Comments for State Plan Amendment 24-0005 - Residential Intensive Treatment and Specialized Residential Intensive Treatment:

Effective Date: October 1, 2024

Note: The DoHS has developed an additional response document to respond to comments which fall outside the scope of this State Plan Amendment. Please go to Residential Redesign Resources (wv.gov) to access the DoHS Residential Reform FAQ document with additional responses and information.

Number	Date Received	Comment	BMS Response/Status Result
1.	March 18, 2024	Just a quick question this State Plan Amendment only incudes the SRIT and RIT I don't see anything about the changes for shelters. Will that not have to be a part of the State Plan Amendment or will that be done at a separate time. Thanks for answering my questions.	The State Plan Amendment includes Residential Intensive Treatment (RIT), Specialized RIT (SRIT), and emergency shelter settings. Structural changes specified in the State Plan Amendment apply to RIT and SRIT. Please refer to 78CSR3 for information on emergency shelters.
2.	March 18, 2024	In reviewing the State Plan Amendment, I noticed that it includes the requirement of a physician/psychiatrist to perform weekly assessments/observations for clients in the RIT model. I know this was in the model draft from October. However, at our November 6th meeting in Clarksburg, I recall expressing concerns over this requirement due to availability of psychiatrists in our area (Wheeling). Following that meeting/discussion, I was under the impression that this requirement was going to be modified to remove the weekly requirement (but maintain the access of a psychiatrist as a requirement and include a monthly assessment). With this being written into the current State Plan Amendment, is there any ability to modify it to reflect	Thank you for your comment. The State has taken this into consideration and as referenced in your comment, the intent of the State Plan Amendment language is to help ensure individuals have access to a physician nurse practitioner or physician assistant to perform assessments/observations or medication management as medically necessary. The State Plan Amendment language will be updated to clarify this. The funding for recruitment is built into the per diem rate.

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		that discussion that we had previously? We have been operating under the assumption that the change discussed in that November meeting would be implemented and basing our planning off that assumption. I am sure we are not the only provider or region with limited psychiatrists available, but it is certainly something that will impact our abilities to implement the model. I will admit this is my first time working through a State Plan Amendment so I'm not familiar with the process of making changes at this stage. If this is going to remain a requirement, does the state have plans to fund the recruitment of psychiatrists to the state/areas with limited resources in this capacity?	
3.	March 27, 2024	I am writing to you on behalf of Davis Stuart, a 105 year old agency that is located "in your back yard" in Lewisburg. We are a Level I and Level II Provider of Residential Treatment Services, serving all of WV Youth ages 12-21. DoHS has submitted a State Plan Amendment for public comment and will be submitting this State Plan Amendment to the Centers for Medicare/Medicaid Services for final federal approval. This State Plan Amendment completely dismantles the current	Thank you for your comment. No changes are being made to the State Plan Amendment at this time. Please see the Department of Human Services (DoHS) Residential Reform Frequently Asked Question (FAQ) document, number 1 for additional information.

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		residential continuum of care and disallows treatment services for those youth who are currently being served by organizations such as ours. In light of the ABC lawsuit as well as the DOJ agreement, it is appalling that DoHS would be allowed to submit such drastic changes to our system of care that will either place children in a much higher level of care than is needed, causing more trauma for our youth and not adhering to Federal Rule of "least restrictive environment" or denying them the services they need since the availability of community based services, especially in Southern WV, are limited at best. I ask that you please slow down the submission of the State Plan Amendment until there are adequate community based services in place to ensure that our most vulnerable youth are cared for appropriately, in the least restrictive environment and with the care and compassion they deserve. Please feel free to contact me, or better yet arrange a visit to our campus should you have further questions or wish to discuss.	
4.	April 1, 2024	For the models does this require a physician to be on staff or can this be a contract position?	No change to the State Plan Amendment. The physician could be employed by or under contract with the RIT/SRIT provider; this will be further clarified in Chapter 503F policy.

