Comments for Chapter 513, Intellectual and Developmental Disabilities Waiver

Effective Date: August 1, 2026

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1	4/8/2026	513.1.1 – This section does not seem to be in the proposed draft. Will a public comment period be provided if this section was inadvertently omitted from the public comment draft? This same question applies to other sections noted as not appearing in the draft.	**Change** The Change Log will be revised to reflect the correct reference to Section 513.11
2	4/8/2026	513.2 –The Council appreciates the addition of training on abuse, neglect and exploitation as a requirement.	**No change**
3	4/8/2026	513.2.2 – The Council supports the clarification of privacy laws in relation to social media.	**No change**
4	4/8/2026	513.2.3.3 – The Council is concerned about the dramatic change in timeframe for the draft exit summary (after the exit summation) to be sent to the provider. Currently, the draft exit summary is required to be sent within 2 weeks of the exit summation. The proposed manual would change this to 120 days. This seems to be too great of a timeframe. How are providers to timely and appropriately corrected issues to best meet the needs of the Member(s)? Providers have 30 days to provide a response once they receive the draft exit summary. It seems reasonable to issue the draft exit summary to the provider within 30 days of the exit summation.	**No change** The current process requires the UMC to conduct an exit summation and inform the provider of all findings and potential monetary disallowances. This process allows the provider to begin corrective action immediately. Providers may also seek technical assistance from the UMC prior to receipt of the final report regarding the appropriateness or effectiveness of proposed corrective action.
5	4/8/2026	513.3.1.3 – This section does not seem to be in the proposed draft.	**Change** The Change Log was revised to correct the reference to this change at Section 513.3.13.
6	4/8/2026	513.3.1.7 – This section does not seem to be in the proposed draft.	**Change** The Change Log was revised to correct the reference to this change at Section 513.3.17.
7	4/8/2026	513.5 – The addition of a provider payment hold for failure to provide BMS and its contractors with requested documentation is a positive Change	**No change**

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8	4/8/2026	513.6.2.1 – The Council is concerned about the exclusion of Level 1 and Level 2 Autism as an eligible related condition for eligibility. The Council would like to see Autism listed as a related condition without specifying any level. We are not implying all people with Level 1 or Level 2 Autism are eligible for the IDD Waiver.	**No change** Eligibility requirements have not changed. The IDDW policy manual was updated to reflect the eligibility requirements of the current IDDW application, approved by CMS effective July 1, 2025. The language regarding autism severity was revised to reflect the levels defined in the Diagnostic and Statistical Manual Fifth Edition Text Revision (DSM-V-TR). This update will not impact eligibility for individuals seeking to enroll or currently enrolled in the IDD Waiver.
9	4/8/2026	513.6.2.2 – The Council has a long history of providing comments on the program's restrictive eligibility criteria. While this is not a new change, the Council continues to be concerned about West Virginia having the most restrictive IDD Waiver eligibility criteria in the nation. BMS should modify the waiver to use the same eligibility criteria to measure adaptive functioning (two standard deviations) as all other IDD Waiver programs across the country.	**No change** The medical eligibility requirements have not changed with this policy manual revision. The definition of substantial deficits will remain as three standard deviations below the mean for purposes of adaptive deficits criteria only. For diagnosis criteria, IDDW continues to use two standard deviations below the mean, in line with national practices.
10	4/8/2026	513.6.2.3 – This section does not seem to be in the proposed draft.	**Change** This section of the policy manual will be revised to correctly reference Section 513.6.2.3, "Active Treatment."
11	4/8/2026	513.3.11.11 – This section appears to be 513.11.1 not 513.11.11.	**Change** The reference to Section 513.11.11 in the "Change Log" was revised to correctly reference 513.11.1.

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12	4/8/2026	513.14.1 and 513.14.2 – The addition of home and vehicle modification is a positive Change	**No change**
13	4/8/2026	513.15.2 – The Council recommends the Bureau keep the existing language as permissive. Prevocational skills may be learned in more than just a day program. Many people have gained employment due to the skills they have learned while volunteering or in other similar situations. If this is permitted under another IDD Waiver service, please disregard this comment.	**No change** The Job Development service allows for the provision of employment-related skills training in community settings and/or integrated employment settings.
14	4/8/2026	513.15.2 – The change to clarify that all employment must pay Members minimum wage or higher is appreciated, except when there is a Department of Labor Waiver.	**No change**
15	4/8/2026	513.15.3 – The Council supports the change to clarify a provider's office is not considered a community setting.	**No change**
16	4/8/2026	513.16.1 – The Council supports the changes to remove the exclusion of nutritional supplements and furniture to meet specific needs and qualifying diagnoses.	**No change**
17	4/8/2026	513.17.5 – The Council appreciates the Bureau's the expansion and increase in crisis services under the IDD Waiver.	**No change**
18	4/8/2026	513.23 – This section does not seem to be in the proposed draft.	**Change** The "Billing Procedures" section was erroneously labeled as Section 513.22 instead of 513.23. This error will be corrected in the published version of the policy manual.
19	4/8/2026	513.26 – The Council supports the addition of language to prohibit case management providers from discharging a member who chooses to self-direct part or all of their services.	**No change**
20	4/9/2026	First, I recommend reconsidering the requirement for quarterly in-person case management visits. While in-person contact can be valuable, a rigid quarterly mandate does not always reflect the needs or preferences of individuals served. Many participants are	**No change** The in-person contact requirement was changed from monthly to quarterly in the July 1, 2025, CMS approved waiver application. Individuals

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		stable, well-supported, and effectively monitored through a combination of remote communication, interdisciplinary coordination, and ongoing oversight of service delivery. Allowing flexibility in visit modality—such as permitting virtual or needs-based in-person visits—would enable case managers to allocate time more effectively, respond more quickly to emerging concerns, and reduce unnecessary disruption for members, particularly those in rural areas or with transportation challenges. A more flexible approach would also support person-centered care by tailoring contact frequency and format to the individual's actual needs rather than a fixed schedule.	may opt for more frequent in-person visits from their case manager based on individual needs, preferences, and circumstances.
21	4/9/2026	Second, I suggest removing the requirement for agencies to run monthly reports in WV CARES to verify that employees are not listed on the registries. This requirement predates the current automated functionality within WV CARES. As it stands today, the system continuously monitors and flags individuals who appear on the registry, providing a notification directly on the main screen that must be manually acknowledged. This real-time alert system is more effective than retrospective monthly reporting and already ensures compliance. Continuing to require monthly report generation is duplicative, creates unnecessary administrative burden, and diverts staff time from direct service and quality improvement efforts.	**No change** The current policy manual revision does not include requirements for agencies to run monthly reports in WV CARES. As stated in various sections of the policy manual, all IDDW providers are required to meet the requirements of *Chapter 700 West Virginia, Clearance for Access: Registry & Employment Screening (WV CARES).*
22	4/9/2026	Finally, I recommend revisiting the limitation on billable time for timecard reviews, which is currently set at 1 unit per month. In practice, timecard review responsibilities often exceed this limit due to the volume of staff, frequency of corrections, and the importance of ensuring accuracy for compliance and payroll integrity. When workload justifies it, allowing additional billable units better reflects the time needed to complete duties thoroughly	**No change** Chapter 513 does not include any description of policies related to billable time for reviewing timecards.

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		and responsibly, and supports agencies in maintaining accurate, compliant documentation.	
23	4/9/2026	Pages 48, 50, 52, 126, and 138 – IPP Timelines & Upload Requirements Page 48 states: IPP must be uploaded to the UMC portal within 10 business days. Also states IPPs must be uploaded and distributed within 14 business days. Page 50 states: IPP must be distributed within 7 calendar days. IPP must be uploaded within 14 calendar days. Page 52 states: Requests/modifications and dissemination must occur within 14 calendar days. Page 126 states: Purchase services must be completed within 7 days of the IDT meeting. Page 138 states: Prior authorizations must be submitted within 10 business days. Concern: These timelines contradict one another. A full IPP should realistically be provided to the team at the same time it is ready for upload to the UMC. The 7 calendar day requirement is not practical, as case managers must wait for documentation and attachments from multiple professionals. Recommendation: Standardize all timelines to 10 business days, which is more realistic.	**Change** The timelines to upload the IPP and service authorizations to the UMC portal and distribute the IPP to IDT members will be revised to 10 business days to ease administrative burden and promote consistent practice.

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		Clarify that authorizations cannot occur without a completed IPP. Replace “calendar days” with “business days” to account for weekends, holidays, and professional availability.	
24	4/9/2026	Pages 48 and 50 – Medley Advocate Attendance Page 48 requires a Medley Advocate to attend the entire meeting. This raises the question: should they be required at all meetings (virtual and in-person)? Concern: These statements appear inconsistent and need clarification.	**Change** The relevant sections of the policy manual will be revised to clarify that a Medley Advocate is required to attend the six-month and annual IDT meeting. The Medley Advocate may choose to attend IDT meetings, including the six month and annual IPP meetings, via teleconference.
25	4/9/2026	Pages 20–21 and 148 – Conflict of Interest Conflict of interest is defined as affiliation with a provider agency resulting in competing interests. Concern & Recommendation: A case manager (CM) or BSP disclosing future employment with a competing waiver provider may constitute a conflict of interest. Proposed addition: Professionals should not disclose new employment if it is with a competing waiver provider within a 50-mile radius of their current employer.	**No change** Limitations on an individual staff member’s ability to seek employment, such as non-compete clauses or restrictions on the sharing of information regarding employment status or offers, are not governed by IDDW policy.
26	4/9/2026	Pages 50, 51, and 65 – Teleconference & Billing Page 50: Teleconference attendees may not bill. Page 51: Meetings may be held virtually with agreement. Page 65: BSPs may attend virtually but must be present for the duration to bill. Concern:	**Change** While existing policy manual language describes the conditions in which a staff member may or may not bill for attendance or participation in IDT meetings, this section of the policy manual will be revised to provide additional clarification.

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		These statements are contradictory. Context & Recommendation: Virtual participation has been billable under COVID allowances and supports workforce efficiency. If attendance via phone/virtual is approved by the team, professionals should be allowed to bill.	
27	4/9/2026	Pages 50 and 126 – IPP Review Frequency Page 50: Uses "90 calendar days / not to exceed 180 calendar days." Page 126: Uses "three months / not to exceed six months." Recommendation: Standardize language to match Page 50, as it aligns better with regulatory expectations.	**Change** IPP review frequency will be revised to reflect a calendar month timeline (i.e., three months/six months).
28	4/9/2026	Section 513.16.1 – Service Accessibility Recommendation: This service should be available under both delivery models. Allow fencing and EAA when there is a documented history of elopement and other safety measures are also in place.	**No change** Fences are listed as excluded items for the EAA service in the CMS-approved application. BMS may consider re-evaluating this exclusion in a future amendment.
29	4/9/2026	Rate Caps – PCS & Day Habilitation Concern: Current cap: 17,520 Recommended cap: 17,920 Rationale: Members can attend day services while families still provide care without exceeding 16 billable hours. Families should not lose own funding to supports community integration.	**No change** The current service limitations, including combined caps for PCS and Day Habilitation, are included in the CMS-approved waiver application and may not be revised at this time.

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30	4/9/2026	Page 64 – BSP Billing Restrictions States' BSP services cannot be billed for administrative activities, including phone calls. Concern: Does this prohibit billing for training conducted via phone? Recommendation: Allow billing for phone-based training, especially given workforce shortages and high caseloads, unless there is evidence of ineffective service delivery. EX: multiple retraining via phone	**Change** This section will be revised to clarify the types of administrative tasks that may not be billed by BSPs, including certain tasks performed via telephone.
31	4/9/2026	Page 53 – Transfer Submission States submission via UMC portal within 5 business days. Concern: Process is still being completed via email. Recommendation: Update documentation to reflect the correct and current submission method.	**No change**
32	4/9/2026	Section 513.8.1.1 – Initial & Seven-Day IDT Meeting Currently requires meeting within 7 calendar days. Concern: Difficult to coordinate within this timeframe, especially for traditional service models or limited attendance schedules. Recommendation:	**No change** The initial and Seven-Day IDT meetings are critical to help ensure member access to necessary services as they begin IDDW services. If all identified IDT participants are unable to meet within the first seven days, the individual (and LAR, when applicable) and their case manager may identify the most needed services during the initial

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		Change to 7 business days or 7 days of attendance. This would align with other waiver processes and reduce unnecessary meetings that do not add value.	or Seven-Day IDT meeting. The IDT may then proceed to finalize any remaining services with the full IDT at the 30-day IPP meeting. In addition, timelines are based on OHFLAC requirements found in *W.Va Code 27-9-1, 27-17-3*.
33	4/10/2026	General: As a parent of a child with high support needs, I want to be clear that access to behavioral health services is not just a system issue, it is something families feel every single day. When services are delayed, limited, or difficult to navigate, it does not just create inconvenience. It creates real instability in the home and increases the risk of crisis. Children with higher support needs, including those on the autism spectrum, require consistent, structured, and timely services to make progress. When there are long waitlists for therapy, gaps in care, or limited provider availability, that progress can quickly be lost. Families are then left trying to manage complex behavioral, emotional, and developmental needs without the level of support that is necessary. As a parent, the expectation to "just manage" while waiting for services is not realistic. Daily routines, school expectations, and safety concerns do not pause while families are on a waitlist. For many of us, missing or delayed care means increased stress, regression in skills, and a heavier burden placed on the entire household.	**No change** IDDW reimbursement rates are reviewed annually, per legislative mandate. In addition, BMS expanded the services available for delivery via telehealth in the July 1, 2025, waiver renewal.

