Comments for Chapter 517-Personal Care Services_
Effective Date Jan. 1, 2018

Comment Number	Date Comment Received	Comment	Status Result	Action for Change Status	Reasoning for No Change Status and FAQs
1.	10/24/17	POC is used for Plan of Care and Plan of Correction. This is confusing. Also, there is no definition for these.	Change	Changed the Plan of Correction to Corrective Action Plan. Added definition of both Plan of Care and Corrective Acton Plan.	
2.	10/24/17	Question #25 in the Medical Criteria section has c) d) then a) b) which is out of order.	Change	BMS Removed the letters.	
3.	10/27/17	517.13.7 If a member reports formal Direct Care Worker services to assist with ADLs are not needed, the report must be documented by the agency and the agency must submit a request for discharge within 7 business days. Can you elaborate on when ADL's are not needed, such as some clients feel better and request no services for a couple of weeks, then they are weak and need assistance. To discharge them and leave them without anyone to assist them seems unfair.	No Change		An eligible member has three long standing deficits that are not intermittent and requires assistance with ADLs on a daily basis.

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4.	10/27/17	After an audit we were told that if a DCW goes into a home and the member states they don't want a bath that day, they are to leave early for that time. This seems unfair to the DCW who has a job with those hours allotted to them. It is very difficult for someone to be employed and not receive their time. I understand BMS doesn't want them to be doing nothing, but sometimes just talking with the member and caring can be very important. I could not find information about this in the manual other than it is not a respite service.	No Change		If the Direct Care Worker is not providing a Medicaid billable service that is listed on the member's Plan of Care the worker cannot substitute other services. They also cannot provide respite or companion services or any other non-Medicaid billable service. The hours are allotted to the member not the worker.
5.	11/3/17	EVV system- what time frame are we looking at to implement this EVV system, will there be a phase in period for it?	No Change		CMS has set an implementation date for EVV for Jan. 2019. States are waiting on guidance information from CMS due in Jan. 2018. Though EVV has been included in the PC Policy manual it is not expected for it to be implemented until BMS has given guidance regarding our State requirements of the implementation.

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6.	11/3/17	I would like to make the following comment on the Personal Care manual. We are expected to thoroughly review, sign, and date the PC POC once it is completed by the Member and the Direct Care Worker, certifying that all activities were performed as needed and met the member's preferences in one unit per month per member. We currently review and sign our POC twice a month. So, we would be unable to bill for the second time we sign them once we switch to daily billing. How can we adequately review these POC in 15 minutes a month?	No Change		Fifteen minutes a month is sufficient time to review the timesheets and POC. Once EVV begins it will make this process much faster. The 10/15/2016 PC Policy has only allowed billing one time a month. This is not a change.
7.	11/3/17	I also have a question regarding the PC monthly report. It has been removed from all areas of the manual, except is still listed under required documentation under 517.16.2. Are we still required to do this monthly report? And if so, is it still due to the OA by the 6th business day of the month?	Change	The Monthly Report will no longer be required the new PC CareConnection© has a discharge feature. This was left in error and removed.	
8.	10/23/17	It is important that when a provider sells the business that the members	No Change		Members have the right to Freedom of Choice of provider

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		automatically transfer with the sale. When a seller works with a person that is looking to purchase their business the purchaser has to be able to calculate what the business is worth. The potential purchaser looks at many items in breaking down the profit and loss statements and balance sheet. They want to know the number of clients by payer source along with the revenue and gross profit margin of the client type. (Private Pay, Insurance, Medicaid, Veteran, Skilled Care, etc...) The only way the seller can get what the business is worth and the potential buyer not be apprehensive in purchasing is for them to have a good idea of how many clients they will keep. This requires the members to automatically transfer. If the goal is to make sure members are aware and have a choice then you should require the purchasing			agencies. BMS does not get involved in the business operations.

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		company to inform the member that the agency has been purchased and therefore you have been given a freedom of choice form to switch if you don't want to stay with the buyer.			
9.	11/1/17	It states that all policies are to be in effect as of January 1, 2018, except that in the recent provider meeting, it was conveyed that the final standards for the Electronic Visit Verification (EVV) have not been received from CMS and would not be required by providers until January 1, 2019. A clarification of the effective date would be appreciated. This will be a major undertaking for service providers in the matter of meeting a January 1, 2018 deadline. It is my understanding that other states are covering the costs for this requirement while WV providers will have to carry the financial burden while not receiving any increase in the reimbursement rates.	Duplicate		CMS has set an implementation date for EVV for Jan. 2019. States are waiting on guidance information from CMS due in Jan. 2018. Though EVV has been included in the PC Policy manual it is not expected for it to be implemented until BMS has given guidance regarding our State requirements of the implementation.

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		My request is that these issues be placed on hold in order to be re-evaluated for their effect on the service recipients, the direct care workers, and the provider agencies. Increase of the reimbursement rates also needs to be a high priority.			
10.	11/1/17	The requirement that each monthly billing be entered as daily units per client will cause an additional financial strain on providers that will need to increase personnel time involvement. Currently the billing is 1 entry per client per month. The average weekdays in a month are 22, so this would create 22 entries per client each month. As an example, if a provider has 50 Personal Care clients, this would be 22 line item entries per client, totaling 1,100 entries per monthly billing. The time constraints, personnel requirements, and costly overhead would be a detriment to providers. Monitoring of this program will suffer from the overload of paperwork necessary to be in compliance. This change will	No Change		CMS has discouraged span billing in all Medicaid program for some time. WV is implementing this process across WV Medicaid programs. Although there is a claim number associated with each day that does not require that they are reviewed every day. They can still be reviewed monthly. Daily billing will not be required at this time as BMS is evaluating including this capacity in the EVV system.

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		inadvertently have an impact on Molina for processing of billing as well. If there are delays in payment processing, this could see providers unable to maintain a financial stability in order to sustain the program. Is this change to be effective January 1, 2018 or is that information incorrect? My request is that these issues be placed on hold in order to be re-evaluated for their effect on the service recipients, the direct care workers, and the provider agencies. Increase of the reimbursement rates also needs to be a high priority.			
11.	11/1/17	The reason for each direct care worker for a provider agency having to apply and establish a NPI number is quite confusing. Questions in mind are the time involved in acquiring a NPI for all current workers and any newly hired workers, if a direct care worker becomes employed with your agency from a different provider agency, does that NPI number follow the worker, if they terminate	No Change		There has been a recommendation from CMS for States to implement the use of an NPI number for all direct care workers. Though the PC Policy Manual is to be effective Jan. 1, 2018, BMS has not yet provided instruction regarding the enrollment process for direct care workers to our providers. BMS will be providing information and timelines for this process in the

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		their employment with your agency and seek employment elsewhere, what happens to that number and whose responsibility is it? This cumbersome process can delay service recipients from receiving care and the providers from maintaining serviceable operations. My request is that these issues be placed on hold in order to be re-evaluated for their effect on the service recipients, the direct care workers, and the provider agencies. Increase of the reimbursement rates also needs to be a high priority.			near future. BMS understands that providers cannot implement this part of policy until information is provided.
12.	10/23/17	I am concerned with the dates you have included as "implementation dates" for the NPI # set for 1/1/2018- I think this is too soon for us to be ready. We need a more realistic implementation date. All these changes will require us to train and will be a cost issue.	No Change		Section 517.11 says "Once available, PC providers must bill daily using the direct care worker's individual NPI number on the claim." The date of the PC manual will be effective on Jan. 1, 2018. The NPI process will not be available until later. Providers are not expected to implement something that BMS has not given guidance on yet.