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5.	April 1, 2024	What is the required role of a nurse in the CQI process or is this left to the agency's discretion?	No change to the State Plan Amendment. This would be left to the agency's discretion; there are no requirements in the State Plan Amendment specific to this.
6.	April 1, 2024	Under current Medicaid guidelines counseling and treatment plan services can be provided based on specific levels of degrees and does not require a license. Will the requirements be changed in the State Plan Amendment to match current guidelines? With the current work force issues it would be impossible to replace current staff and pay for the staff outlined in the State Plan Amendment.	Thank you for your comment. The current requirements in Chapter 503 policy will continue to apply. Non-licensed therapists must be directly supervised by master's level and/or licensed supervisors. A licensed therapist is preferred, but unlicensed with supervision is acceptable. The State Plan Amendment will be edited to reflect this clinical supervision option for unlicensed therapists.
7.	April 1, 2024	Who is the LBHC credentialing committee? Is there a current process for this? How long does it take to get approved?	No change to the State Plan Amendment. Please see the overarching 503 chapter for Licensed Behavioral Health Center (LBHC) credentialing. Please see the DoHS Residential Reform FAQ document, number 2, for additional information.
8.	April 1, 2024	Will training outlined in the State Plan Amendment be a set curriculum that all agencies follow or is this up to the agencies discretion?	No change to the State Plan Amendment. Suggested curriculum will be further defined in policy. The curriculum will be required to be a nationally recognized evidenced-based practice.
9.	April 1, 2024	Please clarify what the role of a physician is intended to be in an agency's CQI process?	No change to the State Plan Amendment. This would be left to the agency's discretion; there are no requirements in the State Plan Amendment specific to this.

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10.	April 8, 2024	Will DoHS commit to annual rate adjustments within contract language? Providers request a review and commitment of annual rate adjustments clearly be outlined.	Thank you for your comment. DoHS will do periodic rate reviews.
11.	April 8, 2024	Will DoHS, in partnership with Aetna, establish an application process for transition funding that is fair, equitable and transparent?	Thank you for your comment. This is outside the scope of the State Plan Amendment for Medicaid services. Please see the DoHS Residential Reform FAQ document, number 4, for additional information.
12	April 8, 2024	Can parameters be identified for specifically what transition funding is available, who/what will be considered for funding, and coordinate funding announcements with State Plan Amendment announcements?	Thank you for your comment. This is outside the scope of the State Plan Amendment for Medicaid services. Please see the DoHS Residential Reform FAQ document, number 4, for additional information.
13.	April 8, 2024	Can awarded projects and funding be announced to the provider group prior to the public, in effort to establish transparency and cultivation of collaborative partnerships and sharing of ideas and successes through transition?	Thank you for your comment. This is outside the scope of the State Plan Amendment for Medicaid services. Please see the DoHS Residential Reform FAQ document, number 4, for additional information.
14.	April 8, 2024	Would DoHS expand the limited admission criteria for Residential Home model to include admission of youth who have identified a need for a family or family-like setting, but do not have the medical need for RIT/SRIT to access this service level?	Thank you for your comment. This is outside the scope of the State Plan Amendment for Medicaid services. Medicaid can only reimburse for medically necessary services. This State Plan Amendment applies to RIT/SRIT and emergency shelters. Residential homes are outside the scope of the State Plan Amendment.

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		Providers request the Residential Home model admission criteria include referrals for youth who need a family or family-like setting, have experienced failed foster/adoptive care placements, require engagement/integration into the community, need appropriate adult relationships, experience social functioning deficits, and/or current treatment needs can be met in community on an outpatient basis.	Please see the DoHS Residential Reform FAQ document, number 5, for additional information.
15.	April 8, 2024	Has WV had an IMD review of child serving programs?	Thank you for your question. This question is outside the State Plan Amendment's scope. Please see the DoHS Residential Reform FAQ document, number 6, for additional information.
16.	April 8, 2024	Is there a potential for WV to lose federal funding under the 'IMD exclusion?'	Thank you for your comment. This question is outside the State Plan Amendment's scope. Please see the DoHS Residential Reform FAQ document, number 6, for additional information.
17.	April 8, 2024	What potential financial risk will RIT/SRIT providers hold if its determined federal financial participation is not generally available?	Thank you for your comment. This question is outside the State Plan Amendment's scope. Please see the DoHS Residential Reform FAQ document, number 6, for additional information.
18.	April 8, 2024	Will WV established determination on CMS's definition of 'institution' and how to determine bed count prior to RIT/SRIT transitions?	Thank you for your comment. This question is outside the scope of this State Plan Amendment.