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		Flexibility in services is essential for families like mine. Rigid scheduling, limited appointment times, and transportation barriers make it difficult to stay consistent in care. For children with high support needs, consistency is everything. Missing even one session can disrupt progress and make it harder to regain stability. As a Master of Social Work student, I understand that these challenges are tied to larger systemic issues, including workforce shortages, high caseloads, and administrative demands on providers. However, understanding the system does not lessen the impact on families who are trying to access care in real time. Stronger action is needed. This includes increasing reimbursement rates to attract and retain qualified providers, expanding and protecting telehealth services, and reducing administrative burdens that limit direct care. In addition, policies must prioritize family-centered approaches, including flexible scheduling and supports that reflect the realities of parenting a child with high support needs. Families like mine should not have to reach a breaking point before receiving help. Behavioral health systems must be responsive, accessible, and built around the needs of those they serve. Until then, families will continue to carry the weight of a system that is not fully meeting them where they are.	
34	4/13/2026	Bottom of page 108 states: Procedure Code: S5125HI 1:1 ratio S5125UN 1:2 ratio S5125UP 1:3 ratio S5125U4 1:4 ratio	**No change** BMS is working with its MMIS vendor to identify, develop, and implement new AMAP code modifiers, if necessary. BMS will keep provider partners informed of any forthcoming changes to the AMAP procedure code

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		Top of page 109 S5125HI AMAP: 1:1 ratio S5125UN AMAP: 1:2 ratio S5125UP AMAP 1:3 ratio This implies there will be separate codes for AMAP and regular UR staffing, but the codes are the same.	modifiers through provider calls, updates to the UMC's FAQs, and/or email distribution list updates.
35	4/13/2026	Section 513.20.2 - Addition of language regarding the new skilled nursing medication administration service. There is no description of this new code only a reference that states on page 132 Med Administration Procedure Code: T1003TE 1:1 ratio Service Units: Unit = Event (1x/day maximum) No definition of this new code? Why is this new med administration code not explained further?	**Change** The reference to the skilled nursing medication administration service was an error and has been removed.
36	4/13/2026	General: I am writing to share my thoughts regarding the safety and oversight of our non-verbal clients. I feel that having at least one, if not more, cameras in the home of a non-verbal client could be a valuable tool for protection. This measure would serve to protect both the client and the caregiver by providing clear documentation and ensuring a safe environment for everyone involved.	**No change** Individuals whose assessed needs indicate they may benefit from electronic monitoring, including oversight and monitoring within the individual's residential setting through off-site surveillance, may access Electronic Monitoring, if deemed appropriate by the individual member's IDT.

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		I would appreciate it if the IDD Wavier program would reconsider this need.	In addition, cameras or other types of surveillance may only be used to monitor an individual in their home if recommended by the IDT and approved by the Human Rights Committee.
37	4/14/2026	To Whom It May Concern, I am writing to submit a public comment regarding the West Virginia I/DD Waiver program and to express my urgent concern about the current waitlist and lack of available funding. I am the parent of a 4½-year-old son who is nonverbal and diagnosed with autism. He has significant safety needs including a high risk of elopement and behavioral challenges that require constant supervision and specialized support. For example, him being able to distinguish what is going to hurt him and what's not. Despite these serious needs our family is still waiting and has not even been assigned a slot number. The uncertainty and length of the waitlist are overwhelming. Every day without services places my child at greater risk and puts an incredible strain on our family. We are doing everything we can to keep him safe and help him grow but without access to waiver services, we are left without the professional support that is critical for his development and safety. The I/DD Waiver program is not optional for families like ours, it is essential. These services provide life-changing support such as behavioral interventions, therapies and assistance that allow children like my son to safely remain at home and in their communities. Without these supports families are left to manage	**No change** Slots for the IDDW are based on CMS-approved waiver enrollment allocations, cost neutrality determinations, and legislative appropriations. BMS anticipates the release of additional IDDW slots in the future.

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		complex and high-risk situations alone which can lead to burnout and in some cases crisis situations that could have been prevented with proper services. I respectfully urge the Bureau for Medical Services to take immediate action to increase funding and expand access to this program. The current waitlist is far too long especially for young children with critical developmental windows and serious safety concerns. Early intervention and consistent support can make a lifelong difference for children like my son. Investing in the I/DD Waiver program is not only the right thing to do, it is a necessary step to protect vulnerable individuals, support families and reduce more costly interventions in the future. Thank you for your time and for considering the urgent needs of families like mine.	
38	4/14/2026	I am reaching out regarding the public comment period for Chapter 513 of the IDD Waiver. Through both my professional work and personal experience as a parent, I have had the opportunity to connect with hundreds of families navigating this system. Because of this, I see firsthand the impact that policies, access to services, and provider structures have on the daily lives of the individuals and families we serve. I would greatly appreciate the opportunity to speak with someone from your team to discuss several areas where we believe meaningful improvements could be made. Our goal is to ensure that the waiver continues to evolve in a way that truly supports families, improves access, and strengthens the overall system for individuals with intellectual and developmental disabilities.	**No change** Contact information for BMS may be found on the BMS website.

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		Please let me know who the appropriate contact would be, or if there is a time we could connect directly. Thank you for your time and for the work you are doing to support this community.	
39	4/16/2026	A review of the IPP requirements within this section appears to reflect multiple timelines governing IPP finalization, distribution, and upload to the UMC portal, which may benefit from clarification to ensure consistent implementation and compliance across providers. The current manual was corrected with this inconsistency for upload/purchase and distribution by 14 calendar days. The changes to the current policy indicate either more or less restrictive case management responsibilities depending on the sentence read by the provider. Specifically, the policy references differing submission and distribution timeframes, including IPPs being uploaded to the UMC portal within ten business days, 14 calendar days, and 14 business days, as well as distribution to team members within seven calendar days and 14 business days of the IDT meeting. As written, it is unclear which timeline takes precedence when these requirements overlap, or whether certain timelines apply to specific IPP types (initial, annual, revision, critical juncture) versus all IPPs universally. Additionally, while the policy requires that the IPP be finalized and signed at the close of the IDT meeting, allowances are also made for delayed signatures in extenuating circumstances. Clarification would be helpful regarding when an IPP is considered “final” for purposes of triggering submission and distribution timelines,	**Change** The timeline to both upload and distribute the IPP will be revised to 10 business days.

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		particularly in situations involving teleconference participation or delayed signatures. Aligning these timelines into a single, clearly defined framework of 14 business days for upload/purchase and distribution (or explicitly stating which requirement controls when multiple timelines apply) would reduce confusion for providers and reviewers and support consistent compliance, documentation, and timely authorization of services. As written, to sum: • 7 calendar days (distribution), • 14 business days (distribution), • 10 business days (upload), • 14 calendar days (upload)	
40	4/16/2026	The IMS reporting change log continues to reference language allowing incidents to be entered on the next business day when an event occurs on a weekend or state holiday; however, this language no longer appears in the updated IMS reporting policy. If this removal was intentional, the change log should be updated to reflect that the allowance has been eliminated, and clarification should be provided to agencies regarding operational expectations. Specifically, guidance is needed to confirm whether BMS and Acentra now expect all agencies to maintain staffing sufficient to complete incident entry and initiate investigations seven days per week, including weekends and state holidays. Clear advance notice is necessary so agencies can plan for weekend and holiday coverage and adjust internal processes prior to enforcement from the significant Change	**No change** The policy revision referenced in this comment was implemented in April 2021. IDDW program providers must maintain staffing patterns adequate to meet the needs of IDDW members at all times, including weekends and holidays. Adequate staffing includes staff available to respond to and investigate incidents that may pose an immediate threat to the health, safety, and welfare of IDDW members, including incidents that occur during holidays and weekends.

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		For example, if this change is accurate and an incident occurred on a state holiday such as Good Friday, when administrative staff are typically not scheduled, the current language would appear to require initiation of the investigation by Easter Sunday. Clarification is requested to ensure consistent interpretation and application of reporting timelines. Alternatively, reinstating the prior "next business day" language in section 513.4 would help maintain consistency between the change log and policy text and prevent confusion for providers and reviewers regarding reporting and investigation timeframes. Absent clarification, agencies may be cited as noncompliant for timelines impacted by weekends or holidays, despite previously allowable practices.	
41	4/16/2026	In section 513.6.2.1 Diagnosis, the following eligibility criterion is listed for MECA review: Within the context of medical eligibility determination, "resource consultant" does not appear to be a diagnosable condition and is otherwise defined throughout IDDW policy as a service role, not a clinical diagnosis. As written, the sentence appears inconsistent with standard waiver eligibility terminology and the surrounding policy structure. Clarification is requested to confirm whether "resource consultant" was intended to reference a related condition associated with intellectual and developmental disability, if this language was inadvertently included during revision, or if a possible AI drafting error from BerryDunn. If unintentional, correction would help ensure consistency with medical eligibility standards and avoid	**Change** This section of the policy manual will be revised to remove the inadvertent insertion "resource consultant" and replace with "related condition."

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		confusion during MECA reviews, audits, and eligibility determinations. Providing clarification or correcting the terminology would support consistent interpretation and application of eligibility criteria by providers, reviewers, and contractors	
42	4/15/2026	Section 513.9.2 (Participant Directed Service Delivery Model) explicitly conditions Participant Directed Goods and Services on access to another participant directed direct care service, stating that participant directed goods and services "can only be participant directed if at least one of either a person-centered support and/or a respite service is also participant directed." This linkage is further reflected in Section 513.16.1 (Participant Directed Goods and Services). However, this same prerequisite is not explicitly stated in the Draft Manual sections governing participant directed Environmental Accessibility Adaptations (EAA) or participant directed extended professional therapy services. Specifically, Sections 513.14.3 and 513.14.4 (Environmental Accessibility Adaptations – Home and Vehicle, Participant Directed Option) describe eligibility, documentation, budget limits, and prior authorization requirements for participant directed EAA but do not require the member to also access participant directed Personal Care Services (PCS) or Respite. Similarly, Sections 513.12.5 through 513.12.8 (Dietary Therapy, Occupational Therapy, Physical Therapy, and Speech Therapy – Participant Directed Option) establish participant directed therapy services as independently accessible, subject to assessed need, prior authorization, and budget limitations, without conditioning	**Change** The relevant sections will be revised to clarify that individuals wishing to access Participant Directed Goods and Services, Environmental Accessibility Adaptations – Home and Vehicle, Participant Directed Option, and/or participant directed professional therapies must be authorized to receive participant directed Personal Care Services (PCS) or Respite.

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		access on concurrent participation in participant directed PCS or Respite. By contrast, Policy Clarification Q224/A224 (dated 2/1/24) indicates that, to access EAA and/or any therapy service through the participant directed option, the member must also access participant directed PCS and/or Respite. This requirement extends beyond the explicit linkage contained in Section 513.9.2 and is not clearly codified in the Draft Manual text governing EAA or participant directed therapy services. In addition, the Personal Options Financial Management Services (FMS) has the operational ability to deny, delay, or discontinue access to participant directed therapy services for both new members receiving a funded slot and members currently self directing services, based on application of policy clarifications FAQ Q224/A224. In practice, the FMS interprets the FAQ requirement to mean that a member must not only select but must be actively purchasing and billing participant directed Personal Care Services (PCS) and/or Respite in order to access or continue participant directed therapy services. This enforcement may occur months after a member has begun self directing therapy services, effectively conditioning both initial eligibility and continued access to therapies on active utilization of participant directed direct care services. As a result, members who are clinically appropriate for participant directed therapies but do not otherwise require participant directed PCS or Respite may be compelled to add and bill services solely to maintain access to therapies or risk service disruption up to discharge from the program due to the direct care service eligibility requirement. This operational practice may affect member choice, service continuity, and individualized service planning and underscores the need for	

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		the Draft Manual to clearly and explicitly state any such prerequisite requirements if they are intended to be enforced. This inconsistency between the Draft Manual and policy clarification creates a lack of transparency regarding service access criteria and may result in inconsistent application of participant directed service eligibility. Clarification or revision is recommended to align written policy with operational requirements, either by expressly extending the linkage requirement to participant directed EAA and therapy services or by revising the policy clarification to reflect the Draft Manual language. Finally, clarification is recommended regarding the meaning of the term “access” as used in FAQ Q224/A224 and in Section 513.9.2 (Participant Directed Service Delivery Model). As currently written, neither the FAQ nor the Draft Manual defines whether “access” to participant directed PCS or Respite means (1) inclusion on the IPP, (2) availability or authorization of the service, or (3) active billing of the service. The Personal Options FMS is operationally interpreting “access” to require active utilization and billing, with denial of participant directed therapies occurring when PCS or Respite is authorized but not billed. If denial of access is contingent on this interpretation, the definition of “access” should be explicitly stated in policy language to ensure consistent application, protect member choice, and avoid retroactive service disruption up to discharge from the program. Absent such clarification, the current ambiguity permits enforcement outcomes that are not clearly supported by the written Draft Manual, which is the ideal opportunity to make everything match BMS's expectations for service planning and delivery.	

