shut down because they cannot afford to provide the service. Why does BSP professional service go up every year and nursing but not the SC. The SC and BSP have similar degrees and most SC's can do BSP work if they have attended yet another special training that is required by Kepro at the expense of the agency. SC's are required to have BA/BS plus they need to have BMS training (new requirement) of some kind. Waiver requires more work for less money, costing the agencies that provide Waiver to take a loss every day. Our rates are Not comparable to states around us. Our minimum wage is lower than all states around us. Waiver has been inundated with regulations. Because of all these ridiculous regulations, and rules like filing an exceptions within a time frame or if you have an ipp late because the guardian can't attend, causing agiencies to miss out on residential services because Kepro will not approve those units, knowing the individual have been living with us for 20 years. Again, taking money from the agencies that provide a service. Having to do exceptions for 2-3 years in a row. That is a waste of time and money. SC has to bill but if we did not have to do the same thing every year that money could be spent of other needs. It is obvious that the individual needs the same amount year to year or close to it, yet the SC has to do more paperwork for the same request. We should be allowed to have what was given (thru exceptions) the following year, unless things	

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		have changed. More often than not, that is the case so SC's are doing the same work, year after year. We have gone from APS allowing all the budgets to be approved and not doing their fiscal duty to not being able to barely provide services for members unless a budget is already approved. The members have suffered because of this. If a zip code is wrong, they will not approve a budget. What does a zip code have to do with a budget anyway? We are waiting on budgets to be approved for months. You can't run a business that way. It does an injustice to our members. But if an SC is late with paperwork, you cut the individuals services and pro-rate everything. You say you want SC to have a life-long meaningful relationship with member then make them switch to other agencies that don't know them. And BMS/CMS REFUSE to see that Conflict-Free CM is not viable alone. The rates will NOT support SC-putting all agencies that provide the service at risk of being unable to provide this service. This will leave us with just the big agencies to provide all services and according to CMS that cannot happen without special permission. What do we do when there is no longer an SC agency within several counties because that is where this is going.	
56	10/14/2020	To Whom It May Concern: My daughter, REDACTED, has been with Solutions since she was 3 years old. She is now 15. We originally had REDACTED as an agency and they were most definitely not a good fit for her and all of her needs.	NO CHANGE - CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi).

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		When we chose Solutions, they made sure we knew what our options & rights were & still do, and also all of our questions have been answered and continue to be answered, whether they have to research the answer and get back to us or know the answers immediately! REDACTED actually, enjoys & looks forward to seeing/talking to her Solutions team, every month! For the State to take away her options, her choices, is NOT FAIR!!! She is completely comfortable with her Team at Solutions.... ALL OF THEM!!! To take that away from her and have her start over, again, will cause undue stress and behavioral issues, which is totally unacceptable! Please read that last paragraph again.... Taking away an individual's rights is WRONG! Especially an individual with different abilities!	
57	10/14/2020	We had had the same pay rate for public partnerships for about 15 yrs 9.88 is not enough to retain and keep staff this places members who are in a one person ISS setting at risk of an institutionalization. People get paid more working at sheetz or McDonald's. Why is wv becoming a managed care state this has proven to be problematic in other states.	NO CHANGE – BMS appreciates the comments. NO CHANGE – The Intellectual and Developmental Disabilities Waiver is not a program under Managed Care.

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		Deemed medically frail means this means to me that you're going to discriminate against people with mental illness this isn't right nor should it be legal.	NO CHANGE – BMS appreciates the comment.
		You are saying that you will promote healthy lifestyles who are you to tell people how to eat healthy food costs more.	NO CHANGE – BMS appreciates the comment.
		Where you are saying medical services should be necessary an associated documentation must be maintained I do not think that you have to know everything about my medical appointments.	
		Why do you get to choose our doctors. This is wrong	NO CHANGE – BMS does not choose doctors.
		EVV monitoring is wrong and barbaric you are treating us that since we have a disability like we are a caged animal.	NO CHANGE – EVV is a federal requirement and must be implemented.
		Whose idea was it to give us wellness education?	NO CHANGE – BMS appreciates the comment.
		Logisticare has not worked well in this state and what makes you think mountain health promise will?	NO CHANGE – BMS appreciates the comment.
		You listen to parents most of them should not get paid for taking care of their children adults with no natural supports should be given a higher priority.; taking into consideration that most of them have no natural supports. The current system allows them to be put on the wait list or die.	NO CHANGE – BMS appreciates the comment. BMS reimburses services provided by a WV Medicaid enrolled vendor/practitioner.
		We should be able to go out of state for doctors appointments One person is settings should be paid at 13 dollars an hour through public partnerships.	