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			Please see the DoHS Residential Reform FAQ document, number 6, for additional information.
19.	April 8, 2024	In order to reduce risk to WV's residential system of care, what mechanisms for stability has the DoHS identified to support in-state providers?	Thank you for your comment. This is outside the scope of the State Plan Amendment that is for Medicaid services. Please see the DoHS Residential Reform FAQ document, number 7, for additional information.
20.	April 8, 2024	What assurances can be made to ensure WV does not exacerbate placement instability for children?	Thank you for your comment. This is outside the scope of the State Plan Amendment that is for Medicaid services. Please see the DoHS Residential Reform FAQ document, number 7, for additional information.
21.	April 8, 2024	How will DoHS ensure these changes don't contribute to an already "insufficient placement array, an insufficient number of placement resources, and an insufficient number of homes that are willing to accept older children?" (Source: Case No. CLASS ACTION COMPLAINT 3:19-cv-00710; Jonathan R. vs. Gov. Jim Justice)	Thank you for your comment. This is outside the scope of the State Plan Amendment that is for Medicaid services. Please see the DoHS Residential Reform FAQ document, number 7, for additional information.
22.	April 8, 2024	Will DoHS commit to establishing a bed vacancy rate that would preserve the ability for all residential providers to keep solid staffing ready and available for referrals?	Thank you for your comment. This is outside the scope of the State Plan Amendment that is for Medicaid services. Medicaid can only reimburse for services provided to members who meet medical necessity. Please see the DoHS Residential Reform FAQ document, number 9, for additional information.

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23.	April 8, 2024	Will DoHS develop a strategic phased implementation process as a preventative of any unforeseen catastrophic system-wide instability within detailed components such as authorizations, referrals, payment reimbursement and other areas that may affect provider stability and system transition success?	Thank you for your comment. This is outside the scope of the State Plan Amendment that is for Medicaid services. DoHS will help ensure that appropriate changes are made to the authorization and claims systems. Please see the DoHS Residential Reform FAQ document, number 1, for additional information.
24.	April 15, 2024	Will the annual cost reports be changed to bi-annual reports to reflect up to date information effectively?	Thank you for your comment. No change to the State Plan Amendment. There have not been any cost report or cost report process changes finalized by the State; therefore, the historic cost reporting forms and time periods are still in place. After the approval for the SPA (subject to CMS review), statewide per diem rates will begin and cost reports will not be used to calculate individual provider rates. Please see the DoHS Residential Reform FAQ document, number 3, for additional information.
25.	April 15, 2024	How will per diem rates be adjusted prior to initial implementation as the proposed diem rate does not accurately reflect the actual costs of treatment as information was garnered, in part, from facilities that do not serve the intense population described as “RIT” and “SRIT,” therefore lowering the overall costs and salaries, etc.?	An actuarial analysis was conducted to support rate development. No change to State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 3, for additional information.

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26.	April 15, 2024	Can additional services be authorized and billed in another way, as “fee for service” will cause providers to incur extra administrative costs for tracking and billing?	Additional services, which would be billed as “add-ons” would be billed under the fee-for-service model. No change to State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 10, for additional information.
27.	April 15, 2024	What is the intent of having physician services be available 24/7? The retainer fee to have this person available to the facility 24/7 will be prohibitively expensive.	This was not the State Plan Amendment language’s intention, and a change will be made to the State Plan Amendment. Each RIT/SRIT must have a Memorandum of Understanding (MOU) and established relationship with a partner provider to help ensure availability and access to physician services 24/7 as needed and in a timely manner.
28.	April 15, 2024	What value is added in having the physician perform assessment and observation weekly for each resident?	This was not the intention, and a change will be made to the State Plan Amendment. Each RIT/SRIT must have a MOU and established relationship with a partner provider to help ensure availability and access to physician services 24/7 as needed and in a timely manner.
29.	April 15, 2024	Why must a nurse be utilized to schedule and coordinate medical appointments? Non-nursing staff are capable of this.	Nurses can be, but are not required to be, the individuals performing activities such as scheduling and coordinating medical appointments.
30.	April 15, 2024	Is the new amendment specifying that AMAP training be required for all staff administering medications?	No change to the State Plan Amendment. Bureau for Social Services (BSS) policy and Office of Health Facility Licensure and Certification (OHFLAC) regulations will be followed.