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43	4/17/2026	The UMC's current interpretation of Environmental Accessibility Adaptations (EAA) treats EAA as a conflicted service when considered within the scope of Case Management activities. However, the Traditional Option service descriptions for both Environmental Accessibility Adaptations – Home (Section 513.14.1) and Environmental Accessibility Adaptations – Vehicle (Section 513.14.2) retain legacy language stating that the Case Management agency must retain payment receipts and must not pay EAA funds directly to the member, family member, staff, or legal representative, and instead must issue payment to the vendor completing the adaptation. As written, the service descriptions for both EAA Home and EAA Vehicle imply that the Case Management agency plays an active role in authorizing and administering these services, with the sole restriction being the method of payment rather than the agency's involvement itself. This language reflects an earlier operational model and is not aligned with the UMC's current interpretation of EAA, whether Home or Vehicle, as a conflicted service for Case Management agencies, despite these being treated as distinct services or funding sources for other policy purposes. This discrepancy creates ambiguity regarding the intended role of Case Management agencies in the authorization and administration of both EAA Home and EAA Vehicle services and may result in inconsistent understanding or application across agencies and reviewers. Clarification or revision of the Draft Manual language for both EAA Home and EAA Vehicle is recommended to ensure it accurately reflects the current conflict of interest interpretation and clearly delineates authorization and payment responsibilities consistent with current operational expectations. In addition, the Draft Manual may provide an opportunity to incorporate Conflict Free Case Management	**Change** This section of the policy manual will be revised to clarify that, while the case manager is expected to retain any documentation received that evidences payment, the provider agency is responsible for issuing payment upon completion of the adaptation.

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		(CFCM) expectations by clarifying that direct care providers are the appropriate entities to submit for Traditional EAA and by outlining related responsibilities for payment processing and record retention.	
44	4/17/2026	The Draft IDDW Manual references "Supported Employment Plans of Instruction" without providing a definition, required elements, or a clear relationship to other required service planning documents. As written, the term lacks sufficient policy clarity to function as an enforceable documentation standard and could be clarified, consolidated, or revised to align with existing documentation requirements, such as the Individual Habilitation Plan (IHP). In addition, the Draft IDDW Manual does not specify a requirement for a letter or other proof of employment prior to the authorization or purchase of Supported Employment services. Any requests for such documentation appear to reflect operational practices from the UMC rather than explicitly stated policy conditions.	**Change** The policy manual will be revised to clarify that previous experience developing and/or implementing "Supported Employment/Job Development Plans" as described in the WV Division of Rehabilitation Services *Client Services Manual* may be sufficient to meet provider qualifications for the Supported Employment or Job Development services.
45	4/22/2026	I respectfully submit this comment to express concern and opposition to the proposed provision that applies a reduced annual limit of Person-Centered Support (combined limits to all PCS services: Family Person Centered Supports, Home-Based Person-Centered Support, Person Centered Support Personal Options) service hours to members who are age 18 or older and still attending public school. While I support the intent to avoid duplication of federally mandated educational services under the Individuals with Disabilities Education Act (IDEA), the proposed limitation exceeds what is required under Federal Medicaid law and guidance and risks inappropriately restricting medically-necessary, non-	**No change** The limitations on the amount of services delivered to transition-aged youth attending school are included in the CMS-approved waiver application. Any change in authorized units of service requires a waiver amendment and CMS approval. BMS may consider re-evaluating annual service limitations for transition-aged youth in a future amendment.

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		educational supports for transition age members and their families. Federal Medicaid regulations governing Home and Community Based Services (HCBS) do not prohibit waiver services solely because an individual over age 18 remains enrolled in a public K–12 educational setting. CMS regulations require that HCBS be provided pursuant to a person-centered service plan, based on assessed need, and furnished to individuals who would otherwise require an institutional level of care (42 C.F.R. § 441.301(b)(1)). CMS permits states to define service limits under a 1915(c) waiver but does not mandate reduced service caps based on age or school enrollment status alone (42 C.F.R. §§ 441.301, 441.302). Federal guidance is clear that Medicaid funding may not be used to duplicate or supplant special education and related services that a Local Education Agency (LEA) is required to provide under IDEA during scheduled instructional time (20 U.S.C. § 1400 et seq.; 34 C.F.R. Part 300). This prohibition is functional and situational, not categorical. It applies to services that are educational in nature or required to be delivered under an Individualized Education Program (IEP), regardless of the student's age. CMS has further clarified that HCBS may be provided outside of scheduled instructional hours and may address needs that are non academic, non instructional, and not otherwise required to be provided by the school system, as long as the services are not duplicative of IDEA obligations and are supported by medical necessity and person centered planning (42 C.F.R. § 441.301(c); CMS HCBS Guidance on Non Duplication of Services). Furthermore, many students age 18 and older in West Virginia	

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		participate in vocational or modified school schedules that do not encompass a full instructional day. A categorical reduction in hours ignores the gap created when school-based vocational programs end mid-day, leaving a member without the habilitative support required for safety and community integration. Individuals age 18 and older who remain in public school often have significant needs that extend beyond the scope of educational services, particularly during transition planning to adult systems. These needs may include skill development related to self direction, independent living, communication, mobility, and community integration, as well as caregiver training and support necessary to prepare for changes in service delivery following exit from the K–12 system. IDEA does not require schools to provide long term habilitation, family training, or adult service transition supports beyond educational outcomes (20 U.S.C. § 1414(d)(1)(A)(i)(VIII); 34 C.F.R. § 300.43). The proposed limitation applies a reduced service cap based solely on age and school enrollment, rather than on assessed need and documented service function. As a result, two members with identical functional needs may receive different levels of HCBS solely because one remains in public school beyond age 18, even when services are provided outside instructional time and do not overlap with school responsibilities. This outcome is inconsistent with person centered planning requirements and the flexibility contemplated under the 1915(c) waiver authority. Reducing these hours risks a violation of the Americans with Disabilities Act (ADA) and the Olmstead decision. By limiting supports necessary for community-based transition, the State may inadvertently increase the risk of institutionalization for individuals	

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		who can no longer be safely supported in the community under the proposed caps. The proposed draft creates an unjustifiable disparity between members living in family homes and those in licensed or unlicensed residential settings. Under Section 513.17.3 (Licensed Group Home PCS) and Section 513.17.4 (Unlicensed Residential PCS), the manual maintains a maximum service cap of 24 hours per day (8,760 hours annually) for adults aged 18 and older. These sections notably lack any explicit reduction or 'school-age cap' for members who choose to remain in public education while living in a residential placement. This creates a policy where two 19-year-old members with identical functional needs and identical school schedules are treated differently: one living in a Group Home may access up to 24 hours of support, while one living with family is arbitrarily capped at 5 hours of FPCS. There is no clinical or legal basis for assuming that a student's 'educational duplication' risk vanishes simply because they move into a residential facility. By applying this cap only to Family and Home-Based Person-Centered Supports, the State is creating a financial disincentive for family-based care, which contradicts the HCBS mission of supporting individuals in the least restrictive, most natural environment possible. If the 'payer of last resort' rule is the true justification, it must be applied based on documented service overlap in the IPP, not through a discriminatory cap that targets family-supported members while exempting residential-supported members. Additionally, the proposed limitation risks creating a disincentive for continued participation in public education for individuals who require extended transition services, contrary to the goals of IDEA, which emphasize preparation for further education, employment,	

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		and independent living (20 U.S.C. § 1400(d)(1)(A)). The 'cliff' that occurs upon graduation is a well-documented crisis in West Virginia. Person-Centered Supports are the primary vehicle for families to build the capacity for adult self-direction. Reducing these hours at the very moment the member is preparing to exit the LEA is counter-productive to the State's goal of fostering independence and long-term cost savings through successful community placement. Furthermore, the proposed limitation ignores the current fiscal and operational reality of vocational support in West Virginia. The Division of Rehabilitation Services (DRS) is currently facing significant budget and staffing constraints. In many of our rural counties, the vocational training and transition supports theoretically available to students over 18 are functionally non-existent due to these shortages. By cutting waiver hours under the assumption that DRS or the LEA is filling the gap, the State is effectively leaving members in rural communities with no support at all. A categorical reduction in Person-Centered Support hours during this critical transition period—when state-level vocational resources are already being capped or delayed—will disproportionately harm members in underserved areas and undermine their path to independence. Finally, The proposed cap of 7,320 annual units for Person-Centered Supports combined limits is mathematically inconsistent with the stated goal of a 5-hour daily average. As documented in previous Bureau for Medical Services (BMS) comment logs, 7,320 units actually averages to 5.014 hours per day in a standard 365-day year, as it is based on a 366-day leap year calculation. Using a limit that does not divide evenly into the stated daily goal creates unnecessary administrative hurdles for families and Care Management providers trying to calculate monthly budgets, resulting in service denials and administrative burdens that can be	

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		prevented with accurate policy documentation. Furthermore, if the State intends to reduce these hours for transition-age members, doing so with a limit that is technically inaccurate further complicates an already burdensome transition process. The State should focus on resolving these long-standing clerical errors rather than implementing new, restrictive caps that ignore the assessed needs of members. A more appropriate and federally aligned approach would be to continue enforcing non duplication requirements while maintaining service limits based on individual assessment and documented need. This includes ensuring that Person Centered Support services (which are the current service guidelines and expectations): • Are delivered outside scheduled instructional time or address needs not required to be provided under an IEP; • Are clearly documented as non academic and non educational in nature; • Support transition planning, independent living skills, caregiver training, and community participation; and • Are justified through assessment and reflected in the Individualized Program Plan, consistent with CMS person centered planning requirements (42 C.F.R. § 441.301). For these reasons, I respectfully request that the proposed reduced service cap for members age 18 and older who are attending public school be reconsidered, revised, or removed, and that service authorization remain grounded in assessed need, functional outcomes, and documented compliance with federal non duplication requirements under IDEA and Medicaid law. The State already possesses a robust mechanism for preventing duplication: the Individualized Program Plan (IPP) and the annual	

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		assessment. These existing tools are sufficient to ensure that services do not overlap with school hours without the need for a blunt, age-based cap. Thank you for the opportunity to provide public comment and for your consideration of these comments/concerns.	
46	4/22/2026	513.16.1 - Participant-Directed Goods and Services I am not convinced Acentra Health actually reviews the submissions for the Participant-Directed Goods and Services, because I have received approval from my Case Manager, but then Palco tells me that I can't have the item or service that we agreed upon. I need to know who actually reviews these items and when. Also, Palco has told me that some of the things we have requested are not "age-appropriate". Who determines this, because my child has been assessed and the assessments that Acentra Health does says my child is the equivalent of a toddler. Finally, in talking to some other families, it seems like whoever approves these picks and chooses which of the requirements have to be met before the items are addressed. If it is a need and documented in the IPP, I don't understand why sometimes things are approved and sometimes we are told that we can't have what we need because the item or service does not decrease the need for Medicaid services. It just seems like whoever looks at these doesn't have a consistent process, and I would like some clarification, please. I also see that this section says there are things that are family responsibilities, but what if we get a recommendation from a therapist? Would this not qualify as something outside of a regular family's responsibilities?	**Change** This section of the policy manual will be revised to clarify that Participant-Directed Goods and Services (PDGS) may only be provided in accordance with federal and state requirements, including the HCBS Settings rule and the West Virginia Statewide Transition Plan. Specifically, PDGS may only be provided in an “age-appropriate” manner, which means the item or service is suitable for individuals of a particular age or age group. This does not mean that the individual must participate in only age-appropriate activities, but, to bill WV Medicaid, services (including PDGS), must be provided in an age-appropriate manner. In addition, a recommendation by a licensed clinician is not the sole factor in determining whether an item or service is a permissible PDGS. All other requirements must be met to approve a PDGS request.