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13.	10/23/17	The Electronic Visit Verification from CMS- is not required until 1/1/19. My staff do not have the computers to support this effort and it would cost (Agency Name) a lot of money a and we have not had a changed in our reimbursement rates for almost 10 years. We have had minimum wage increases on top of all of that with no change in staff salaries- just trying to keep our head above water. Can there be some kind of subsidy for senior centers to receive some of this equipment for free- I would be billing to test this at our site.	Duplicate		CMS has set an implementation date for EVV for Jan. 2019. States are waiting on guidance information from CMS due in Jan. 2018. Though EVV has been included in the PC Policy manual it is not expected for it to be implemented until BMS has given guidance regarding our State requirements of the implementation.
14.	10/23/17	I am further not pleased with the inability to bill by totaling at the end of the month. This will require additional manpower for daily entry, create excess paperwork and make it difficult to stay on top of it all. I do not have this kind of manpower and operate on a dime as it is.	Duplicate		CMS has discouraged span billing in all Medicaid program for some time. WV is implementing this process across WV Medicaid programs. Although there is a claim number associated with each day that does not require that they are reviewed every day. They can still be reviewed monthly. Daily billing will not be required at this time as BMS is evaluating including this capacity in the EVV system.

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15.	11/1/17	Daily Billing – Span billing should be allowed as long as the days are consecutive. If there is a day missed such as a Thursday then span billing would be appropriate for Monday – Wednesday and then daily billing for Friday only.	Duplicate		CMS has discouraged span billing in all Medicaid program for some time. WV is implementing this process across WV Medicaid programs. Although there is a claim number associated with each day that does not require that they are reviewed every day. They can still be reviewed monthly. Daily billing will not be required at this time as BMS is evaluating including this capacity in the EVV system.
16.	11/1/17	Electronic Visit Verification – This is another additional cost to agencies who have not had an increase in reimbursement for years. We try our best to compensate our PA's more than a minimum wage, but with all the increases in agency costs including WV Cares, CPR cards, and losing billable nursing units it is getting extremely difficult. In the ADW program the pittance of a reimbursement that is given for the mounds of work that a case manager is responsible for should be an embarrassment. If EVV is implemented where do we find revenue to pay for this when we	Duplicate		CMS has set an implementation date for EVV for Jan. 2019. States are waiting on guidance information from CMS due in Jan. 2018. Though EVV has been included in the PC Policy manual it is not expected for it to be implemented until BMS has given guidance regarding our State requirements of the implementation.

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		have had no reimbursement increases. There is overregulation In both the ADW and PC programs (which is supposed to be "person-centered") and the participants are truly the ones that will suffer.			
17.	11/1/17	National Provider Identifier (NPI) numbers – This does not make any sense due to the high turnover rate of direct care workers (PA's).	Duplicate		There has been a recommendation from CMS for States to implement the use of an NPI number for all direct care workers. BMS has started this process already with the SFC PC providers. Though the PC Policy Manual is to be effective Jan. 1, 2018, BMS has not yet provided instruction regarding the enrollment process for direct care workers to our providers. BMS will be providing information and timelines for this process in the near future. BMS understands that providers cannot implement this part of policy until information is provided.
18.	10/20/17	According to the date on the proposed manual, all policies are effective 1/1/2018. However, in the most recent provider meeting, we	Duplicate		CMS has set an implementation date for EVV for Jan. 2019. States are waiting on guidance information from CMS due in Jan.

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		were told the final standards for Electronic Visit Verification (EVV) from CMS have not been received and this would not be required until 1/1/2019. So, what is the effective date for this change? January 1, 2018, is not enough time to implement this type of major change. The cost associated with this requirement will be huge and fall solely on the shoulders of providers. Most other states are paying for the costs associated with EVV, why isn't West Virginia? This is a cost providers will be facing without an increase in reimbursement rates. I would like to see and would be willing to participate in a pilot program established for the EVV requirement to increase the likelihood of success. As a large provider of Personal Care and ADW services, I understand and appreciate the efforts to safeguard our seniors and disabled, while maintaining the integrity of the Medicaid program. However, the concerns I mentioned above will,			2018. Though EVV has been included in the PC Policy manual it is not expected for it to be implemented until BMS has given guidance regarding our State requirements of the implementation.

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		without a doubt, force providers out of business. If this happens, the service recipients will be the ones who suffer. These changes require time, training, additional funding, and cooperation between all involved to be successful. To propose requirements which are as costly as the three I listed above, without an increase in reimbursement rates will cripple the provider network and reduce the quality of care we all strive to achieve. Providers are currently having a difficult time attracting and retaining qualified staff with the current rates. Accountability can be achieved without forcing a provided crisis if we work together and are reasonable.			
19.	10/20/17	Another change is that providers are no longer allowed to bill in monthly totals. The requirement to show services provided on a daily basis will increase billing time, generate ungodly amounts of paperwork, and make the monitoring process an absolute	Duplicate		CMS has discouraged span billing in all Medicaid program for some time. WV is implementing this process across WV Medicaid programs. Although there is a claim number associated with each day that does not require that they are reviewed every day.

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		nightmare. Direct care provider logs show services provided on a daily basis and have been adequate for over 25 years. Why are we reinventing the wheel? This is another costs the providers will absorb without any rate increase. Does Molina have the capability to handle this increase in billing volume? If not, how will delays in payments be addressed? Providers are operating on a razor thin margin and any disruption will force some providers to end operations. Will this begin on 1/1/2018? As a large provider of Personal Care and ADW services, I understand and appreciate the efforts to safeguard our seniors and disabled, while maintaining the integrity of the Medicaid program. However, the concerns I mentioned above will, without a doubt, force providers out of business. If this happens, the service recipients will be the ones who suffer. These changes require time, training, additional funding, and cooperation between all involved to be successful. To			They can still be reviewed monthly.