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31.	April 15, 2024	Why is a new system of assigning kids to different levels of service (RIT, SRIT) being developed? The mixture of behaviors/kids could be volatile and unnecessarily compromise the safety of kids.	Thank you for your comment. This falls outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 11, for additional information.
32.	April 15, 2024	Will the fact that community resources are not readily available in many areas of WV, impacting the ability to discharge kids with supportive services be factored into a child's need for residential services?	Thank you for your comment. This falls outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 12, for additional information.
33.	April 15, 2024	Will the cost of the required accreditation be reimbursed?	Thank you for your comment. This falls outside the scope of the State Plan Amendment. The statewide per diem rates were set using the cost report information submitted by providers. Cost reporting includes costs of accreditation or certification, among other costs of doing business. Providers are not reimbursed for accreditation expenses outside of the per diem rate. Please see the DoHS Residential Reform FAQ document, number 4, for additional information.
34.	April 15, 2024	Where will children currently being served in Level 1 and 2 placements go? Most cannot be effectively served in their community or with their current family.	Thank you for your comment. This falls outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 8, for additional information.

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35.	April 15, 2024	Why is the focus on reducing length of stay arbitrarily? Some treatment takes more time.	Thank you for your comment. This falls outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 13, for additional information.
36.	April 15, 2024	Why focus on reduced length of stay when research shows that longer residential stays for individuals with substance abuse issues is most beneficial?	Thank you for your comment. This falls outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 13, for additional information.
37.	April 15, 2024	Why weren't providers consulted prior to the redesign and asked to provide information based upon their knowledge, expertise, and experience?	Thank you for your comment. This falls outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 1, for additional information.
38.	April 15, 2024	How will the therapy time requirements be met in a normal day with academic requirements as well as daily activities such as meals, hygiene, recreation, medication administration, small groups, etc.?	Thank you for your comment. This falls outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 14, for additional information.
39.	April 15, 2024	What is the plan to accommodate increased service requirements during the current workforce crisis to achieve clinical coverage and staffing during vacations, leaves of absence, conferences, continuing education to maintain licensure, training, etc.?	Thank you for your comment. This falls outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 14, for additional information.

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40.	April 15, 2024	What is the plan to assist providers with meeting the increased supervision requirements with the current workforce challenges? Will there be any flexibility in the staffing ratio?	Thank you for your comment. This falls outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 14, for additional information.
41.	April 15, 2024	Why is nighttime supervision identical to daytime? What is the intent of having multiple staff watch sleeping children?	Thank you for your comment. This falls outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 15, for additional information.
42.	April 15, 2024	Why aren't the additional costs of supporting multiple additional staff (payroll insurance, worker's comp, unemployment insurance) being reflected in the proposed rate?	Employee-related expenses incurred by employers were included in the development of the per diem rate. No change to State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 3, for additional information.
43.	April 15, 2024	Will the reimbursement rates for psychiatric services be increased to cover the actual cost?	Thank you for your comment. This falls outside the scope of the State Plan Amendment. Depending on the service, some codes are built within the bundle codes and some may be billed outside the bundle code. Please see the DoHS Residential Reform FAQ document, number 3, for additional information.
44.	April 15, 2024	What will be offered in terms of flexibility for accommodating more than one kid in a bedroom?	Thank you for your comment. This is outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 16, for additional information.

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45.	April 15, 2024	Will the expense that programs incur to remodel existing buildings to achieve one kid per bedroom be reimbursed?	Thank you for your comment. This is outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, numbers 4 and 16, for additional information.
46.	April 15, 2024	If a facility is grandfathered for the total number of kids currently in their facility, will that total ever decrease to meet the proposed total (10 per license)?	Thank you for your comment. This is outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 16, for additional information.
47.	April 15, 2024	What is the expected staffing ratio of therapists to clients for any therapeutic groups?	Thank you for your comment. This is outside the scope of the State Plan Amendment. Please consult policy.
48.	April 15, 2024	What is the plan to assist providers with the prohibitive costs of the redesign, such as applying for additional behavioral health licenses if only ten clients can be served per license?	Thank you for your comment. This is outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 4, for additional information.
49.	April 15, 2024	Why did you choose not to pilot this service line change on a small scale to remedy any issues and address any inconsistencies prior to rolling it out state-wide? Currently providers are still struggling because the billing system being utilized is still not operating properly and payments are not issued in a timely manner. Why implement statewide changes during this time?	Thank you for your comment. This is outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 1, for additional information.