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47	4/22/2026	513.2 - Provider Enrollment and Responsibilities This new manual says we are not required to turn in documents for transportation services, but it does not say who or what is responsible to cover any issues if something would happen. What kind of protections does signing this supposed affidavit provide to families who choose to use transportation services. We have enough to keep up with without having to monitor that as well.	**No change** This revision comports with the new requirement of Senate Bill 325 to allow for an affidavit in lieu of the listed documentation.
48	4/27/2026	When will these changes be implemented?	**No change** The changes included in the IDDW Policy Manual revision will be effective as of the date of publication.
49	4/28/2026	NOTE: Multiple internal consistency and implementation issues were identified within the Draft Policy Manual's Case Management service description. To allow for clear consideration of each issue, comments are being submitted separately per issue found in the 513.19.1 Case Management (Traditional Option) section of the Draft Manual. These issues relate to policy areas where interpretation and implementation guidance had previously been clarified and finalized in Statewide Provider Calls, but where aligned updates are not fully reflected in the current Draft Manual. The Draft Policy Manual contains internal inconsistencies between the Case Management service description, required home visit frequencies, and the Per Member Per Month (PMPM) service codes and rates associated with different residential settings. These inconsistencies create implementation challenges for Case Managers, providers, and utilization management reviewers and may result in incorrect authorization, billing, or monitoring expectations. The Draft Manual lists the following Case Management procedure codes and service units:	**Change** The policy manual will be revised to clarify that Specialized Family Care settings are subject to monthly in-person case management visits and subject to the enhanced per member/per month case management rate.

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		Procedure Code: G9002U3 Case Management Natural Family & SFC G9002U4 Case Management ISS & Group Home Service Units: Unit = Per member / Per month As written, the G9002U3 service code continues to include Specialized Family Care (SFC) within the service name and PMPM rate structure. However, the Case Management duties outlined later in the service description establish different minimum in person visit frequencies based on residential setting, which no longer align with the current service code configuration. Specifically, the Draft Manual requires Case Managers to personally meet monthly in person with members residing in a 24 hour setting and/or a Specialized Family Care setting, while members living in a natural family setting require quarterly in person visits with electronic or telephonic contacts in the intervening months. These requirements are clearly differentiated within the duties section, yet the service code naming and PMPM structure do not reflect this distinction. As a result, the G9002U3 service code currently groups Natural Family and SFC settings together despite materially different service delivery expectations, including increased travel, time, and monitoring requirements associated with monthly in person visits for SFC placements. This misalignment creates confusion regarding which PMPM rate applies to which residential setting and complicates compliance monitoring for visit frequency requirements. Additionally, the Utilization Management Contractor authorization portal, CareConnection©, does not reflect a corrected separation of Specialized Family Care within the Case Management service	

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		codes, currently the service code reads, "G9002U3 - Case Management: Family-SFC" but the correct service to purchase for SFC placements is "G9002U4 - Case Management: ISS-Group Home". The continued inclusion of “SFC” within the G9002U3 service name reinforces outdated expectations and increases the risk of inconsistent authorization and billing practices across providers. To resolve these inconsistencies and support clear, enforceable implementation, it is recommended that the Draft Policy Manual be revised to realign service codes, service names, and visit frequency requirements. Specifically, revising the service codes as follows would directly align billing, authorization, and monitoring expectations: • G9002U3: Case Management – Natural Family • G9002U4: Case Management – ISS, Group Home, and Specialized Family Care This revision would clearly associate the higher PMPM rate with residential settings requiring monthly in person visits, reflect the additional resources necessary to meet those requirements, and allow Case Managers, providers, and utilization management staff to readily identify and apply the correct service expectations. Corresponding updates should also be made within CareConnection© to ensure consistent authorization and system alignment. Aligning the Draft Manual’s service descriptions, visit frequency requirements, service code naming, and authorization systems will reduce implementation confusion, promote compliance, and support consistent statewide application of Case Management standards.	

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50	4/28/2026	NOTE: Multiple internal consistency and implementation issues were identified within the Draft Policy Manual's Case Management service description. To allow for clear consideration of each issue, comments are being submitted separately per issue found in the 513.19.1 Case Management (Traditional Option) section of the Draft Manual. These issues relate to policy areas where interpretation and implementation guidance had previously been clarified and finalized in FAQs, but where aligned updates are not fully reflected in the current Draft Manual. The Draft Policy Manual contains internal inconsistencies regarding Case Management responsibilities for purchasing services, uploading Individualized Program Plan (IPP) documentation to the Utilization Management Contractor (UMC) portal, and the timing required for services to receive authorization. These inconsistencies present operational conflicts for Case Managers and create avoidable risk of delayed or denied service authorizations. Within the Case Management servicCe description, one duty requires Case Managers to "purchase services to obtain authorizations or change existing authorizations within seven days of the IDT meeting or team's approval of a service plan addendum." A separate duty within the same section requires Case Managers to "upload any required documentation into the UMC's portal within 14 calendar days of the IDT meeting," with a note stating that no services will be prior authorized until the current IPP is uploaded to the portal. As written, these two requirements conflict. Service authorizations cannot be issued until the IPP is uploaded to the UMC portal, yet Case Managers are also directed to obtain or modify authorizations within seven days, while having up to 14 calendar days to upload the IPP that is required for those authorizations.	**Change** The timelines to obtain authorizations, disseminate copies of the IPP, and upload documentation into the UMC's portal will be revised to reflect the 10-business day requirement, consistent with the revisions noted above to 513.8.

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		This sequencing creates an impossible compliance expectation and exposes Case Managers to noncompliance despite adherence to one requirement over the other. This inconsistency mirrors an error previously identified in the 2018 Policy Manual and formally clarified through the Bureau's Frequently Asked Questions finalized on July 22, 2021. FAQ Q204 explicitly stated that the seven day purchasing requirement was not an intentional change and confirmed that the Bureau would continue to require Case Managers to submit purchase requests and upload required documentation to the member's file in CareConnection© within 14 calendar days following the date of the IDT meeting or the team's approval of a service plan addendum. That clarification resolved the prior conflict by aligning purchasing and documentation requirements within a single, consistent timeframe. The Draft Policy Manual does not reflect this clarification and reintroduces the same timing conflict, despite the earlier resolution. Additionally, the Draft Manual does not specify whether the seven-day requirement for purchasing services is measured in calendar days or business days, further increasing implementation of inconsistency across Case Management agencies and reviewers. To resolve this issue and align with both prior clarification and operational feasibility, it is recommended that the Case Management service description be revised to require that service purchasing, authorization requests, and IPP documentation uploads occur within 14 business days of the IDT meeting or team approval of a service plan addendum. This timeframe should be applied consistently across all references to IPP development,	

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		purchasing, and authorization requirements, including earlier sections addressing IPP development prior to the Case Management service description, such as Section 513.8 INDIVIDUAL PROGRAM PLAN (IPP). Clarifying and standardizing this timeline will prevent contradictory compliance requirements, reduce risk of authorization delays due to administrative sequencing conflicts, and ensure consistent implementation across service models, Case Management agencies, and utilization management processes.	
51	4/28/2026	The Draft Policy Manual contains conflicting timelines governing Individual Program Plan (IPP) submission, service purchasing, and prior authorization requests, all actions that are administratively required at the same time in practice. Conflicting timelines throughout the policy sections create uncertainty for Case Management agencies and increases the risk of inconsistent implementation. Section 513.22 Prior Authorizations states that services requiring prior authorization "must be submitted to the UMC within 10 business days of the IDT meeting at which the services were chosen," and assigns responsibility to the case manager for ensuring that all prior authorizations for chosen IDDW providers are sent to the UMC. This timeline differs from and conflicts with multiple timelines established elsewhere in the Draft Manual. Within Section 513.8 Individual Program Plan (IPP), several different submission deadlines are stated, including: • "The IPP must be uploaded to the UMC portal within ten business days."	**Change** Each relevant section will be revised to reflect a consistent 10-business-day timeline to distribute and upload the IPP throughout Chapter 513.

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		• "All IPPs must be uploaded into the UMC's portal and given to all team members within 14 business days and must include:..." • "A copy of the IPP is kept in all participating provider agency records and distributed, via secure electronic means, to all team members by the case manager within seven calendar days of the date of the IDT team meeting. The IPP must be uploaded into the UMC's portal within 14 calendar days of the IDT meeting to ensure timely authorization of services." Additionally, Section 513.19.1 Case Management (Traditional Option) establishes different timelines for purchasing services and documentation upload: • "Purchase services to obtain authorizations or change existing authorizations within seven days of the IDT meeting or team's approval of a service plan addendum." • "Upload any required documentation into the UMC's portal within 14 calendar days of the IDT meeting. NOTE: No services will be prior authorized until the current IPP is loaded into the portal." These timelines were previously addressed through formal clarification. FAQ Q204, finalized on July 22, 2021, stated: • "No. BMS will continue to require that Case Managers make purchase requests and upload documentation to member's file in CareConnection© within 14 calendar days following the date of the IDT meeting or team's approval of a service plan addendum." When read together, the Draft Manual establishes multiple, conflicting deadlines—seven calendar days, ten business days,	

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		fourteen calendar days, and fourteen business days—governing interdependent actions required to secure prior service authorization, which occur at the same time in practice and expectations for Case Management delivery. Section 513.22 introduces a ten business day prior authorization submission requirement that is not reconciled with IPP upload requirements or Case Management purchasing timelines, despite the stated requirement that services cannot be prior authorized until the IPP is uploaded to the UMC portal. Absent clear alignment or hierarchy among these sections, Case Management agencies may be unable to comply with all requirements simultaneously, creating avoidable administrative burden and authorization risk unrelated to service need. Clarification and alignment of timelines across Sections 513.22, 513.8, and 513.19.1 are necessary to ensure consistent implementation and enforceable compliance expectations. The recommended timeline for IPP documentation deadline, upload deadline, purchase deadline, and distribution deadline should be all the same and documented in the policy sections consistently for 14 business days.	
52	4/28/2026	Section 513.8 Individual Program Plan (IPP) introduces a new requirement that the IPP "must be signed in real time, by all IDT members who attended the meeting prior to the conclusion of the IPP meeting," and further conditions IPP validity on all required parties signing prior to the end of the meeting. This requirement is cited as being required "per 42 CFR 441.301(c)(2)." However, the cited federal regulation does not require real time signatures prior to the conclusion of the meeting. The CMS person centered planning rule requires that the plan be finalized, agreed	**No change** Existing policy manual language complies with federal requirements at 42 CFR § 441.301(c)(2), requiring that all IPPs be finalized with the informed written consent of the individual and signed by all individuals and providers responsible for implementation. However, in the absence of real-time signatures, there is a risk that an IPP could be modified

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		to, and signed, but it does not prescribe the timing or method of signature collection. Specifically, 42 CFR § 441.301(c)(2) requires that the person centered service plan: "Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation." The regulation does not state that signatures must be obtained during the meeting itself, nor does it prohibit post meeting signature collection, electronic signatures, or delayed signatures due to logistical barriers. CMS requirements in this section focus on informed consent, agreement, and accountability, not real time execution during the meeting. Additionally, the Draft Manual contains internally conflicting language. While requiring real time signatures prior to the conclusion of the IPP meeting, the same section allows that: "A copy of the IPP is kept in all participating provider agency records and distributed, via secure electronic means, to all team members by the case manager within seven calendar days of the date of the IDT team meeting," and "If the legal representative attends via teleconference the case manager must obtain their signature within seven calendar days." These provisions acknowledge that signatures may be obtained after the meeting in certain circumstances, directly contradicting the asserted requirement that real time signatures are required for IPP validity under CMS policy. In addition, previously submitted comments identify multiple, differing timelines for IPP finalization and processing across sections of the Draft Manual, further	without the knowledge or consent of the member, the legally authorized representative (LAR), or other members of the interdisciplinary team (IDT). Requiring real-time signatures helps safeguard the individual and all IDT members by ensuring transparency, alignment, and accountability and by reducing the potential for conflicting or unauthorized information to be included in the IPP.