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		propose requirements which are as costly as the three I listed above, without an increase in reimbursement rates will cripple the provider network and reduce the quality of care we all strive to achieve. Providers are currently having a difficult time attracting and retaining qualified staff with the current rates. Accountability can be achieved without forcing a provided crisis if we work together and are reasonable.			
20.	10/20/17	The requirement for each direct care provider to have a National Provider Identification number is something I cannot understand. This is a very time consuming process and, in some cases, will cause delays in the ability to provide care. As providers, we have an endless list of standards, requirements, regulations, and laws we must adhere to in order to participate in the Medicaid system. If this is going to be implemented, January 1, 2018, is a very unrealistic start date. More time and direction are needed for this requirement	Duplicate		Section 517.11 says "Once available, PC providers must bill daily using the direct care worker's individual NPI number on the claim." The date of the PC manual will be effective on Jan. 1, 2018. The NPI process will not be available until later. Providers are not expected to implement something that BMS has not given guidance on yet.

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		because there are many types of NPI numbers and any delays will only hurt the providers' abilities to maintain operations. As a large provider of Personal Care and ADW services, I understand and appreciate the efforts to safeguard our seniors and disabled, while maintaining the integrity of the Medicaid program. However, the concerns I mentioned above will, without a doubt, force providers out of business. If this happens, the service recipients will be the ones who suffer. These changes require time, training, additional funding, and cooperation between all involved to be successful. To propose requirements which are as costly as the three I listed above, without an increase in reimbursement rates will cripple the provider network and reduce the quality of care we all strive to achieve. Providers are currently having a difficult time attracting and retaining qualified staff with the current rates. Accountability can be achieved without forcing a provided			

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		crisis if we work together and are reasonable.			
21.	10/18/17	Regarding 517.18- "NOTE: Once available, PC providers must bill daily using direct care worker's individual NPI number. By billing daily, it is meant that each day will be billed separately, thereby eradicating span billing. This will enable program integrity and reduce opportunities for fraud. " As one of the 2 employees in our nonprofit organization that does billing for Personal Care services, I find the above listed information in section 517.18 to be, to put it in plain terms, insane. To process billing each day is just not efficient. In our agency we have approximately 45 Personal Care clients. When their billing is sent through the Molina portal once monthly, even that takes multiple days to complete. An agency would have to hire someone to do just this billing alone daily. For many agencies this is simply not possible due to budget constraints.	Duplicate		Section 517.11 says "Once available, PC providers must bill daily using the direct care worker's individual NPI number on the claim." The date of the PC manual will be effective on Jan. 1, 2018. The NPI process will not be available until later. Providers are not expected to implement something that BMS has not given guidance on yet.

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		Should this disappointing and inefficient change a become a reality, how would it work? Would there be a way to submit the forms electronically directly to Molina through an upload process…an upload process that included sending everything…direct care workers NPI, codes, etc??? Is Medicaid going to increase the reimbursement rate to allow for the hiring of another employee just to submit this daily billing??			
22.	10/25/17	My comment is regarding the new EVV from CMS. The cost associated with this change will fall on the agencies. There are many agencies that simply can not afford to purchase what is required to implement this task. Also, our agency is in a rural area of the state where cell phone service and internet are not always available so how is this going to work? And what happens when the equipment malfunctions while our homemakers are out in the field?	Duplicate		CMS has set an implementation date for EVV for Jan. 2019. States are waiting on guidance information from CMS due in Jan. 2018. Though EVV has been included in the PC Policy manual it is not expected for it to be implemented until BMS has given guidance regarding our State requirements of the implementation.

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		Will agencies not be able to bill for that time that was worked?			
23.	10/25/17	Another issue I have with the proposed changes is regarding Kepro completing the initial/annual evaluations for the Personal Care Program. Why pay this company for something that agencies have been doing for years? There are so many people on waiting lists for other programs offered but so much of the state's money is going to be spent to pay Kepro to do these reviews. Why not use that money to put more members on the waiver, lighthouse or fair programs? Thank you for your time	No Change		CMS has recommended that states use independent assessment for eligibility determination for Personal Care Services programs. WV has chosen to follow the recommendation.
24.	11/2/17	517.3 ELECTRONIC VISIT VERIFICATION • Federal law does not require EVV be in place until 1/1/2019 • Little to no guidance has been given by WV regarding EVV • Time line is unrealistic, as PC providers must determine how they will	Duplicate		CMS has set an implementation date for EVV for Jan. 2019. States are waiting on guidance information from CMS due in Jan. 2018. Though EVV has been included in the PC Policy manual it is not expected for it to be implemented until BMS has given guidance regarding our State requirements of the implementation.

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		fund this unfunded mandate, obtain hardware, training and then in turn train direct care staff.			
25.	11/2/17	517.7 OFFICE CRITERIA • Item 12- Current policy requires a response within 12 hours or less. PC providers are prohibited from providing skilled nursing services, which could warrant a rapid response.	No Change		There is a response time of 2 hours not 12. This does not require a skilled nurse to do the call back, someone else can call the member to address the situation. This is a safety issue for our members and is necessary.
26.	11/2/17	517.8.3 Direct Care Worker Annual Training Requirements • Last paragraph-3rd sentence. Just as BMS has identified trainings that need to be provided each year, PC providers have also identified trainings that should be provided each year.	No Change		The policy states "It is recommended that the same trainings not be repeated from year to year. It is suggested that providers evaluate and identify trends at their agencies when identifying potential training topics." This would include any trainings that the agency has identified as an annual training. Agencies should not get in a "training rut" because it is easier for them to use the same ones over and over again each year.

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27.	11/2/17	• Item 7-If the rationale for this change is to assure unbiased, independent assessments, it would follow suit that the UMC RN should also complete an interim PAS, if a PC Agency RN reports a member no longer appears to be eligible for PC services.	No Change		(Section 517.13.4 Item 7) The UMC will evaluate information (including the PAS performed by the agency) provided by the agency and will make the ultimate determination about PC eligibility.
28.	11/10/17	RE: Page 8 517.3 Electronic Visit Verification Comment:	Duplicate		CMS has set an implementation date for EVV for Jan. 2019. States are waiting on guidance information from CMS due in Jan.