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50.	April 14, 2024	Providers continue to have concerns regarding the timeline of implementation of the new Residential Care Redesign due to the urgent need for foster care and community based services to be funded adequately and for these services to be expanded. There is fear that the Residential changes may destabilize our child welfare system even more and young people may not receive vital services, especially in more remote areas of the state.	Thank you for your comment. This is outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, numbers 1 and 12, for additional information.
51.	April 14, 2024	Providers continue to have concern with the new rates and these rates covering full costs of programming. Costs must be considered regarding the evidence based/supported program models of care as these are expensive and an on-going costs; capital costs especially when serving high acuity youth with aggression and physical plant damages; increased costs of insurance coverage; recruitment and retention of quality workforce during a workforce crisis, etc. The add-on services being a fee for service payment structure is of concern. This will be complicated for billing, especially when providers are still struggling to get timely payment for services within the current structure. The authorization process and approval for the add-on services are	Thank you for your comment. This is outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, numbers 4, 10, and 14, for additional information.

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		complicated and of concern. A monthly case rate would be more appropriate.	
52.	April 14, 2024	Staffing ratios having no flexibility within the models is of concern. WV has an urgent workforce crisis and there is concern that the workforce and some of the staffing ratio requirements may continue to feed this crisis. There are creative ways Residential care programs can meet the needs of youth, maintain proper staffing on campus, and have processes/protocols to ensure safety and proper supervision/crisis response. For example, the need to have 3 direct care staff in a cottage of 10 youth at all times is an unnecessary requirement when the staffing ratio is required at 1:4 youth. Technically having 3 staff at all times with 10 youth is technically more than what the ratio calls for. Flexibility would mean having additional staff on campus at all times and in some cases within the same building; video surveillance; and processes in place to respond to cottages as necessary increasing efficiencies. The rate is still supported, as providers still have the staff hired and embedded into programming, they are just able to be used for effectively and efficiently per youth need increasing ratio where necessary.	Thank you for your comment. This is outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 14, for additional information.

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53.	April 14, 2024	Costs for transitions are of concern for providers, as there has been no clear direction as to how the costs of provider transitions will be covered.	Thank you for your comment. This is outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 4, for additional information.
54.	April 14, 2024	There is still concern by providers regarding the IMD rule. There is a question if WV will lose federal funding due to this issue. It is unclear if WV has addressed this and if it has been addressed, providers would appreciate information.	Thank you for your comment. This is outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 6, for additional information.
55.	April 14, 2024	There is some confusion regarding AMAP requirements. Can there be some additional explanation about these requirements? Currently in a Residential Treatment program in WV serving youth 13-18 years old, youth self-administer medications. These medications are not given directly to youth by a Registered Nurse. All staff are trained on medication management. Clarification on the AMAP requirements would be appreciated if this requirement is changing from current practices.	Thank you for your comment. BSS policy and OHFLAC regulations will be followed, including for Approved Medication Assistive Personnel (AMAP) requirements.
56.	April 14, 2024	In the new WV Residential Redesign models for Residential Intensive and Specialized programs, it is unclear if all Therapists must be licensed or if the current practice will continue, that Therapists can be directly supervised by Master Level/Licensed	Thank you for your comment. As mentioned above, the current practice will continue. Non-licensed therapists must be directly supervised by master's level and/or licensed supervisors. A licensed therapist is preferred, but an

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		Supervisors. If Therapists must be licensed, this results in additional concern of workforce, and costs.	unlicensed individual who is directly supervised is allowable.
57.	April 14, 2024	Providers are urgently concerned about readiness to implement this redesign in the proposed timeframe. Transitions are significant for several providers and there is concern if the timeline of October 1st is implemented, some providers may not be ready and the continuum of care to serve the most vulnerable youth in WV will be destabilized.	Thank you for your comment. This is outside the scope of the State Plan Amendment. The timeline has already been adjusted to provide additional time, since the initial July 1 date. Please see the DoHS Residential Reform FAQ document, numbers 1 and 16, for additional information.
58.	April 12, 2024	Elimination of Levels related: The proposed new structure will eliminate the ability to deliver crucial treatment services within current Level II residential treatment facilities and create a gap for youth who do not need highly intensive treatment interventions. Level II residential treatment facilities currently make up the largest number of treatment beds for WV youth and effectively provide a moderate level of treatment services to youth while receiving supports, resources, and stability that cannot currently be found within their home settings and rural communities. Further, these levels of care provide a much-needed step down of treatment before a youth reenters their community after discharging from higher levels of care.	Thank you for your comment. This is outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 7, for additional information.