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		undermining the assertion that real time signatures are required under federal policy. Requiring all IDT members and providers to sign the IPP in real time creates significant administrative burden without a corresponding federal mandate. IDT meetings routinely include multiple provider agencies, legal representatives, advocates, and participants attending remotely or across geographic areas with varying levels of technological skills. Conditioning IPP validity on real time signatures increases the likelihood of delayed authorizations, invalid successful meetings, repeated meetings, missed eligibility, service access denials from the UMC, and administrative noncompliance unrelated to service need or person centered planning principles. Clarification is needed to remove the real time signature requirement and align Section 513.8 with the actual CMS requirement and with the Draft Manual's own allowance for post meeting signature collection. Absent such clarification, the Draft Manual imposes a more restrictive standard than required under 42 CFR § 441.301(c)(2) and creates internal inconsistency within IPP processes and timelines.	
53	4/29/2026	Can there be a cap put back on Case Management for how many people a case manager is allowed to have on their case load? It's already hard for agencies to keep Case Management due to it not getting a rate increase. As a result some agencies may not want to hire new Case Managers. With the wait list slots being released each year, the demand may be more than the number of case management agencies/case managers in the state can handle. Also, with IDD Waiver being a life long program, the only way that someone loses it is: if they pass away, decline it, go to a higher	**No change** Agencies are responsible for setting each Case Manager's case load based upon the needs of the assigned members, the Case Manager's experience and skills, and the agency's systems/ supports that enable Case Managers to efficiently perform required tasks.

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		level of care, or somehow become ineligible. The number of people that could be leaving IDD Waiver, seems to be less than the number that comes off the wait list each year, so that also makes it hard to keep up with the demand for Case Management. Thanks for your consideration of this matter.	
54	4/28/2026	The Draft Policy Manual uses inconsistent language to describe eligibility related service access requirements, creating ambiguity regarding when a member may be subject to discharge versus when an eligibility extension is appropriate. Section 513.26 Discharge states that a member may be discharged when: “A member does not access or use at least one IDDW Service each month (except for case management).” This language broadly references “IDDW Service” without specifying whether eligibility is tied to receipt of direct care services or to any non-case management waiver service. As written, this section establishes a discharge trigger that is broader and less defined than other sections addressing the same eligibility concern, as well as prior memos and clarifications. The lack of specificity creates the potential for differing interpretations regarding whether access to professional or ancillary services alone satisfies ongoing eligibility requirements in the absence of direct care service utilization. By contrast, Section 513.24 Payments and Payment Limitations uses more specific language aligned with prior guidance, stating: “If the member has or will go a calendar month without accessing a direct care service, the service coordinator [case manager?]	**Change** Section 513.26 will be revised to clarify that a member may be discharged if they do not access or use at least one IDDW direct care service each month.

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		must send an I/DD 12 to the UMC as soon as they become aware of the member's circumstances." Section 513.24 clearly ties eligibility risk and extension requirements to the absence of direct care services, not to waiver services generally. This distinction is consistent with prior memos and FAQs and provides a narrower, more clearly defined eligibility standard. The differing language between Sections 513.26 and 513.24 creates uncertainty regarding which standard controls eligibility and discharge determinations. Absent clarification, the Draft Manual establishes two different thresholds for eligibility action—one based on "IDDW Services" generally and one based specifically on "direct care services"—which may lead to inconsistent application, inappropriate discharge decisions, and avoidable administrative burden for Case Management agencies. Clarification is needed to align discharge criteria in Section 513.26 with the direct care service standard used elsewhere in the Manual, or to clearly define what constitutes an "IDDW Service" for eligibility and discharge purposes. The recommended change would be to add limited descriptor language to the existing sentence, as follows: "A member does not access or use at least one IDDW Direct Care service each month (except for case management)."	
55	4/30/2026	(513.2.3.3) The timeliness of oversight processes is critical to protecting individuals receiving services, and the proposed extension of the timeframe for issuing a draft exit summary from 2 weeks to 120 days introduces unnecessary delays. Such a delay may hinder providers from implementing corrective actions and may negatively impact individuals receiving services. A revised	**Duplicate**

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		timeframe of approximately 30 days would better support accountability, responsiveness, and quality improvement.	
56	4/30/2026	(513.6.2.1) Eligibility criteria remain a concern regarding Olmstead compliance, particularly the exclusion of individuals with Autism based on level designations. A more including approach that recognizes Autism broadly as a related condition would better reflect individual needs and support access to services in community settings.	**Duplicate**
57	4/30/2026	(513.6.2.2) West Virginia continues to maintain more restrictive eligibility standards than other states, which may limit access to community-based supports and increase the risk of institutionalization. Aligning adaptive functioning criteria with national standards would reduce barriers and better support individuals who require services to remain in integrated settings.	**Duplicate**
58	4/30/2026	(513.15.2) Restrictions on where prevocational skills can be developed may unintentionally limit opportunities for meaningful employment preparation and community engagement. Skill development often occurs in a variety of real-world environments, including volunteer and community-based experiences, and flexibility should be maintained to support competitive integrated employment outcomes.	**Duplicate**
59	4/30/2026	(513.2) The addition of required training on abuse, neglect, and exploitation strengthens protections for individuals receiving services and supports and supports system accountability. This requirement aligns with best practices for safeguarding individuals in community-based settings	**No Change**
60	4/30/2026	(513.2.2) Clarification regarding privacy protections, including social media use, reflects current service environments and promotes respect for individual rights and dignity.	**No change**

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61	4/30/2026	(513.5) Implementing provider payment holds for failure to submit required documentation may improve compliance, oversight, and program integrity.	**No change**
62	4/30/2026	(513.14.1, 513.14.2) Expanding access to home and vehicle modifications supports independence and reduces barriers to living in the most integrated setting	**No change**
63	4/30/2026	(513.15.2) Clarifying that employment must meet minimum wage standards promotes equitable workforce participation and supports competitive, integrated employment. This change reinforces the expectation that individuals receiving services have access to fair and meaningful employment opportunities	**No change**
64	4/30/2026	(513.15.3) The clarification that provider offices are not considered community settings reinforces the importance of true community integration and avoids reliance on facility-based models.	**No change**
65	4/30/2026	(513.16.1) Removing exclusions for nutritional supports and essential household items helps individuals maintain stability and health in their homes and communities.	**No change**
66	4/30/2026	(513.17.5) The expansion of crisis services strengthens the system's ability to respond to urgent needs and may prevent unnecessary institutional placements.	**No change**
67	4/30/2026	(513.26) Protecting individuals who choose to self-direct their services by preventing discharge from case management supports autonomy, choice, and person-centered service.	**No change**
68	4/30/2026	Under Appendix K, BSPs and RNs have been able to train staff and bill to complete the training remotely (gaining physical signatures as soon as possible from the trainee). This has greatly aided in ensuring that our members/consumers have staff working with them that are adequately trained upon the individuals, most particularly in times needing immediate coverage and when changes occur via incidents and critical junctures which facilitate the need for immediate training for all staff working with the	**Change** The policy manual will be revised to clarify that BSP and RN services, including staff training, may be provided via telehealth pursuant to Chapter 519.17**,** if appropriate and in line with the individual's needs and preferences.

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		individuals. I have been working in the Title XIX Waiver field for almost 20 years and have seen a notable decrease in the number of professionals (BSPs, CMs, RNs) causing these professionals to have a higher number of consumers assigned on their caseloads. The direct care staffing shortage continues to be a critical issue for agencies statewide. Taking these things into account that I just mentioned, permitting remote trainings to continue allows for agencies to be able to ensure that the staff working with the consumers are adequately trained on their plans, health, safety, crisis, etc. Please consider this allowance.	
69	5/3/2026	Comment: Page 16 final bullet- what about when members and guardians determine to leave the program and refuse a written discharge plan.	**No change** IDDW providers must document efforts to develop and implement a viable discharge/transfer plan and may seek technical assistance from BMS and/or the UMC regarding the specific circumstances of a challenging discharge or transfer.
70	5/3/2026	Pg 128 LPN doesn't allow medication pass- I thought we had figured out that didn't work. There has even been discussion of a separate code for LPN medication pass and AMAP medication pass.	**No Change** AMAP codes with enhanced rates will be offered in lieu of LPNs billing for mediation passes.
71	5/3/2026	Page 36. And 145 As of November 7, 2024, the DD-11 form (Notification of Death) has been discontinued. Providers no longer complete a DD-11 form or attach completed forms in The UMC's web-based portal. The DD-11 has been replaced by the Notification of Death in the Atrezzo IMS. When a member passes away, providers must complete an incident report, the Notification of Death in the Atrezzo IMS, and start the discharge process in the UMC's portal. Since this goes into effect after November 24th I would simply start with when a member passes away providers	**No change** The current draft policy manual replaces the previous September 2024 version. Existing language in the policy manual is necessary to ensure accuracy and provide historical context.

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		must complete an incident report, the notification of death in the atrezzo ims, and start the discharge.	
72	5/3/2026	Pg 46 All members utilizing IDDW services must have financial eligibility redetermined annually by their local or county West Virginia DoHS. Members who are found financially eligible will receive documentation from the West Virginia DoHS (ESNL-A) The documentation of financial eligibility must be shared with the individual's case management provider. The member must provide their Notice of Decision letter re establishing their medical eligibility to the West Virginia DoHS before financial eligibility can be established. Is this absolutely necessary for people receiving SSI? Aren't they automatically eligible. It seems that it could save some tax dollars to	**No change** Existing language in the policy manual is necessary to ensure all IDDW members are supported in maintaining their financial eligibility, regardless of eligibility type.
73	5/3/2026	Pg 48 The IPP must be uploaded to the UMC portal within ten business days. IPP includes the Initial IPP which must be developed within seven calendar days of intake/admission to a new provider agency, the annual IPP, and subsequent reviews or revisions of the IPP, Critical Juncture, Transfer, and Discharge IPPs. Activities conducted before or after the meeting may meet the criteria for case management activities. All IPPs must be uploaded into the UMC's portal and given to all team members within 14 business days and must include: can it be consistent? 10 or 14? Personally I love something with business days versus calendar days, but it is inconsistent throughout the new manual with most siting 14 calendar days as previously outlined.	**Duplicate**
74	5/3/2026	513.8 INDIVIDUAL PROGRAM PLAN (IPP)- can there be some additional information about face to face attendance vs electronic attendance- we have an issue with CMs deciding rather frequently to attend via phone when the rest of the team is face to face. Or maybe on Page 50.	**Duplicate**

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75	5/3/2026	Pg 49. Professional services may be purchased in any order that meets the individual's unique support needs. I like this change- it is much more individualized.	**No change**
76	5/3/2026	Page 49 thanks for the restrictive measures examples.	**No change**
77	5/3/2026	Pg 50 Medicaid cannot reimburse services delivered when the IPP has expired, has not been reviewed within required timelines, and/or does not include required signatures or services.- should this address the DD-12.	**No change**
78	5/3/2026	Pg 139. If a member is jailed or imprisoned, the service coordinator should submit an I/DD-12 to the UMC and request an eligibility extension. If the member has or will go a calendar month without accessing a direct care service, the service coordinator must send an I/DD-12 to the UMC as soon as they become aware of the member's circumstances. This section is somewhat confusing. First change Service Coordinator to Case Manager. Also, Is CM not able to bill for a member who is jailed, but is for psychiatric hospitalization, etc.? for 3 months. Can the slot still be on hold for up to 6 months?	**Change** "Service coordinator" will be revised to "case manager" in all relevant sections of the policy manual.
79	5/4/2026	Pages: 59, 139, 155, 156, 164 Please change from Service Coordinator/Service Coordination to Case Manager/Case Management.	**Duplicate**
80	5/4/2026	When will the Annual Review Tool be changed to reflect the manual changes?	**No change** Updates to the quality review tool will be shared with IDDW providers in the event that revisions are implemented.
81	5/4/2026	Is there a list of approved programs for obtaining electronic signatures?	**No change** IDDW providers are permitted to utilize the modality of their choice, in accordance with state and federal rules regarding the dissemination of protected health information (PHI), including *Chapter*

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			100, General Information of the BMS Policy Manual.
82	5/4/2026	Page 10, All HCBS Settings Last sentence, "Case managers and direct-support professional staff must complete mandatory training on the Statewide Transition Plan. Members will receive educational information on the Statewide Transition Plan from their case manager" Is the HCBS Assessment adequate for the "educational information"?	**Change** This section of the policy manual will be revised to clarify that case managers and direct support professional staff must complete mandatory training on the Statewide Transition Plan upon hire. BMS does not prescribe the contents of this training; however, case managers and direct support staff are expected to be knowledgeable about the requirements of the Statewide Transition Plan, including the HCBS Settings Rule Requirements.
83	5/4/2026	Page 10, All HCBS Settings The mandatory training on the Statewide Transition plan, if still applicable, should also be included in the training requirement list and/or staff qualifications to stand out better.	**No change** The current training requirements for case managers on the Statewide Transition Plan are described in other sections of the policy manual. BMS may consider revising the policy manual to include additional training requirements regarding federal rules, including the HCBS Settings Rule and the Ensuring Access to Medicaid Services Final Rule in a future revision.
84	5/4/2026	513.2, page 16 Administrative Standards, 7th bullet: Shouldn't agencies that provide both CM and HCBS assign 2 agency IDDW contact persons? There is a lot of effort separating the two except here.	**No change** IDDW providers are free to assign additional contact people to ensure administrative separation between their case management and provider functions if doing so is necessary to ensure compliance with