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		This section needs to contain a period of time to implement EVV from the date of BMS notice to implement EVV. Currently it states "as determined by BMS." If BMS decides that they wanted it implemented in two weeks, that is not feasible by the provider agency. My request is that if BMS makes a decision to implement EVV, that it should state that the provider agency has at least 180 days to comply.			2018. Though EVV has been included in the PC Policy manual it is not expected for it to be implemented until BMS has given guidance regarding our State requirements of the implementation.
29.	11/9/17	There is concern that the effective date of the manual is 1/1/2018. Will there be training on this manual and will it be conducted in a timely manner so we can adhere to the new policies?	Duplicate		There will be training on the new PC Policy Manual on Dec. 14, 2017 and a recorded training placed on the Public Learning Center site.
30.	11/9/17	Section 517.3 Electronic Visit Verification – This new requirement is of major concern to every small agency in the state. The initial cost of implementation and continued operational costs may force many agencies to discontinue providing this service. Service reimbursements cover only the cost	Duplicate		CMS has set an implementation date for EVV for Jan. 2019. States are waiting on guidance information from CMS due in Jan. 2018. Though EVV has been included in the PC Policy manual it is not expected for it to be implemented until BMS has given guidance regarding our State

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		of providing the service. Will there be any supplemental funding provided by the state to aid in implementation of this requirement?			requirements of the implementation.
31.	11/9/17	Section 571.8.5 RN Training Requirements – Do not understand why RN's must have CPR/First Aid Training. These are licensed individuals with extensive training. This is an added cost to service provision and is unnecessary.	No Change		The recommended techniques used for performing CPR/First Aid change periodically. RN's need to be using/teaching the current recommended standards.
32.	11/9/17	Section 517.131.1 – Medical Eligibility Determination – The addition of a Utilization Management Contractor (UMC) is an added cost to this program. In dire budgetary times it seems extremely unreasonable to add such an increased cost to this program. The amount being paid to KEPRO for these additions needs to be publicized. Of major concern is the fact that this additional layer will drastically increase the time frame it takes to get an eligible individual approved and to begin services.	Duplicate		CMS has recommended that states use independent assessment for eligibility determination for Personal Care Services programs. WV has chosen to follow the recommendation.

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33.	11/9/17	Section 517.16.3 Personal Care Service, Sub section C. – Can assist with errands but there is no reimbursement to the agency for travel. This is an added cost to service provision. There cannot be continued added costs without reimbursement and expect agencies to remain viable. Providing this assistance is extremely important to the members receiving personal care services.	No Change		A Direct Care Worker can bill for the time they are performing the errands even if the member is not with them. This is allowed in lieu of billing for travel.
34.	11/9/17	Section 517.18 – a.Obtaining NPI numbers for direct care workers is going to be extremely difficult and time consuming and not sure of the reasoning of why this is deemed necessary or important. b.Daily billing is going to create additional time for review by the RN and financial staff at our agency. This process will exponentially increase review time per provider per day. This is a real time unrealistic expectation.	a.-Duplicate b.-Duplicate		A.There has been a recommendation from CMS for States to implement the use of an NPI number for all direct care workers. Though the PC Policy Manual is to be effective Jan. 1, 2018, BMS has not yet provided instruction regarding the enrollment process for direct care workers to our providers. BMS will be providing information and timelines for this process in the near future. BMS understands that providers cannot implement this part of policy until information is provided.

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					b. Fifteen minutes a month is sufficient time to review the timesheets and POC. Once EVV begins it will make this process much faster. The 10/15/2016 PC Policy has only allowed billing one time a month. This is not a change.
35.	11/10/17	According to the date on the proposed manual, all policies are effective 1/1/2018. However, in the most recent provider meeting, we were told the final standards for Electronic Visit Verification (EVV) from CMS have not been received and this would not be required until 1/1/2019. So what is the effective date of this change? January 1, 2018, is not enough time to implement this type of major change. The cost associated with this requirement will be huge and fall solely on the shoulders of providers. Most other states are paying for the costs associated with EVV, why isn't West Virginia? This is	Duplicate		CMS has set an implementation date for EVV for Jan. 2019. States are waiting on guidance information from CMS due in Jan. 2018. Though EVV has been included in the PC Policy manual it is not expected for it to be implemented until BMS has given guidance regarding our State requirements of the implementation.

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		a cost provider will be facing without an increase in reimbursement rates. I would like to see and would be willing to participate in a pilot program established for the EVV requirement to increase the likelihood of success.			
36.	11/10/17	Another change is that providers are no longer allowed to bill in monthly totals. The requirement to show services provided on a daily basis will increase billing time, generate ungodly amounts of paperwork, and make the monitoring process an absolute nightmare. Direct care provider logs show services provided on a daily basis and have been adequate for over 25 years. Why are we reinventing the wheel? This is another costs the providers will absorb without any rate increase. Does Molina have the capability to handle this increase in billing volume? If not, how will delays in	Duplicate		CMS has discouraged span billing in all Medicaid program for some time. WV is implementing this process across WV Medicaid programs. Although there is a claim number associated with each day that does not require that they are reviewed every day. They can still be reviewed monthly.

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		payments be addressed? Providers are operating on a razor-thin margin, and any disruption will force some providers to end operations. Will this begin on 1/1/2018?			
37.	11/10/17	The requirement for each direct care provider to have a National Provider Identification number is something I cannot understand. This is a very time-consuming process and, in some cases, will cause delays in the ability to provide care. As providers, we have an endless list of standards, requirements, regulations, and laws we must adhere to in order to participate in the Medicaid system. If this is going to be implemented, January 1, 2018, is a very unrealistic start date. More time and direction are needed for this requirement because there are many types of NPI numbers and any delays will only hurt the providers' abilities to maintain operations. As a large provider of Personal Care and ADW services, I understand and	Duplicate		There has been a recommendation from CMS for States to implement the use of an NPI number for all direct care workers. Though the PC Policy Manual is to be effective Jan. 1, 2018, BMS has not yet provided instruction regarding the enrollment process for direct care workers to our providers. BMS will be providing information and timelines for this process in the near future. BMS understands that providers cannot implement this part of policy until information is provided.

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		appreciate the efforts to safeguard our seniors and disabled, while maintaining the integrity of the Medicaid program. However, the concerns I mentioned above will, without a doubt, force providers out of business. If this happens, the service recipients will be the ones who suffer. These changes require time, training, additional funding, and cooperation between all involved to be successful. To propose requirements which are as costly as the three, I listed above, without an increase in reimbursement rates will cripple the provider network and reduce the quality of care we all strive to achieve. Providers are currently having a difficult time attracting and retaining qualified staff with the current rates. Accountability can be achieved without forcing a provided crisis if we work together and are reasonable.			
38.	11/8/17	In regards to the reevaluation requests for IDD Duals, the draft process as written does not seem possible.	No Change		If the anchor date is approaching the PC Agency will need to communicate with the UMC to expedite the assessment process.