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59.	April 12, 2024	Risk to Access to Care & Needed Community-Based Service Development: Considerations and priorities for a youth to have full access to all available service arrays within their community should also include access to the Residential Home placement. Would DoHS expand this limited criteria to allow all youth would need a family or family-like setting, but do not have the medical need for RIT/SRIT to access this service level? The Residential Home model is a critical resource within the residential system of care and when appropriate should be considered before an out-of-community placement option in order to prevent removal from a youth's school and community.	Thank you for your comment. The Residential Homes are outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 5, for additional information.
60.	April 12, 2024	Implementation Timeline: There are significant concerns regarding not only the prudence of the proposed changes, but in the manner and speed of which the changes are required to be implemented by providers. Timelines are extremely aggressive for providers to implement by Oct. 1. A phased approach with an 18–24-month implementation process would allow residential providers to carefully develop individual implementation plans that are more stable for their operations and prudently preserve their resources. Proper vetting of contracts and required modifications for licensing and certifications take	Thank you for your comment. This is outside the scope of the State Plan Amendment. The timeline has already been adjusted to provide additional time, since the initial July 1 date. Please see the DoHS Residential Reform FAQ document, number 1, for additional information.

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		significant time when making such a large system transition. It further would allow time to build community-based services, strengthen foster care components, configure day programs with schools, and more carefully evaluate referrals for shelter, residential group home and residential treatment bed availability.	
61.	April 12, 2024	Assurance of Stability: Stability is a necessary attribute for successful change and significantly influences the effectiveness of transition. In order to reduce risk to WV's residential system of care, what mechanisms for stability has the DoHS identified to support in-state providers? What assurances can be made to ensure WV does not exacerbate placement instability for children? How will DoHS ensure these changes don't contribute to an already "insufficient placement array, an insufficient number of placement resources, and an insufficient number of homes that are willing to accept older children?" (Source: Case No. CLASS ACTION COMPLAINT 3:19-cv-00710; Jonathan R. vs. Gov. Jim Justice) The referral process and level of need within this line of service is fluid and will be unstable as providers transition their campuses, cottages and facility structures. In order to prevent loss of beds, staffing shortages and potential disruptions to the system of care,	Thank you for your comment. This is outside the scope of this State Plan Amendment. Please see the DoHS Residential Reform FAQ document, numbers 1, 7, and 9, for additional information.

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		establishing a bed vacancy rate would offer steadiness. Will DoHS commit to establishing a bed vacancy rate that would preserve the ability for all residential providers to keep solid staffing ready and available for referrals? Will DoHS develop a strategic phased implementation process as a preventative of any unforeseen catastrophic system-wide instability within detailed components such as authorizations, referrals, payment reimbursement and other areas that may affect provider stability and system transition success? I urge you to consider my concerns and withdraw the proposed State Plan Amendment.	
62.	April 12, 2024	Where is the empirical data to provide guidance for daily reimbursement rates?	This was provided in discussions of rate development that BMS and BSS held with providers in the July 20, 2023, and November 6, 2023, meetings. Please refer to that data. Please see the DoHS Residential Reform FAQ document, number 3, for additional information.
63.	April 12, 2024	Is the Cost Report Data submitted by provider agencies available for public review?	Thank you for your comment. This is outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 3, for additional information.

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Number	Date Received	Comment	BMS Response/Status Result
64.	April 12, 2024	What is the amount of cost allocated for treatment per hour?	Thank you for your comment. Please see the DoHS Residential Reform FAQ document, number 3, for additional information.
65.	April 12, 2024	Will the use of telehealth be approved as an appropriate alternative to face-to-face consultation, services, and appointments?	Yes – telehealth will be permitted and will be specified in policy that will include scope and duration.
66.	April 12, 2024	Clinical Supervision definition is needed to provide adequate supervision guidelines.	Thank you for your comment. This will be specified in policy.
67.	April 12, 2024	Is a Licensed Independent Clinical Social Worker (LICSW) required for Clinical Supervision?	Thank you for your comment. Please refer to Chapter 503 for clinical supervision requirements in policy.
68.	April 12, 2024	There are some discrepancies between the State Plan Amendment and RIT/SRIT guidelines as to whether Evidence Based/Evidence Informed curriculum is required.	Policy will specify that nationally recognized evidenced-based practices must be utilized. Please see the DoHS Residential Reform FAQ document, number 17, for additional information.
69.	April 12, 2024	Is a Board Certified Behavior Analyst (BCBA) required for Autism Spectrum Disorder (ASD) population?	If utilizing Applied Behavior Analysis (ABA), the evidence-based practice must be followed, including having required credentialed individuals rendering the services.
70.	April 12, 2024	Is there currently an accepted evidence-based/informed modality for treating Problematic Sexual Behaviors in Adolescents? If so, please provide the name/link.	Thank you for your comment. Please see the DoHS Residential Reform FAQ document, number 17, for additional information.