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			the Conflict Free Case Management requirements.
85	5/4/2026	513.2, page 20 Responsibilities to Agency Staff, top of page 20, first full bullet point on the page, last bullet for this section. How often is the agency required to have the written approval from the UMC for their online training?	**No change** Please refer to the UMC for clarifications regarding obtaining written approval for online training.
86	5/4/2026	513.2, page 21 2nd bullet If legal representative does not participate in the annual functional assessment, the legal representative must sign the Freedom of Choice within 10 days. However, if this is not possible, the form should be completed at or before the member's annual IPP meeting. Case Manager should document the circumstance which prohibited completion within 10 calendar days. When and where is the CM required to document this?	**No change** Case managers may document the circumstances surrounding the inability to obtain the legal representative's signature on the Freedom of Choice form on the form itself or in any other method accepted by the UMC.
87	5/4/2026	513.2.3.6, page 26 It states "IDDW agencies must submit evidence every calendar year to document continuing compliance will all certification requirements specified in this manual. Evidence reports must include a signed attestation from an appropriate official of the provider agency (e.g., executive director, Board Chair, etc.). Reports may be sent from a provider's human resources (HR) system. For example, providers may send an Excel spreadsheet or any other format that includes all applicable fields and documents training dates of employees." Providing training dates of employees was removed and is not listed on the excel form provided by Acentra (conference call 1/4/2024).	**No change** The reference to training dates is included in an example of acceptable methods of recording and reporting self-review information to the UMC.
88	5/4/2026	513.3.10, page 33 Please amend to include the 8/1/2025 allowance for having the affidavit instead of maintaining the driver's license, insurance, etc.	**Change** This section of the policy manual will be revised to include a reference to the August 1, 2025, WV Code permitting the use of an affidavit to attest to the validity of the driver's license, current vehicle insurance, and

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			registration for any staff providing transportation to IDDW members.
89	5/4/2026	513.3.17, page 34 Transportation Services Agency Staff Qualifications: This states that the provider is "required to maintain documentation at all times verifying that agency staff…. have a valid driver's license, proof of current vehicle insurance, inspection and registration". Please change to reflect the 8/1/2025 allowance for having an affidavit.	**Change** This section of the policy manual will be revised to include a reference to the August 1, 2025, WV Code permitting the use of an affidavit to attest to the validity of the driver's license, current vehicle insurance, and registration for any staff providing transportation to IDDW members.
90	5/4/2026	513.4, page 35 In the current manual, if an incident happens on a weekend or holiday, it is acceptable to enter the incident the following business day. This is not stated in proposed manual. Please amend to allow this.	**Duplicate**
91	5/4/2026	513.4, page 35 First paragraph at the top of the page: "Staff who observe or is informed of the incident should report in WV IMS" – Please clarify. This allows the possibility of either duplicating reports or neglecting to report. The last sentence in this paragraph indicates that the CM is the responsible party for making the report, not the observer. If an agency staff observes or suspects abuse, shouldn't that individual complete the report? Taking the time to contact the CM, who may not be available (they could be out of the county/office, off work, etc., and this would delay or possibly prevent the report from being made. Especially with CFCM, there is a potential layer of bureaucracy and implication that the staff just needs to inform the CM.	**No Change** Current language in the policy manual states that any staff members who observe, are involved in, or are informed of an incident should report the incident in the WV IMS.
92	5/4/2026	513.4, page 36 1st paragraph There should be no discussion of "in the event the individual receives Case Management from another agency" as the CFCM mandate was effective for all IDDW members in 2023. Since CFCM is now mandatory for all IDDW	**Change** The policy manual will be revised to state that "when an individual receives case management from another agency…" to acknowledge that,

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		members, incident reports and IMS entry should be the responsibility of the service provider agency (traditional or self-directed option).	while conflict-free case management is in effect, some individuals are served by one agency when geography or other circumstances necessitate the provision of both case management and direct support services by a single IDDW program provider.
93	5/4/2026	513.4, page 36 Last paragraph of this section states the Case Manager must notify the UMC of a member's transfer to another Case Management provider or if the member chooses another delivery system within 2 working days. So, 2 working days from what? Is this referring to the DD2? Please clarify.	**Change** The policy manual will be revised to clarify that notice to the UMC must take place within two business days of the IDT transfer meeting and completion of the Freedom of Choice form (DD-2) form indicating the individual's transfer to another case management provider or to another service delivery system.
94	5/4/2026	513.4, page 36 Last two paragraphs and 2 bullet points seem out of place in this section. The CM is responsible for ensuring that the information about the member is accurately depicted in the UMC website and notifying the UMC of transfer of CM or service delivery model.	**No change** This section of the policy manual describes reporting requirements in the IDDW, which includes maintaining accurate information in the UMC portal.
95	5/4/2026	513.5, page 37 Specific Requirements section, 3rd bullet States all Waiver providers must maintain Case Management logs. Is this a new requirement for all IDDW members or is it only required to be documented when a member is on eligibility extension/hold status? Please clarify.	**Change** This section of the policy manual will be revised to clarify and provide examples of documentation that must be retained by IDDW provider agencies that evidence the delivery of IDDW services.
96	5/4/2026	513.8, page 47 It is stated that when the legal representative attends the IDT meeting via teleconference due to extenuating circumstances, the IPP must be signed electronically, and the signature must include a date and time stamp. What if the legal	**Duplicate**

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		representative does not have the ability to sign electronically or the ability to include date and time stamp?	
97	5/4/2026	513.8, page 47 With the Extension of Appendix K, all IDT members have been able to successfully participate in IPP meetings via teleconferencing. The new manual draft allows for the guardian, in extenuating circumstances. Can this be changed to allow team members to participate via teleconferencing? Concerning electronic signatures, the CM has 14 days to finalize, distribute, and upload (when applicable) so this should allow for the 14 days to obtain signatures when a person doesn't have the means to electronically sign.	**Duplicate**
98	5/4/2026	513.8.1, pages 47 and 51 Page 47 states that if there is a legal representative, they must attend the meeting in person, however, can participate via teleconference in extenuating circumstances. Page 51 states that the IDT can agree to hold the meeting virtually other than the annual IPP. Can it also extend that in extenuating circumstances, the IDT can agree to hold even the annually virtually?	**Duplicate**
99	5/4/2026	513.8, page 48 Top of page 1st paragraph includes old language. Please clarify about the requirement to sign "agreement" that it reflects the new IPP signature page. There are members who still refuse to sign in agreement due to the old language. Additionally, within this same paragraph, last sentence is that the IPP is to be uploaded within 10 days of the IPP Meeting. Please amend to 14 days.	**No change** The IPP includes the IDT Signature Sheet, which documents the "Rationale for Disagreement." There is no reference to the timeline for upload to the UMC portal in this section of the policy manual.
100	5/4/2026	513.8, page 48 After 2nd paragraph All IPPs must be uploaded into the UMC's portal. Is this required for all IPPs or only IPPs which require purchase(s) and/or modification request(s)?	**No change** All IPPs must be uploaded to the UMC's portal.

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101	5/4/2026	513.8, page 48 IPP contents In case of a member's refusal to sign the IPP, the reason for the refusal must be documented in the IPP. Where is this to be documented? And who documents this? Please also clarify what language is acceptable as these have been doc requested for not using correct language.	**No change** The "IDT Signature Page" of the IPP includes a section to document any IDT members' "Rationale for Disagreement."
102	5/4/2026	513.8, page 49 "If a finalized IPP needs changes,…" Is this referring to documentation requests? If so, can this addendum be part of the IPP and therefore not require an additional signature page?	**No change** Any changes to the IPP, including an addendum, must be agreed upon by the individual, their LAR (if applicable), and the IDT as evidenced by each IDT member's signature.
103	5/4/2026	513.8, page 50 The first full paragraph regarding signatures conflicts with the new IPP (7.2024). The meeting minutes include a section on participation, and the signature page outlines specifics but total times are not included. Additionally, signing in real time isn't possible for those who participated by electronic means.	**Duplicate**
104	5/4/2026	513.8, page 50 1st paragraph A copy of the IPP is kept in all participating provider agency records and distributed, via secure electronic means, to all team members by the Case Manager within 7 calendar days of the date of the IDT meeting. Please amend to 14 days.	**Duplicate**
105	5/4/2026	513.8, page 50 2nd paragraph In extenuating circumstances, IDT members may take part by teleconferencing. May IPPs still be conducted electronically or will all or some IPPs be required to be held in person? Please clarify but the electronic IPPs have been permitted and work well when needed. If required to be held in person, will a DD-12 be required to be submitted and approved before any team members can participate electronically? How will this impact the ability for team members to bill for time spent in the meeting? This paragraph also states Case Manager must obtain	**Duplicate**

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		legal representative signature within 7 calendar days, which is not a reasonable time frame for cases where the legal representative does not live locally.	
106	5/4/2026	513.8, page 50 3rd paragraph States spending plans are a required IPP attachment. Is it acceptable for the Case Manager to attach the email request sent to the assigned Palco RC for cases where the spending plan is not provided by the Palco RC as requested? Are Case Managers required to obtain utilization reports from the Palco RC for self-directed services for each IPP? If so, is it acceptable for the Case Manager to attach the email request sent to the assigned Palco RC for cases where the utilization report is not provided by the Palco RC as requested?	**No change** Personal Options Resource Consultants are expected to provide utilization reports one month prior to the anchor date. In addition, the Resource Consultant is expected to provide the spending plan to the case manager within 10 business days of the IDT meeting. If the case manager is unable to obtain required documentation from the Personal Options vendor, the case manager may submit documentation evidencing attempts to obtain the spending report to the IPP. In addition, case managers are encouraged to contact supervisory staff of the Personal Options vendor if they are unable to obtain information or documentation necessary to support the development and authorization of a member's IPP.
107	5/4/2026	513.8.1, page 51 2nd paragraph States if all team members agree, meetings (other than annual) may be held virtually through a secure platform. Is this accurate? Will the annual IPP meeting be required to be held in person? If so, will there be any acceptable extenuating circumstances? If so, will a DD-12 be required? If a DD-12 is not required, how will the Case Manager gain approval from BMS to hold the annual IPP meeting virtually?	**Duplicate**

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108	5/4/2026	513.8.1.1, page 52 Seven-Day IDT: Please clarify and expand "one day setting to another". Does this include if a member gets a job or is starting job exploration? Does this include when a member graduates high school even if they don't start a day program? At first glance it appears to be when a member starts at a day program, but it doesn't translate when you go to the next section for 30-day IDT, see below	**No change** There would be no need for a Seven-Day IDT for a member who starts a job unless starting a job or exploring opportunities for a job involved transferring to a new day setting or residential provider.
109	5/4/2026	513.8.1.2, page 53 Please clarify if the 30 day is only required for new Waiver slot or change in residential setting and not the change in day setting.	**No change** This section states that the 30-Day IDT meeting is only required for new members whose services were not finalized at the Seven-Day IPP or members "who've transferred residential providers".
110	5/4/2026	513.8.1.3, page 53 Service provider transfer States Case Manager responsible for submitting the transfer via the UMC's portal and attaching the DD-10 within 5 business days. So, 5 business days from what? The date of the meeting? The effective transfer date?	**Change** The policy manual will be revised to clarify that the Transfer/Discharge form must be uploaded to the UMC's portal within five business days of the Transfer/Discharge IDT Meeting.
111	5/4/2026	513.8.3, page 54 Discharge from the IDDW program. States Case Manager is responsible for completing and submitting the DD-10 to the UMC's portal within 7 calendar days. So, 7 calendar days from what? The date of the meeting? The effective discharge date?	**Change** The policy manual will be revised to clarify that the DD-10 must be submitted into the UMC's portal within five business days of the date of discharge.
112	5/4/2026	513.14, pages 81-86; 513.16, pages 94-97 EAA/PDGS, both traditional and PO: The request is to increase the $1000 cap. This could be done in a cost-effective way that would have parameters set that the assigned budget couldn't be exceeded for example and possibly offer a range, $1000.00 – 10,000.00.	**No change** The amount of funds available for EAA and PDGS is based on the amount approved by CMS in the waiver application.