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		The IDD approved budget is not available until within 30 days prior to the shared IDD/PC anchor. It is not possible to submit the IDD approved budget with the PC mner under the written requirements of 45-90 days due to the budgets availability. Please provide clarification.			
39.	11/9/17	Section 517.2 L. d. Profits using public WiFi connections According to Computer Technology Professionals, using public wifi is safe if a secure connection is made and then the information is sent. Public wifi will be necessary for the use of some of the EVV systems. Please change this section to allow public wifi if a secure connection is made with the EVV system.		Added: "without use of a secure connection."	
40.	11/9/17	Section 517.3 Electronic Visit Verification	Duplicate		CMS has set an implementation date for EVV for Jan. 2019. States

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		According to the date on the proposed manual, all policies are effective 1/1/2018. However, in the most recent provider meeting, we were told the final standards for Electronic Visit Verification (EVV) from CMS have not been received and this would not be required until 1/1/2019. So what is the effective date for this change? January 1, 2018, is not enough time to implement this type of major change. The cost associated with this requirement will be huge and fall solely on the shoulders of providers. Most other states are paying for the costs associated with EVV, why isn't West Virginia? This is a cost providers will be facing without an increase in reimbursement rates. I would like to see and would be willing to participate in a pilot program established for the EVV requirement to increase the likelihood of success.			are waiting on guidance information from CMS due in Jan. 2018. Though EVV has been included in the PC Policy manual it is not expected for it to be implemented until BMS has given guidance regarding our State requirements of the implementation.
41.	11/9/17	Section 517.6.2 Fingerprinting	No Change		WVCARES has the ability to extend on a case by case basis, if

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		Provisional employment is not to exceed 60. I feel that this needs to be extended. If a person's fingerprints are not readable they have to be electronically redone two times and then we have to send hard cards to WV Cares and then WV Cares sends them to the state police and FBI. This takes a lot longer than 60 days. I would suggest changing this to 120 days at least. Section 517.6.4 Provisional Employees Same as above			needed. The 60 days is in state code and therefore cannot be changed in the policy manual. If the case is needed WVCARES provides the needed documentation to allow for the extension.
42.	11/9/17	Section 517.6.7 Responsibility of the Hiring Entity This section has a note that states the WV Cares registry recheck report must be researched, printed and maintained onsite for each month. This file can be saved electronically instead of being printed every month and it will save paper. I suggest that it be changed	No Change		The PC Policy states that Providers must maintain documentation establishing no negative finding for currently employees. This can be printed, on an e-record as long as it is accessible to the monitors.

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		to printed or electronically saved and printed as needed.			
43.	11/9/17	Section 517.7 7) Office Criteria This requires a fax. Everything is moved toward electronic data. I think fax should be an option not mandatory.	Change	Changed to "fax and/or e-fax".	
44.	11/9/17	Section 517.7 12) Office Criteria This section states that the agency must maintain a method to be contacted 24-hours per day/7 days a week with a response required within 2 hours. There is some messages that I think don't require a 2 hour response time. If someone calls and leaves a message that they have a doctor's appointment next week and wants to know if they can change their time of service for that day would require a return call in 2 hours. The two hour return call needs to specify emergency calls only.	Change	Added: "Urgent issues should be addressed within 2 hours. Other issues require a response the next business day."	

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45.	11/9/17	Section 517.8.2 B. Direct Care Worker Initial Training Currently our personal attendants complete First Aid online and it is an extensive 5 class session. With an 80% score from a test on each section they receive a certificate not a card. This cost is around $1.50. In order to get a card you have use a provider like American Red Cross. This is shorter one class session that does not cover as much and the card but will cost at least $18 per person. I request that you continue to accept the First Aid online class. Section 517.8.3 B. Direct Care Worker Annual Training Requirements Same as above	Change	Added: Card/Certificate that corresponds with the certified entity for both CPR and First Aid.	
46.	11/9/17	Section 517.8.4 Registered Nurse Qualifications This section required a copy of the RNs transcripts to prove staff qualifications. It is the responsibility	Change	Only licensure documentation must be maintained in the employee's file.	

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		of the WV State Nursing Board to determine if their transcripts make them eligible to be a Registered Nurse. I feel it is not necessary for us to require a copy of their transcripts.			
47.	11/9/17	Section 517.9 Training Documentation Currently our personal attendants complete First Aid online and it is an extensive 5 class session. With an 80% score from a test on each section they receive a certificate not a card. This cost is around $1.50. In order to get a card you have use a provider like American Red Cross. This is shorter one class session that does not cover as much and the card but will cost at least $18 per person. I request that you continue to accept the First Aid online class.	Duplicate	Add: Card/Certificate that corresponds with the certified entity for both CPR and First Aid.	
48.	11/9/17	Section 517.11 Documentation and Record Retention Requirements	Duplicate		CMS has discouraged span billing in all Medicaid program for some time. WV is implementing this process across WV Medicaid programs. Although there is a

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		Another change is that providers are no longer allowed to bill in monthly totals. The requirement to show services provided on a daily basis will increase billing time, generate ungodly amounts of paperwork, and make the monitoring process an absolute nightmare. Direct care provider logs show services provided on a daily basis and have been adequate for over 25 years. Why are we reinventing the wheel? This is another cost the providers will absorb without any rate increase. Does Molina have the capability to handle this increase in billing volume? If not, how will delays in payments be addressed? Providers are operating on a razor thin margin and any disruption will force some providers to end operations. Will this begin on 1/1/2018. The requirement for each direct care provider to have a National Provider Identification number is something I cannot understand. This is a very time consuming process and, in some cases, will			claim number associated with each day that does not require that they are reviewed every day. They can still be reviewed monthly.

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		cause delays in the ability to provide care. As providers, we have an endless list of standards, requirements, regulations, and laws we must adhere to in order to participate in the Medicaid system. If this is going to be implemented, January 1, 2018, is a very unrealistic start date. More time and direction are needed for this requirement because there are many types of NPI numbers and any delays will only hurt the providers' abilities to maintain operations.			
49.	11/9/17	Section 517.13.3 Initial Medical Evaluation Please clarify if someone is discharged but wants to restart services and their prior is still current, then do we do a PC MNER to initiate services again? Does the Kepro nurse have to come back out?	Change	Added: "If the time is less than three months since the anchor date the member can keep their services with no new assessment. It the time is greater than ninety days since the anchor date the individual would need to submit a new PC-MNER to start the application process."	