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58	10/15/2020	1. The conflict free case management is not fair to consumers or their families. Most consumers and families have worked with their service coordinators for years and have not had any issues. If issues do arise, the families and members know that they can go to administration for assistance. You are taking away the right for a consumer or family member to choose who they feel would best represent and advocate for them or their loved ones. There is such a breakdown in communication when the service coordinator is with a different agency. They typically do not follow up on medicaid reviews, SNAP reviews, HUD reviews, etc. This is typically done by the residential provider because they want to ensure that they can continue to provide services. I have also personally had issues with different Service Coordinators at other agencies that refused to submit modifications even though it would allow them to obtain more SC units. We've had issues where they didn't submit at all and units had to be billed down because it was out of time frame even though they were submitted to the SC weeks before budget ending. 2. If conflict free case management does begin, then the agency that provides Service Coordination should be able to provide therapies as long as the therapy company is not owned by the SC agency. Most agencies contract with outside agencies to provide these services. 3. Service Coordination needs to be paid by the units billed. Billing a per diem per month is not fair especially when you have consumers that require more time at the current rate then would be reimbursed during a month if switched to a per diem.	NO CHANGE – BMS appreciates the comments. CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). NO CHANGE – BMS appreciates the comments. CFCM is being implemented due to Federal Regulations (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). NO CHANGE - The two rates are an average of services billed in natural family homes and those

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		4. If you switch therapies to be under self-directed, who will be responsible for setting up these contracts for payment and services. Many parents do not have the understanding or ability to be able to set this up. Many struggle to find staff unless it's a family member. 5. The rate of pay for Respite through PPL needs to be increased. Almost every agency in the state pays more than is being paid through PPL. Also, jobs outside of this industry pay more than Respite workers make including gas stations, grocery stores, fast food restaurants, etc. 6. With clearing the waitlist, we have found that there are not consumers to fill up 3 person and sometimes 2 person locations. The DSSLA process needs to be simplified because you cannot add a person to the home if there are not people with slots that want/need to more or if there are no other members on the list that need 24 hour care. 7. There needs to be another provider other than PPL providing personal options services. They are very hard to get a hold of and they give out incorrect information all the time.	billed in 24/7 ISS and group home settings. NO CHANGE – Most of the new codes added are the self-directed codes and Public Partnerships, LLC (PPL) will manage those. The family will have both a case manager and a resource consultant to assist them. NO CHANGE – BMS appreciates the comment. NO CHANGE – This section has not changed from the previous application and thus is not open for public comment. NO CHANGE – BMS utilize the government sub-agent model of self-direction and can only have one provider. PPL was the lowest bidder and thus, won the contract.

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		8. Training for agencies and PPL staff should be the same. Agencies have a much higher standard than staff 9 and family members working through PPL. This is an unfair practice.	NO CHANGE – All staff are required to be trained in accordance with policy.
		9. The DD9's for nursing services requires too much information and are constantly getting doc requested. BMS needs to come up with a list of direct nursing services and a range of units that can be allowed per the consumers needs.	NO CHANGE – This section has not changed from the previous application and thus is not open for public comment.
		10. The assessments completed by Kepro to determine budget could be completed by the IDT. The service coordinator can be trained to complete these assessments and then submit to Kepro for budget review. This would also cut down on the cost that BMS pays Kepro. These assessments could be billed in units (if this remains) or be part of the per diem (if this begins).	NO CHANGE – This section has not changed from the previous application and thus is not open for public comment.
		11. BMS needs to have their own program that trains BSP's within the state. Many charge huge fees for the classes and pass professionals off as passing but when submitting plans to Kepro, they do not meet the criteria to pass if there were an audit within the agency.	NO CHANGE – This section has not changed from the previous application and thus is not open for public comment.
		12. Kepro needs to have deadlines for turnaround times for budget purchases, modifications, DSSLA requests, exception requests, etc. Purchases and modifications seem to be taking 12 to 18 days before	