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71.	April 12, 2024	Has the model proposed in the State Plan Amendment been successful elsewhere? Where are the supportive data outcomes?	Thank you for your comment. The proposed rate model is based on nationally accepted rate-setting methodologies. Please see the DoHS Residential Reform FAQ document, number 18, for additional information.
72.	April 12, 2024	Will an accommodation be made for the timeline to become accredited for programs who do not currently have accreditation (i.e., new providers in West Virginia).	Thank you for your comment. Please see the DoHS Residential Reform FAQ document, number 16, for additional information.
73.	April 15, 2024	Strongly suggest reconsidering the requirement that a physician must observe and assess individuals in the RIT program once per week. Due to a shortage of psychiatrists in our region, this will be a hardship for providers to secure and facilitate, especially given the limited funding allotted. Instead, once per month observation and assessment should be an acceptable alternative for this level of care, provided a psychiatrist is available for any emergent issues. a. If this is not an acceptable change, will tele-psychiatry be permitted so that we can seek services from a psychiatrist outside the region? b. Or is there room to increase payment amounts to allow for successful psychiatrist recruitment?	Thank you for your comments. Please refer to responses above to similar comments regarding both the observation and assessment component and telehealth permissions.

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74.	April 15, 2024	Are individuals in the RIT permitted to self-administer medications under supervision of staff as currently permitted in residential facilities? Or will staff be required to have AMAP or nursing credentials? If so, was that considered when determining the rates and staffing requirements for programs?	Thank you for your comment. BSS policy and OHFLAC regulations will be followed, including for AMAP requirements.
75.	April 15, 2024	The purpose for this State Plan Amendment is indicated to "authorize Medicaid coverage for RIT and SRIT services provided to children who need intensive care in a residential setting" however does not indicate the additional intended purpose to eliminate any availability of a "less restrictive environment" for the treatment needs of children that do not rise to the intensive level of treatment outlined in RIT/SRIT. The number of children that will be impacted is not indicated, but currently in West Virginia the number of children that fall into this eliminated category is the highest of any treatment group. Where will these children who currently require residential treatment receive needed treatment? While the desire is for children to remain in their homes and receive treatment either thought Wrap-around or CSED, there are not enough providers currently to provide services to those	Thank you for your comment. This is outside the scope of this State Plan Amendment. Please see the DoHS Residential Reform FAQ document, numbers 7 and 12, for additional information.

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		children who qualify for such services and are not currently in need of residential services.	
76.	April 15, 2024	The current cost reporting mechanism will be abolished and facilities "will be reimbursed with standardized per diem rates established for Residential Care Facilities." The current proposed rates were established by several inaccurate attempts at gathering documentation via a survey from current providers who do not provide such an intensive level of services at this time and was presented as a voluntary survey. With this change in model, the addition of required physician services, which are not required/provided by current residential providers in no way could be calculated using acquired information thus the survey information did not account for those costs. There was only an assumption of provider staffing costs related to overtime, paid time off, and health insurance costs. Please provide additional documentation that outlines what wage/staffing was utilized as well as how the requirement for physician services and additional licensed clinical staff were calculated into the current rate.	Thank you for your comment. This is outside the scope of the State Plan Amendment. Please see the DoHS Residential Reform FAQ document, number 3, for additional information.
77.	April 15, 2024	There is no indication for an evaluation of the proposed rate with regards to increased	Thank you for your comment. This is outside the scope of the State Plan Amendment.

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		costs/inflation/staffing needs at any other juncture in time such as annual review, etc. What will be the process to ensure that costs are being evaluated to ensure that the reimbursement rate is sufficient for what the state wishes to receive as services?	Please see the DoHS Residential Reform FAQ document, number 3, for additional information.
78.	April 15, 2024	The current West Virginia BMS Provider Manual, Chapter 503 Behavioral Health Rehabilitation Services Appendix 503F Residential Children's Services, Residential Children's Services Level III is defined as "Residential Children's Services, Level III is a highly structured, intensively staffed, 24-hour group care setting targeting youth with a confirmed ICD or DSM diagnosis which manifests itself in severe disturbances in conduct and emotions. As a result, they are unable to function in multiple areas of their lives. Residential treatment facilities provide a highly structured program with formalized behavioral programs and therapeutic interventions designed to create a therapeutic environment where all planned activities and applied interventions are designated with the goal of stabilizing the child's serious mental condition." The current Level III model does not require physician services that the RIT/SRIT are requiring yet the components outlined in Chapter 503 match the components outlined in RIT/SRIT. Why is there physician services required in RIT/SRIT when	Thank you for your comment.