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50.	11/9/17	517.3 a. EVV: As determined by BMS - Does this indicate that BMS will be selecting an EVV provider to meet all criteria required? b.. EVV: Will there be any reimbursement for the implementation of the EVV for agencies? c. EVV: What will be protocol when EVV fails? Regardless of mechanism used for EVV the potiential for equipment failure is a possiblity, what would be protocol in that event? Would member services not be provided? If services ARE provided and EVV was ineffective will services be non-billable?	Duplicate		CMS has set an implementation date for EVV for Jan. 2019. States are waiting on guidance information from CMS due in Jan. 2018. Though EVV has been included in the PC Policy manual it is not expected for it to be implemented until BMS has given guidance regarding our State requirements of the implementation.
51.	11/9/17	5.17.7.3 a.Technical and Face to Face assistance: Will there at anytime be a RN training module provided by BMS.	No Change		TA and Face to Face assistance is available at any time. Contact the OA to request assistance.

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52.	11/9/17	517.10.1 a. IMS: Time line on WV IMS becoming available. b. Timeline of reportable incidents? i.e. if upon learning of a fall that happened 6 months prior, would this be an appropriate incident to report due to passage of time from incident to notification of providing agency?	a.-No Change b.-No Change		a.BMS is anticipating a July 1, 2018 implementation date for WV IMS. b. Incidents must be entered into the WV IMS within one business day of learning of the incident. i.e. Yes
53.	11/9/17	517.13.1 a. When will the MNER form be available for review b. Where will the MNER be available	No Change		a. New forms will be presented at the PC Policy Manual Training. b. On the BoSS and BMS websites.
54.	11/9/17	517.13.3 a. The UMC will attempt to contact the applicant 3 times, but it does not indicate if this is 3 consecutive days, 3 calls in a day, or any time	a.-No Change		a.- The three contacts are not attempted in the same day.

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		line over which contact may begin and end. b. Who is defined as a contact person? Who may or may not function as a contact person (To be present during evaluation by UMC to assist member with dementia...) c. Completing a PAS within 30 days of receipt of completed MNER will greatly prolong the process of providing services to those in need r/t acute illness or disability. These conditions may not be considered Emergent to the UMC or BMS, but are emergent to the applicant and/or applicants family. Currently a referral can be received, PAS completed and received and services began in a very short time frame. Will there be any process of requesting expedited evaluations on behalf of applicants with sudden change in circumstance or health who require assistance in the home more urgently in order to remain safe?	b.-No Change c.-No Change		b.-The contact person listed on the PC-MNER as the contact person. c.-No
55.	11/9/17	517.13.4	A.-No Change		A.-Yes.

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		a. If a member is unable to be contacted for re-evaluation and is closed, can the same MNER that was submitted to initiate PAS completion be resubmitted if signatures remain less than, <60 days old. (Manual indicates a new MNER may be submitted at any time) b. If DURING A MEMBERS SERVICE YEAR, the providing agency feels member is no longer eligible for PC services, the PC agency must obtain OR COMPLETE and submit a PC PAS. This needs further clarification – will agency nurse complete a PAS (as done prior to determine eligibility) using current available form and submit to physician for signature and then to UMC for review of eligibility? OR what's the process for initiating an evaluation outside of annual scheduled evaluation by UMC to determine eligibility? I feel this section is vague and needs further explanation. c. In the event the member requests transfer to UMC, it states	b.-No Change c.-No Change		B.The UMC will evaluate information (including the PAS performed by the agency) provided by the agency and will make the ultimate determination about PC eligibility. C. The UMC will tell the member to contact their current agency or OA to initiate the transfer. This will be covered more during the PC Policy training.

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		they will contact OA or PC agency to initiate transfer – What does this entail? Will the UMC complete a transfer request at that time, will they simply be notifying the providing agency of the members wishes and no other action? This could benefit from expansion.			
56.	11/9/17	517.14 a. No mention of monthly PC report being submitted to OA, will this be required after 1/1/17?	Duplicate	The Monthly Report will no longer be required the new PC CareConnection© has a discharge feature. This was left in error and removed.	
57.	11/9/17	517.15 a. Providing PC services to children: Manual indicates environmental tasks should not be included in services provided to a minor, it also indicates PC services do not replace the age appropriate care that any child would need from a parent or guardian. Providing services to children is vastly different than providing care to adults, this manual and the one prior is incredibly lacking in services that CAN be provided to children, especially young children.	A.-No Change		a. Developing a POC for a child is difficult. Please contact the OA for technical assistance.

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		b.Where there is more than one recipient of waiver services in one home, environmental tasks may not be duplicated or provided twice. This is a broad statement. Environmental tasks will often require duplication. 2 beds need made, 2 showers were performed thus the bathroom would need straightened 2 times, OR services were provided for one person in the AM, morning dishes would need cleaned for that person and Lunch dishes for the PM member. If double amount of work is being provided it should be billable to the person the service is being provided for. Understandable if two members share a bed the task of changing the sheets or making the bed is only performed 1x so it is sensible to only apply that to one member. Otherwise nearly all environmental tasks would require duplication with some exceptions. c.THERE IS NO INDICATION OF LENGTH OF TIME POC IS VALID. An assessment and POC must be	b.-No Change c.-Change	c. Added in Section 517.15 Service Plan Development "The PC RN is responsible for development of the Plan of Care every six	b. A PC Direct Care Worker can only bill for one PC member at a time. If there are two PC members living in a home together, each Plan of Care would reflect different times to do things. If there are two beds, two different meal times, etc., then the expectation is that the POC for each member would very clearly indicate that the member's bed will be made, the living area of the member will be straightened, mopped, etc. If a PC member also has a waiver service the dual schedule will reflect what services are to be provided/when/and what program.

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		completed every 6 months or upon condition change. Although the manual does not indicate the duration of a POC i.e., if an assessment is completed on 11/17/2017 and the POC plan period would be dated Nov 2017 – May 2018? Is the 6th month visit due anytime within the month of May? And the current POC developed in November continues to be in compliance until the end of the plan period or upon the development of a new POC with RN assessment? Also, the annual would be considered current anytime within the month of November (ex: if assessment was completed on 11/29)		months or as needed in collaboration with the member." In the example presented: yes, if it expires in May, you can go anytime during the month of May.	
58.	11/9/17	517.16.3 a. Direct care worker may assist member with essential errands, there is no notation of reimbursement of mileage used to perform such tasks to maintain member in the home, if performed using worker private vehicle or public transport. Are members responsible for cost of transportation? The worker is not	a.Duplicate		a. A Direct Care Worker can bill for the time they are performing the errands even if the member is not with them. This is allowed in lieu of billing for travel.