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		being reviewed. DSSLA and exceptions requests seem to take over a month before review. 13. Dietary needs removed from the total units available for OT and PT. This should have it's own cap. I have children on the program and work with an agency. These services are vital to the all the individuals that we serve! Thank you for your attention to this matter!	NO CHANGE – This section has not changed from the previous application and thus is not open for public comment. All contractors are expected to follow timelines outlined. NO CHANGE – This section has not changed from the previous application and thus is not open for public comment.
59	10/15/2020	I work as a behavior support professional at a small agency in Lavalette, WV. The majority of the families we serve have been with our agency for many years, and they start to feel like family. Our families believe that the conflict-free case management rule (forcing them to receive service coordination/case management from one agency and any other services from a separate agency) takes away their ability to choose who they are most comfortable with. Many of our families would be forced to choose between keeping their beloved service coordinator who has been visiting their home for years and who they have a rapport with, or keeping their same behavior specialist, nurses, day hab facility, and in many cases, their employment at the same agency. Mainstream Services has never refused to facilitate a client in transferring agencies or receiving a service elsewhere. Several of my consumers attend FBDH at other facilities, and this has never been a problem for me	NO CHANGE – Conflict Free Case Management (CFCM) is being implemented due to the Code of Federal Regulations (CFR) (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This requirement cannot be waived and must be implemented.

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		or others at my agency. We would be completely cooperative with a family choosing to seek services elsewhere. But by enforcing conflict-free case management, you are taking away their ability to choose to keep the staff that they are comfortable with. I realize this may not be an issue for new consumers just starting on the Waiver program who have not yet built a rapport with any case managers or other staff. Perhaps exceptions should be made, and some things should be taken into consideration. These could include the amount of time a family has been at one agency, how long they have had their various staff, if changing agencies would affect their employment, and their home address and the distance to other agencies. Please take the lives of our beloved families into consideration. Thank you.	
60	10/15/2020	• Case Management ○ Regarding the licensing and degree requirments for case managers, will current case managers not meeting those credentials be grandfathered in? • Family PCS and Home Based PCS ○ The application indicates individuals 18 and older but still in public school cannot exceed the 7320 units per year for FPCS, however, it does not indicate this for HBPCS- will these individuals be subject to the cap for HBPCS as well?	NO CHANGE – All Case Managers who are Licensed Social Workers, Licensed Professional Counselor or Registered Nurses will be grand-fathered in. Other Case Managers currently employed can become certified through the on-line case management system. NO CHANGE – The application states “The maximum annual units of Home-Based Agency PCS services for a child under the age

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		• Transportation Miles
		    o Applications lists valid driver's license, vehicle insurance and registration for qualified providers. V. Inspection is omitted. Will that no longer be required as it is currently?
		
		• Provider Reviews
		    o Application indicates self reviews will be every other year and on site reviews will occur on a 24 month cycle. Will we be moving from the annual reviews and will these reviews rotate with OHFLAC reviews as in past years?
		
		• CM Rate
		    o Thank you revising the CM rate to rates previously listed in the original application. However, it would be even more beneficial to providers and consumers if this rate would currently be assessed for increase due to the impact Covid has had on providing quality and adequate CM services. Additionally, annual rate increases for this service would allow agency providers to plan service provision in a more efficient manner as well as be better prepared and equipped to hire a qualified workforce to provide this service. With the increased credentialing and qualifications for Case Managers, it will be even more difficult to locate and maintain quality case managers.
			of 18 living in a natural family/Specialized Family Care home settings cannot exceed 7,320 15-minute units per IPP year".
			
			NO CHANGE – This item was not open for public comment. All staff providing this service are expected to adhere to applicable laws and policies.
			
			CHANGE – This was an error and has been updated to "annually".
			
			NO CHANGE – BMS appreciates the comment.

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		• Rates o We recommend that BMS utilize the rate setting methodology set forth in 2011, using the calculation based on the DOL Wage statistics for WV 2019. We have attached PowerPoint on rates, AMAP and staffing. • Our agency has grave concerns about the effect Independent Case Management will have on some of our members. We do understand the need for a system of accountability, however, Case Managers are ofter our members only known life-line. Many times they and/or their families have spent years with this person and that is who they go to for everything. We also understand there are bad Case Managers and that presents a need for options but if there could be a way for individuals to chose if they want to stay with their Case Manager, it would be more in line with Individualized Treatment Planning. The proposed rates are vastly different than the original $339.50 per month that agencies were asked to consider when a per diem was proposed by BMS. The reduced reimbursement rate will force agencies to stop providing the service and lend itself to hardship on other agencies, possibly to the point where member need cannot be met.	NO CHANGE - BMS has implemented increases in the recent past and will continue to research rates in the future. NO CHANGE – Conflict Free Case Management (CFCM) is being implemented due to the Code of Federal Regulations (CFR) (79 CFR 2948 and 42 CFR 431.301 (c)(1)(vi). This requirement cannot be waived and must be implemented. The two rates are an average of services billed in natural family homes and those billed in 24/7 ISS and group home settings.