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		11We see so many NF settings in which the assigned budget is higher than the individual could access just based on services they're accessing within and outside of the IDDW funding. Modifications to a vehicle making them accessible is very costly and $1000.00 doesn't stretch that far.	
113	5/4/2026	513.14.3, pages 84 and 94 EAA, PDGS: Change to reflect the 3/1/2025 changes that eliminate the DD8 and include the PO Payment Request from the Palco RC approving the item prior to authorizing EAA/PDGS	**Change** This section of the policy manual will be revised to reference the Personal Options vendor's Payment Request Form or equivalent.
114	5/4/2026	513.17.1.1, page 97 FPCS - Thank you for the possibility of extending this to domestic partner of a member's parent.	**No change**
115	5/4/2026	513.17.1.1, page 97 FPCS – The family member who is also the legally appointed guardian who lives with the member may provide FPCS, but the motion for authorization is a requirement. This isn't identified within the manual but it would be helpful to spell it out here or in the limitations section. Can this be addressed?	**No change**
116	5/4/2026	513.17.1.1, page 99 When a member turns 18 within a budget year (and if not in school), why can't the IDT plan for the 18th birthday and include the new cap starting on their birthday. So the CM could prorate the daily limit of 5 hrs/day from the first day of the new budget year until the day before the 18th birthday and beginning on the 18th birthday prorate the 8 hrs/day through the end of the budget year.	**No change** If a change in circumstances, including turning 18, occurs during the individual's IPP year, the individual may choose to convene the IDT to review and update the IPP.
117	5/4/2026	513.17.1.1, page 99 Limitations/caps, 4th bullet: Many school age members receive in-home schooling and it's not a full 8 hours of day in school. In addition, there are days when school is closed to include the full summer. Why limit the FPCS for a member who is 18 and chooses to remain in school until they turn 21? The FPCS	**Duplicate**

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		is still an assessed need and could be used up to 8 hours on many, if not most, days.	
118	5/4/2026	513.17.3, page 106 It is imperative that AMAPs are permitted to bill the AMAP modifier for the entire duration of their shift. Limiting the modifier to only the moments in which a medication is physically administered does not reflect the full scope of AMAP responsibilities. AMAPs are responsible for continuous monitoring, documentation, medication security, error prevention, and adherence to all medication-related protocols for the entirety of the shift, not just during the act of administration. In order to maintain safe and compliant medication administration across all shifts, it is essential that providers have enough AMAP-certified staff available at all times. Due to ongoing workforce turnover and the unpredictability of staffing patterns, we must train the majority of our direct support staff as AMAPs to ensure adequate coverage. If the AMAP modifier is limited or restricted, it becomes financially unsustainable to maintain the number of trained AMAPs required to safely staff programs. Providers cannot rely on a small subset of AMAPs when turnover is constant; the only viable model is to train most staff so that every shift has appropriate medication-certified personnel available.	**No change** There is no limitation in the current policy that prevents the AMAP code from being billed for the entirety of an AMAP shift.
119	5/4/2026	513.19.1, page 124, 9th bullet Conflict of Interest Assurance Form: Is this developed by each agency and does it have to have this exact title?	**No change** While BMS does not prescribe a particular form, a "Case Manager Conflict of Interest Assurance Form for Home and Community Based Waiver Services" form is available on the BMS website. IDDW agencies may opt to develop and implement their own form as long as it includes the

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			components noted on the form provided by BMS.
120	5/4/2026	513.19.1, page 125 Please add that the CM will upload the lease agreement for members in an ISS/GH setting if this is still a requirement.	**Change** This section of the policy manual will be revised to clarify that a copy of the signed lease must be uploaded to the UMC's portal for all members residing in an ISS or group home setting.
121	5/4/2026	513.19.1, page 126, 1st bullet Purchase services.. "within 7 days": Please change to 14 days.	**Duplicate**
122	5/4/2026	513.19.1, page 126, 3rd bullet Please change to "compile" not "coordinate". This was addressed in the public comments of the IDDW Application (Feb/Mar 2025).	**Change** This section of the policy manual will be revised to "compile" to reflect the language in the approved waiver application.
123	5/4/2026	513.19.1, page 126, 2nd from last bullet Follow reporting requirements of the WV IMS for members on their caseload. Incident reports and IMS entry should be the responsibility of the service provider agency (traditional or self-directed option). Case Managers should receive a copy of the reports for record retention and IPP requirements but not be responsible for documenting the reports or entering the reports into IMS, especially incidents that are not observed by the CM.	**No change** Pursuant to existing policy, any staff member, including case managers, who observes or learns of an incident must report to the UMC by entering the incident into the WV IMS within 24 hours. In addition, anyone providing IDDW services who suspects an incidence of abuse or neglect is mandated by Behavioral Health Centers Licensure Legislative Rules (Title 71 Series 25), West Virginia State Code§ 9-6-1, § 9-6-9, and § 49-6A-2 to report the incident.
124	5/4/2026	513.19.1, page 126, 11th bullet Please clarify: Is the CM required to upload each IPP into CC?	**Duplicate**
125	5/4/2026	513.19.1, page 127 Process the DD2 within 2 business days – This isn't consistent throughout the manual but also doesn't	**No change** This section of the policy manual states that the form must be

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		specify within 2 business days from when. The member/guardian may make the request but until the other agency accepts and there's an IPP, it wouldn't make sense to upload a DD2 prior to then.	entered within two days of the member's request to change case management agency, service provider agency, and/or service delivery models.
126	5/4/2026	513.19.1, page 127 Procedure codes: G9002U3 Case Management Natural Family The procedure code G900U4 should be CM ISS/GH and include SFC – please amend.	**Duplicate**
127	5/4/2026	513.19.1, page 128 Documentation: A progress log for each service – is this a new expectation? Up until now, the CM log has been to document CM services for a member who is on member-hold, for example, but not a required document	**No change** This section does not include new language or policy.
128	5/4/2026	513.19.1, page 128, 1st bullet Limitations/Caps – there wouldn't be an exception because the cap is a pmpm rate. The first 2 bullets seem out of place and unnecessary.	**Duplicate**
129	5/4/2026	513.22, page 138 "…submitted to the UMC within 10 business days of the IDT meeting…" Please change to 14 days	**Duplicate**
130	5/4/2026	513.26, page 145 Please clarify the timelines on the due date for the CM to upload the DD10 – 7 days from when? If it's pretty straightforward and the member is electing or agreeing to the discharge and there's an IDT – is the DD10 uploaded within 7 days of that meeting? On the DD10, it states within 7 days of the transfer/discharge. If a member doesn't receive direct services within 30 days and isn't communicative with the CM, when does the DD10 get completed?	**Duplicate**
131	5/4/2026	513.27, page 146 Please clarify "within 7 days", from when?	**Change** The policy manual will be revised to clarify that the IDD-10 must be submitted to the UMC within 10

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			business days of the effective date of discharge.
132	5/4/2026	Glossary, page 148 The last sentence in the definition of Critical Juncture is out of place. It just states, “Days: Calendar days unless otherwise specified” but there is no reference to the word “days” within the definition.	**Change** The glossary will be revised to reflect a separate entry for the definition of “Days” within the policy manual.
133	5/4/2026	513.2, page 17 Responsibilities to Agency Staff - Bullet 7 removes "except contracted extended professional staff". Does this mean contracted extended professional staff will now need the following trainings maintained by the agency; Crisis Intervention, Reporting Abuse/Neglect, First Aid, CPR and PBS?	**Change** The exception will be reinstated for contracted extended professional staff.
134	5/4/2026	513.2, page 18 In addition, any staff person who provides transportation services must abide by local, state, and federal laws about vehicle licensing, registration, and inspections upon hire and checked annually thereafter. Responsibilities to Agency Staff - Bullet 6 refers to vehicle "inspections". We have received clarification that Acentra no longer looks at inspection stickers. Are inspection stickers going to be a requirement? Additionally, under the same bullet it states, "…an affidavit, complete by the staff... attesting to the validity of their driver's license, current vehicle insurance, and registration may serve as evidence of compliance..." This sentence omits inspection stickers.	**Duplicate**
135	5/4/2026	513.2, page 18 Responsibilities to Agency Staff - Bullet 6 pertaining to the affidavit states the affidavit is to be completed by the staff providing transportation. However, FAQ 231 states the affidavit is signed by the agency's leadership as well as the individual providing transportation. This seems to imply that the agency is also attesting to the validity of the individual's driver's license, insurance and registration and not just the staff providing transportation. The draft manual does not make this distinction.	**No change** This revision comports with the new requirement for an affidavit in Senate Bill 325. Senate Bill 325 does not include a requirement for agency leadership to attest to the validity of the affidavit’s contents.

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		Who needs to attest and sign the affidavit; the staff, the agency, or both?	
136	5/4/2026	513.2, page 18 Licensed RNs and LPNs are excluded from CPR training and certification requirements. Is this true that Licensed RNs and LPNs do not have to have CPR training?	**Change** This section of the policy manual will be revised to clarify that RNs and LPNs are not excluded from CPR training and certification requirements.
137	5/4/2026	513.2, page 18 Responsibilities to Agency Staff - Bullet 6 pertaining to the affidavit states the affidavit is to be completed by the staff providing transportation. However, FAQ 231 states the affidavit is signed by the agency's leadership as well as the individual providing transportation. This seems to imply that the agency is also attesting to the validity of the individual's driver's license, insurance and registration and not just the staff providing transportation. The draft manual does not make this distinction. Who needs to attest and sign the affidavit; the staff, the agency, or both?	**Duplicate**
138	5/4/2026	513.2, page 18 Licensed RNs and LPNs are excluded from CPR training and certification requirements. Is this true that Licensed RNs and LPNs do not have to have CPR training?	**Duplicate**
139	5/4/2026	513.2, page 19 Responsibilities to Agency Staff - Direct care ethics training excludes, Person-Centered Support LPN. Are LPN's no longer required to have this training annually?	**No change** The existing policy manual language states that this training applies to direct support professionals who provide person-centered supports, day habilitation supports, and respite. If an LPN provides those services, then the training requirements will apply.
140	5/4/2026	513.2, page 21 Conflicts of Interest - Bullet 4 - What distinquishing factors determine if files are separate in an EMR?	**No change** The current policy manual language does not refer to a requirement for a separate electronic medical records system.

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141	5/4/2026	513.2.3.6, page 26 Reports may be sent from a provider's human resources (HR) system. For example, providers may send an Excel spreadsheet or any other format that includes all applicable fields and documents training dates of employees. Please clarify this because Self-Reviews no longer require documentation of training dates of employees	**Duplicate**
142	5/4/2026	513.3.17, page 34 In addition to meeting all IDDW staff requirements in Sections 513.2 - 513.2.1, the provider is required to maintain documentation at all times verifying that agency staff providing transportation services have a valid driver's license, proof of current vehicle insurance, inspection and registration. Please clarify that Inspection Stickers are no longer required as long as there is a signed Affidavit. The manual refers to vehicle inspections and does not mention affidavit.	**Duplicate**
143	5/4/2026	513.4, pages 34-35 Last bullet on page 34 added, "but does not require treatment beyond basic first aid provided at the location of the injury". Does that mean anyone taken for outside care, even if as a precaution and only found to have a sprain or other minor issue, or no problem at all, will need to be considered a critical incident for investigation purposes?	**No change** This section of the policy manual states that any injury requiring treatment beyond basic first aid at the location of the injury must be reported. Transporting an individual for outside care indicates treatment beyond first aid provided at the location of the injury.
144	5/4/2026	513.4, page 35 Any incident involving a person utilizing IDDW services must be reported to the UMC by entering the incident into the WV IMS within 24 hours of learning of the incident. The following statement (effective 2/1/2028) has been removed: All incidents must be entered into the WV IMS within 24 hours of the provider becoming aware of the occurrence. If the provider becomes aware of the incident on a weekend or holiday, it is acceptable to enter the incident the following business day. Was this an oversight or is it truly being removed and we only have 24 hours to enter, even on a weekend or holiday? Please do not	**Duplicate**

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		eliminate the option to enter WVIMS incidents the next work day when the incident falls on a week or holiday.	
145	5/4/2026	513.4, page 35 They added, "The IDDW provider's director or designated staff will immediately review each Incident Report and decide whether the incident calls for a thorough investigation. Investigations must be started within 24 hours of learning about the incident." Similar to our question above, is this intended to be an additional requirement during weekends and holidays as to timing of beginning the investigation process?	**Duplicate**
146	5/4/2026	513.4, page 35 They added, "A completed Incident Report must be entered into the WV IMS (when available) within 14 calendar days of the incident. At any time during an investigation should an allegation or concern of abuse or neglect arise, the provider shall immediately notify Adult Protective Services (APS) or Child Protective Services (CPS) as mandated by State Code. Providers are responsible for investigating all incidents, including those reported to APS or CPS. The provider will inform the person and/or their legal representative (if applicable) of the results of an investigation." Please clarify if the 14 days starts after the 24 hours timeframe to enter into IMS.	**No change** Anyone providing IDDW services who suspects an incidence of abuse or neglect is mandated by Behavioral Health Centers Licensure Legislative Rules (Title 71 Series 25), *West Virginia State Code§ 9-6-1, § 9-6-9, and § 49-6A-2* to report any incident within 24 hours of observing or learning of a suspected incident.
147	5/4/2026	513.4, page 36 The agency whose staff observe, are involved in, or are informed of the incident should report it in the WV IMS. In the event the individual receives case management from another agency, or self-directs via the Personal Options Service Delivery model, the residential/day service agency or resource consultant, as applicable, is responsible for notifying the case manager of the incident, as well as for completing follow-up in the IMS. That agency or resource consultant, as applicable, must also provide the case manager with copies of all related documentation. If the incident occurs in a residential or day setting where the individual also receives case management services, the observer can notify	**Change** This section of the policy manual will be revised to clarify that the service provider agency or resource consultant should notify the case manager of any reported incident within two business days. As stated in existing policy language, the notification to the case manager is made by providing the case manager with copies of all related documentation, which may include an