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		expected to provide the transportation using private resources without reimbursement. b. Please clarify "Rounding" of personal care service units. Rounding up, totaling??? Completely unsure of the use of this term in this manual.	b.Change	b. The rounding of any Personal Care Services units billed is not allowed.	
59.	11/9/17	517.18 a.Once daily billing commences? What is the time line for this? b.How will daily billing be submitted? c.What training will be provided for daily billing? d.How will daily billing reduce opportunities for fraud? e.When will direct care workers require NPI numbers? f.Who will facilitate daily billing? Molina? g.Increased workloads required with daily billing will require increased time and effort without	a.-e. and f.-g.:No Change		a.Daily billing will begin 7/1/18. b. Each day will be billed separately, however each day doesn't have to be submitted daily. c. Before its implementation training will be provided. d. BMS will be able to connect direct care service worker's face to face contact time to a specific member to ensure there is no duplication of hours for members. e. There has been a recommendation from CMS for

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		noted compensation or reimbursement			States to implement the use of an NPI number for all direct care workers. BMS has started this process already with the SFC PC providers. Though the PC Policy Manual is to be effective Jan. 1, 2018, BMS has not yet provided instruction regarding the enrollment process for direct care workers to our providers. BMS will be providing information and timelines for this process in the near future. BMS understands that providers cannot implement this part of policy until information is provided. f. BMS and Molina. g. BMS and Molina.
60.	11/9/17	517.23 a. Travel reimbursement is not listed as not eligible for reimbursement.	Duplicate		A Direct Care Worker can bill for the time they are performing the errands even if the member is not with them. This is allowed in lieu of billing for travel. Travel has never been a covered service in the PC program.
61.	11/9/17	517.28	a.-No Change		a.Correct.

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		a.noted new time line on discontinuation of services (if not received over 30 days) b.although no process for discontinuation of services in skilled facility (180 days?) need time to process or handle discontinuations of PC services for those transferred to skilled facilities for long term placement	b.-No Change		b. Members admitted to a Skilled Nursing Facilities must be discharged from the PC agency.
62.	11/9/17	a. The Change log does not seem to reflect the totality of changes accurately. There is concern that the effective date of the manual is 1/1/2018. Will there be training on this manual and will it be conducted in a timely manner so that we can adhere to the new policies? b.Section 517.3 Electronic Visit Verification – This new requirement is of major concern to every small agency in the state. The initial cost of implementation and continued operational costs may force many	A.-No Change b.-Duplicate		a.There will be training on the new PC Policy Manual on Dec. 14, 2017. A morning and afternoon session. A recorded training will be placed on the Public Learning Center site. b. CMS has set an implementation date for EVV for Jan. 2019. States are waiting on guidance information from CMS due in Jan. 2018. Though EVV has been included in the PC Policy manual it

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		agencies to discontinue providing this service. Service reimbursements cover only the cost of providing the service. Will there be any supplemental funding provided by the state to aid in implementation of this requirement?			is not expected for it to be implemented until BMS has given guidance regarding our State requirements of the implementation.
		c.Section 517.8.5 RN Training Requirements – Do not understand why RN's must have CPR/First Aid Training. These are licensed individuals with extensive training. This is an added cost to service provision and is unnecessary.	c.-No Change		c. The recommended techniques used for performing CPR/First Aid change periodically. RN's need to be using/teaching the current recommended standards.
		d.Section 517.131.1 – Medical Eligibility Determination – The addition of a Utilization Management Contractor (UMC) is an added cost to this program. In dire budgetary times it seems extremely unreasonable to add such an increased cost to this program. The amount being paid to KEPRO for these additions needs to be publicized. Of major concern is the fact that this additional layer will drastically	d.-Duplicate		d. CMS has recommended that states use independent assessment for eligibility determination for Personal Care Services programs. WV has chosen to follow the recommendation.

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		increase the time frame it takes to get an eligible individual approved and to begin services. e.Section 517.16.3 Personal Care Service, Sub section C. – Can assist with errands but there is no reimbursement to the agency for travel. This is an added cost to service provision. There cannot be continued added costs without reimbursement and expect agencies to remain viable. Providing this assistance is extremely important to the members receiving personal care services. f.Section 517.18 – Obtaining NPI numbers for direct care workers is going to be extremely difficult and time consuming and not sure of the reasoning of why this is deemed necessary or important. Daily billing is going to create additional time for review by the RN and financial staff at our agency. This process will exponentially increase review time per provider per day. This is a real time unrealistic expectation.	e.-Duplicate f.-Duplicate		e. A Direct Care Worker can bill for the time they are performing the errands even if the member is not with them. This is allowed in lieu of billing for travel. f. There has been a recommendation from CMS for States to implement the use of an NPI number for all direct care workers. BMS has started this process already with the SFC PC providers. Though the PC Policy Manual is to be effective Jan. 1, 2018, BMS has not yet provided instruction regarding the enrollment process for direct care workers to our providers. BMS will be providing information and

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					timelines for this process in the near future. BMS understands that providers cannot implement this part of policy until information is provided.
63.	11/8/17	I think it would be beneficial for many reasons if the Personal Care and Aged and Disabled Waiver required trainings were the same for each program. In order for this to occur, I recommend adding Person Centered Planning to the direct care worker required trainings, and I recommend removing Abuse, Neglect, and Exploitation Training from the nurse required trainings.	No Change		The Aged and Disabled Waiver is a waiver issued through CMS. The Personal Care Services Program is a State Plan program. Each program has approval and requirements from CMS. Person Centered Planning has been added to the PC policy manual for the development of the Plan of Care. There is nothing in policy restricting an agency from providing person centered care training to their direct care workers.
64.	11/9/17	Section 517.2 L. d. Profits using public WiFi connections According to Computer Technology Professionals, using public wifi is safe if a secure connection is made and then the information is sent.	Duplicate	Added: “without use of a secure connection.”	

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		Public wifi will be necessary for the use of some of the EVV systems. Please change this section to allow public wifi if a secure connection is made with the EVV system.			
65.	11/9/17	Section 517.3 Electronic Visit Verification According to the date on the proposed manual, all policies are effective 1/1/2018. However, in the most recent provider meeting, we were told the final standards for Electronic Visit Verification (EVV) from CMS have not been received and this would not be required until 1/1/2019. So what is the effective date for this change? January 1, 2018, is not enough time to implement this type of major change. The cost associated with this requirement will be huge and fall solely on the shoulders of providers. Most other states are paying for the costs associated with EVV, why isn't West Virginia? This is a cost providers will be facing without an increase in	Duplicate		CMS has set an implementation date for EVV for Jan. 2019. States are waiting on guidance information from CMS due in Jan. 2018. Though EVV has been included in the PC Policy manual it is not expected for it to be implemented until BMS has given guidance regarding our State requirements of the implementation.