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		residential services are rehabilitative and not administered in a medical facility? All current residential programs have access to medical professionals when necessary including psychiatric services, thus the requirement to have the equivalent of a Medical Director is an unnecessary burden and not sustainable with the rate proposed. Will a consideration of an MOU or formalized agreement with a medical provider be an approved alternative? The State Plan Amendment indicates that "Agencies providing RIT and SRIT services are organized and staffed to provide both general and specialized residential (e.g. non-institutional, non-hospital) interdisciplinary services twenty-four (24) hours a day, seven (7) days a week." thus the need for an MD, DO, APRN, PA is questionable at best.	
79.	April 15, 2024	The State Plan Amendment indicates "RIT and SRIT services are organized to provide treatment where the individual resides." which is within the RIT/SRIT facility. How can the services provided within a facility setting be classified as "community based"?	Thank you for your comment. This State Plan Amendment does not address residential homes. Please see the DoHS Residential Reform FAQ document, number 7, for additional information.
80.	April 15, 2024	Throughout the proposed State Plan Amendment, there is reference to "less restrictive level of care." What does this refer to as the proposed remodel only provides for high intensive services through	Thank you for your comment. Please see the DoHS Residential Reform FAQ document, numbers 7 and 11, for additional information.

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		RIT/SRIT? Specifically, please note the definition of "less restrictive level of care" used in the State Plan Amendment and how that specific type of treatment is provided, by whom, and the involvement of Medicaid reimbursable services?	
81.	April 15, 2024	When a child is not able to receive the appropriate and medically necessary treatment services in their home setting through community based services and does not require the high intensity treatment of RIT/SRIT, what are the alternative settings in which the child can be served? This redesign for residential services will create a gap for youth who do not need highly intensive treatment interventions yet are unable to maintain in their home. How will Medicaid treatment services be made available to these children in need?	Thank you for your comment. This is outside the scope of this State Plan Amendment. Please see the DoHS Residential Reform FAQ document, numbers 7 and 12, for additional information.
82.	April 15, 2024	According to the Foster Care Bill of Rights, W. Va. Code §49-2-126, youth have a "right to live in a safe and healthy environment and the least restrictive environment possible" and their "right to receive mental health services as needed". How does the State Plan Amendment address least restrictive environment possible with the only option being high intensity?	Thank you for your comment. Please see the DoHS Residential Reform FAQ document, numbers 7, 11, and 12, for additional information.

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83.	April 15, 2024	West Virginia has attempted to provide community based services for several years through a fee-for-service structure which has not covered costs to providers thus the current community based providers are supplementing the cost for these services through other programming. There is little to no interest in additional providers committing to provide these services under the current model. How will the number of children being served in Level I and Level II programs be provided the needed services in their homes as indicated through the re-structure and elimination of these services via the State Plan Amendment?	Thank you for your comment. Please see the DoHS Residential Reform FAQ document, numbers 7 and 12, for additional information.
84.	April 15, 2024	What assurances can be made to ensure WV does not exacerbate placement instability for children and how will DoHS ensure these changes do not contribute to an already “insufficient placement array, an insufficient number of placement resources, and an insufficient number of homes that are willing to accept older children?” (Source: Case No. CLASS ACTION COMPLAINT 3:19-cv-00710; Jonathan R. vs. Gov. Jim Justice)	Thank you for your comment. Please see the DoHS Residential Reform FAQ document, number 7, for additional information.
85.	April 15, 2024	The State Plan Amendment indicates “The change would increase Medicaid program costs in Federal Fiscal Year (FFY) 2025 by $7,446,744.80 (of which	Thank you for your comment. Please see the DoHS Residential Reform FAQ document, number 19, for additional information.

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		$5,498,676.36 is the projected Federal Share), and in FFY 2026 by $7,655,632.04 (of which $5,656,844.56 is the projected Federal share). Non-Medicaid State funds associated with this change are estimated to be $28,964,205.05 in FFY 2025 and $29,776,285.57 in FFY 2026." Please provide detailed information regarding these increased costs, including any and all loss of matching IV-E funding, including the loss of matching funding for eliminated treatment services with the elimination of Level I and Level II treatment.	