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		reimbursement rates. I would like to see and would be willing to participate in a pilot program established for the EVV requirement to increase the likelihood of success.			
66.	11/9/17	Section 517.6.2 Fingerprinting Provisional employment is not to exceed 60. I feel that this needs to be extended. If a person's fingerprints are not readable they have to be electronically redone two times and then we have to send hard cards to WV Cares and then WV Cares sends them to the state police and FBI. This takes a lot longer than 60 days. I would suggest changing this to 120 days at least. Section 517.6.4 Provisional Employees Same as above	Duplicate		WVCARES has the ability to extend on a case by case basis, if needed. The 60 days is in state code and therefore cannot be changed in the policy manual. If the case is needed WVCARES provides the needed documentation to allow for the extension.
67.	11/9/17	Section 517.6.7 Responsibility of the Hiring Entity	Duplicate		WVCARES has the ability to extend on a case by case basis, if

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		This section has a note that states the WV Cares registry recheck report must be researched, printed and maintained onsite for each month. This file can be saved electronically instead of being printed every month and it will save paper. I suggest that it be changed to printed or electronically saved and printed as needed.			needed. The 60 days is in state code and therefore cannot be changed in the policy manual. If the case is needed WVCARES provides the needed documentation to allow for the extension.
68.	11/9/17	Section 517.7 7) Office Criteria This requires a fax. Everything is moved toward electronic data. I think fax should be an option not mandatory.	Duplicate	Added "or emailed via secure email if applicable"	
69.	11/9/17	Section 517.7 12) Office Criteria This section states that the agency must maintain a method to be contacted 24-hours per day/7 days a week with a response required within 2 hours. There is some messages that I think don't require a 2 hour response time. If someone	Duplicate	Added: "Urgent issues should be addressed within 2 hours. Other issues require a response the next business day."	

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		calls and leaves a message that they have a doctor's appointment next week and wants to know if they can change their time of service for that day would require a return call in 2 hours. The two hour return call needs to specify emergency calls only.			
70.	11/9/17	Section 517.8.2 B. Direct Care Worker Initial Training Currently our personal attendants complete First Aid online and it is an extensive 5 class session. With an 80% score from a test on each section they receive a certificate not a card. This cost is around $1.50. In order to get a card you have use a provider like American Red Cross. This is shorter one class session that does not cover as much and the card but will cost at least $18 per person. I request that you continue to accept the First Aid online class. Section 517.8.3 B. Direct Care Worker Annual Training Requirements	Duplicate	Added: Card/Certificate that corresponds with the certified entity for both CPR and First Aid.	

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		Same as above			
71.	11/9/17	Section 517.8.4 Registered Nurse Qualifications This section required a copy of the RNs transcripts to prove staff qualifications. It is the responsibility of the WV State Nursing Board to determine if their transcripts make them eligible to be a Registered Nurse. I feel it is not necessary for us to require a copy of their transcripts.	Duplicate	Only licensure documentation must be maintained in the employee's file.	
72.	11/9/17	Section 517.9 Training Documentation Currently our personal attendants complete First Aid online and it is an extensive 5 class session. With an 80% score from a test on each section they receive a certificate not a card. This cost is around $1.50. In order to get a card you have use a provider like American	Duplicate	Added: Card/Certificate that corresponds with the certified entity for both CPR and First Aid.	

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		Red Cross. This is shorter one class session that does not cover as much and the card but will cost at least $18 per person. I request that you continue to accept the First Aid online class.			
73.	11/9/17	Section 517.11 Documentation and Record Retention Requirements a. Another change is that providers are no longer allowed to bill in monthly totals. The requirement to show services provided on a daily basis will increase billing time, generate ungodly amounts of paperwork, and make the monitoring process an absolute nightmare. Direct care provider logs show services provided on a daily basis and have been adequate for over 25 years. Why are we reinventing the wheel? This is another cost the providers will absorb without any rate increase. Does Molina have the capability to handle this increase in billing volume? If not, how will delays in payments be addressed? Providers	a.Duplicate		a.CMS has discouraged span billing in all Medicaid program for some time. WV is implementing this process across WV Medicaid programs. Although there is a claim number associated with each day that does not require that they are reviewed every day. They can still be reviewed monthly.

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		are operating on a razor thin margin and any disruption will force some providers to end operations. Will this begin on 1/1/2018. b.The requirement for each direct care provider to have a National Provider Identification number is something I cannot understand. This is a very time consuming process and, in some cases, will cause delays in the ability to provide care. As providers, we have an endless list of standards, requirements, regulations, and laws we must adhere to in order to participate in the Medicaid system. If this is going to be implemented, January 1, 2018, is a very unrealistic start date. More time and direction are needed for this requirement because there are many types of NPI numbers and any delays will only hurt the providers' abilities to maintain operations.	b.- Duplicate		b.There has been a recommendation from CMS for States to implement the use of an NPI number for all direct care workers. Though the PC Policy Manual is to be effective Jan. 1, 2018, BMS has not yet provided instruction regarding the enrollment process for direct care workers to our providers. BMS will be providing information and timelines for this process in the near future. BMS understands that providers cannot implement this part of policy until information is provided.
74.	11/9/17	Section 517.13.3 Initial Medical Evaluation	Duplicate	Added: "If the time is less than three months since the	

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		Please clarify if someone is discharged but wants to restart services and their prior is still current, then do we do a PC MNER to initiate services again? Does the Kepro nurse have to come back out?		anchor date the member can keep their services with no new assessment. It the time is greater than ninety days since the anchor date the individual would need to submit a new PC-MNER to start the application process."	
75.	11/8/17	517.2 Provider Agency Certification "An existing provider who stops providing PC services for more than 365 days will lose their CON and certification" Does this include agencies who have CONs, but have never provided personal care services, such as Senior Centers?	Change	This was removed.	
76.	11/8/17	517.7.2 Provider Reviews The providers have timelines to follow in regards to asking for a document/desk review. What is the	No Change		The BMS legal department handles all document/desk reviews.

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		timeline for BMS to complete a document/desk review?			
77.	10/31/17	Can BMS implement time lines for providers to accept referrals in CareConnection and begin direct care worker services like in the ADW.	Change	Section 517.13.3 Initial Medical Evaluation- added “A PC provider agency will have five calendar days to accept a referral through the UMC web portal. Emergency/discharges must be accepted with in twenty-four hours or the next business day. If the provider cannot accept the referral the OA will be notified so they can assist the applicant with choosing a different provider. If it is an emergency/discharge the OA will respond in twenty-four hours or the next business day. Section 517.15 Plan of Care Development- added “Once the Plan	

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				of Care is developed, the agency providing Direct Care services will begin providing services within ten calendar days. For Emergency/discharges Direct Care services will begin upon the latter of: the calendar day after facility discharge or the day medical eligibility is approved.	