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		the case manager, who can then enter the incident. What is the timeline for notifying case managers? Does documentation include the actual incident report or just a description/summary of the incident?	incident report and/or a description or summary of the incident.
148	5/4/2026	513.8, page 47 If the member has a legal representative, the legal representative must attend the IPP in person. The legal representative may participate via teleconference in extenuating circumstances. Does the legal representative have to attend in person or can they participate via teleconference in extenuation circumstances? Needs to be clearly written. The guardian can attend via telephone but only in extenuating circumstances - Does a DD12 still need to be done?	**Duplicate**
149	5/4/2026	513.8, page 48 The IPP must be uploaded to the UMC portal within ten business days. Does the IPP need to be uploaded to the UMC portal within ten business days or 14 business days?	**Duplicate**
150	5/4/2026	513.8, page 48 All IPPs must be uploaded into the UMC's portal and given to all team members within 14 business days. Does the IPP need to be uploaded to the UMC portal within ten business days or 14 business days? Does the IPP need to be distributed to all team members with 14 business days or within seven calendar days from the IDT meeting?	**Duplicate**
151	5/4/2026	513.8, page 50 A copy of the IPP is kept in all participating provider agency records and distributed, via secure electronic means, to all team members by the case manager within seven calendar days of the date of the IDT team meeting. The IPP must be uploaded into the UMC's portal within 14 calendar days of the IDT meeting to ensure timely authorization of services. Does the IPP need to be distributed to all team members within seven calendar days from the IDT meeting or within 14 days? Does the IPP need to be uploaded to the UMC portal within ten business days or 14 business days?	**Duplicate**

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152	5/4/2026	513.8, page 50 An IPP includes the completed IPP (WV-BMS-IDD-5) and the following attachments: Crisis Response Plan, Behavior Support Plan/Protocols (if applicable), tentative weekly schedule, budgeted cost of planned services, spending plans (if the member self-directs eligible services), and meeting minutes. Should the CM submit/upload the IPP to avoid deadline expiration, if the member's Palco RC does not get them the spending plan on time?	**No Change** If a unique circumstance arises that may delay the timely upload of the IPP, the case manager should seek technical assistance from the UMC regarding how to address the individual circumstances causing delay.
153	5/4/2026	513.8.1.1, page 52 The initial meeting occurs within the first seven calendar days of admission/intake by a provider/case management agency… Does the seven days start when the client becomes active in CareConnection or when their chart becomes active with the agency? Does this meeting have to be held face to face?	**No Change** The existing policy manual language states that the initial meeting occurs within the first seven calendar days of admission/intake by a provider/case management agency. The date of intake indicates the date when the individual becomes active with the agency.
154		513.8.1.1, page 52 The initial meeting occurs within the first seven calendar days of admission/intake by a provider/case management agency…	**Change** This section of the policy manual will be revised to clarify that the initial IDT meeting occurs in person.
155	5/4/2026	513.8.1.4, page 54 A face-to-face meeting may be held under any of the following circumstances….. It says "may", so a face to face meeting is not mandatory in the situations outlined?	**No Change** A face-to-face meeting is encouraged, but it is not mandatory. This section of the policy manual provides examples of when an in-person Critical Juncture IDT Meeting may be needed.
156	5/4/2026	513.9.2, page 59 The Personal Options FMS acts as the fiscal/employer agent to the member, and is therefore responsible to: Monitor spending of budget funds following approved spending plans. Do the PD - RCs have a timeline to upload Spending Plans to CareConnection?	**Change** This section of the policy manual will be revised to include the timeline (10 business days) by which Resource Consultants are expected to upload spending plans to the UMC

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			portal for all Personal Options Authorizations.
157	5/4/2026	513.9.2, page 59 The Personal Options FMS acts as the fiscal/employer agent to the member, and is therefore responsible to: Make available a monthly utilization report to identify the members' use of budget funds. Is this given to the member, the PR, the provider or the CM?	**No Change** This section of the policy manual states that the Personal Options FMS is required to make the monthly utilization report available. The individual member or case manager may request this report from the Resource Consultant or FMS.
158	5/4/2026	513.14.2, page 82 Site of Service: This service may be provided to a vehicle owned or leased by the member of the member's family. Modifications can be made to a leased vehicle?	**No Change** The policy manual states that adaptations may be made to a vehicle owned or leased by a member of the member's family.
159	5/4/2026	513.15.1, page 87 "Facility based day habilitation activities must be based at the licensed site, but the member may access community services and activities from the licensed site". Then at the bottom under "Site of Service:" The service may be provided in the community or in a licensed IDD Facility Based Day Program facility. "This service may be provided in the community" is new to the manual. If you look at the sentence at the top of the page and the "site of service" addition, they are contradicting. What do they mean by "based" at the licensed site? Do they have to start or stop at the site? Is there a minimum number of hours they have to be "at" the site?	**No Change** The referenced section of the policy manual was not updated. Existing policy manual states that the members may access community services and activities *from the licensed site.* There is no requirement that the member must spend a minimum number of hours at the licensed site prior to or following access to the community from the licensed site.
160	5/4/2026	513.15.3, page 90 The addition in the Site of Service "The provider's office is not considered a community setting." The definition is "to assist in getting and keeping competitive employment" Some tasks of "getting" competitive employment would be completed in a providers office. However, site of service now prevents that from being done. Can this be clarified?	**No Change** Examples of Job Development services are included in the service description. The examples provided do not appear to reflect activities that would occur in a provider office setting. Providers may seek technical assistance from the UMC for

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			guidance regarding specific Job Development activities that may be effectively accomplished in a provider's office.
161	5/4/2026	513.15.4 Added "supported Employment may not be billed without documentation of a referral to the Division of Rehab Services" What type of documentation is required?	**No Change** Providers may utilize any documentation indicating that a referral to DRS was completed. For example, providers may obtain documentation such as receipt of the online referral record, copy of the paper application, email, or other communication with DRS evidencing the application.
162	5/4/2026	513.16.1, page 95 Under Documentation requirements. There is no mention of the Payment Request Form (from the RC) being required. Should it be mention here?	**Change** This section of the policy manual will be revised to reference the Payment Request Form or any equivalent form provided by the Personal Options vendor.
163	5/4/2026	513.17.1.1, page 98 Other relationships may be considered with prior approval by the BMS… What is the process of obtaining prior approval from the BMS?	**No Change** Requests for prior approval may be submitted by email to: WVIDDWaiver@acentra.com.
164	5/4/2026	513.17.3 It has been added under Documentation requirements that The Case management provider name be on all Direct Support Service Logs for this service. Current DD-7s do not require the CM Provider agency to be listed, only the service provider agency is required. Will the DD-7 form be changed to include this requirement?	**Change** This section of the policy manual will be revised to remove the requirement to include the case management provider name from the DD-07 form.
165	5/4/2026	513.19.1, page 126 Disseminate copies of all IPPs, via secure electronic means, to the IDT members and PD service option providers…. Do we not have to send hard copies to all direct care providers (PCS and Day Hab)?	**Change** This section of the policy manual will be revised to clarify that copies of all IPPs will also be disseminated to service providers via *electronic means*. Providers may

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			choose to disseminate hard copies to staff.
166	5/4/2026	513.20.2, page 132 T1003TE 1:1 ratio Does this mean the RN can only do 1:1 service?	**No Change** There is no group code for RN services. RN services are authorized and delivered based on each individual member's unique support needs and service authorization.
167	5/4/2026	513.20.2, page 132 Unit = Event (1x/day Maximum) Is this a change? This is not in current regulations and the new regulations seems to have two service unit sections? Can this be clarified?	**No Change** BMS will work with the MMIS vendor to clarify and implement the code for the new Skilled Nursing Medication Administration service. BMS will keep providers informed of any developments through standard channels, including provider meetings, FAQS, and/or updates via the IDDW listserv.
168	5/4/2026	513.20.3, page 134 Staff provided Skilled Nursing RN IPP services may live in the member's home. Should this say "may not live in the member's home"?	**Change** This section of the policy manual will be revised to clarify that the staff providing Skilled Nursing RN IPP services may not live in the member's home.
169	5/4/2026	513.21.1, page 134 "Documentation: Agency staff must complete the transportation log section of the Direct-Support Documentation form (WV-BMS-IDD-07) to include all the following items. • Member's name • Service code • Date of service • "From" location (Specific Site: example member's home) • "To" location (Specific Site: example Beckley Walmart) • Purpose of trip	**No Change** An odometer reading is not required. The existing policy language requires documenting the "to" and "from" location from which the mileage can be calculated.

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		• Total number of miles per trip Is an odometer reading no longer required?"	
170	5/4/2026	513.21.3 Added "A trip may be billed concurrently with person - centered support services, Crisis services, respite and any day services. These services may not be provided by the driver of the vehicle". If an individual is going on an outing, will there need to be two staff in order to bill the trip and the service?	**No Change** If an individual requires additional staff, beyond the transportation provider, to meet their unique support needs for an outing, an additional staff member may be provided and bill for the unique service they provide during the outing.
171	5/4/2026	513.22, page 138 Claims may be processed for less than a full unit of service - Is this accurate? Can we get clarification on the statement "billing must take place on the last date in the service range". At present, we consolidate services over a calendar month, capturing the first and last dates of service, with a total units billed (rounded down). Can you confirm if this date span approach is still correct, or if we should instead submit claims using only the last date of service ratha than a beginning and ending date? HHA has their rates configured to round up, which appears to be contributing to occasional payment mismatches, as we round down.	**Change** This section of the policy manual will be revised to clarify the parameters for rounding billing units.
172	5/4/2026	513.24, page 139 The member has or will go a calendar month without accessing a direct care service, the service coordinator…. Should the terminology be changed to Case Manager instead of Service Coordinator?	**Duplicate**
173	5/5/2026	513.19.1, page 124 “There shall be no sharing of supervisory staff between the case management and HCBS.” This should be member specific, not blanket. The CM and other HCBS services for that member should not be supervised by the same person, however there is no reason a CM and a BSP cannot be supervised by the same person for different waiver members. Several agencies have split BSP/CM positions due to limitations	**No Change** Per federal Conflict Free Case Management requirements, any staff providing both case management and behavior support services to IDDW members for a single agency must have separate lines of supervision for the

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		with staffing, limited case load availability. They do not serve the same members for these services, however this section indicates that they would need to have a different supervisor for each service. Also "The case management offices are in a separate location from the other HCBS (they may be in the same building but physically separated)" what do they mean by this? How many offices apart do they need to be? Again, what about split CM/BSP caseloads? There aren't always enough clients for a BSP to have a full time position, and keeping a part time professional staff is not a viable solution.	delivery and oversight of each waiver service.
174	5/5/2026	513.8, page 47 "There shall be no sharing of supervisory staff between the case management and HCBS." This should be member specific, not blanket. The CM and other HCBS services for that member should not be supervised by the same person, however there is no reason a CM and a BSP cannot be supervised by the same person for different waiver members. Several agencies have split BSP/CM positions due to limitations with staffing, limited case load availability. They do not serve the same members for these services, however this section indicates that they would need to have a different supervisor for each service. Also "The case management offices are in a separate location from the other HCBS (they may be in the same building but physically separated)" what do they mean by this? How many offices apart do they need to be? Again, what about split CM/BSP caseloads? There aren't always enough clients for a BSP to have a full time position, and keeping a part time professional staff is not a viable solution.	**Duplicate**
175	5/5/2026	513.8, pages 48 and 50 There are several places where the days required for IPPs to be uploaded, disseminated, and purchases requested don't match up. "The IPP must be uploaded to the UMC portal within ten business days." "All IPPs must be uploaded into	**Duplicate**

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		the UMC's portal and given to all team members within 14 business days and must include", Pg 50 "The IPP must be uploaded into the UMC's portal within 14 calendar days of the IDT meeting to ensure timely authorization of services". Is it 10 business days? 14 business days? Or 14 calendar days? Would need to check the whole manual for these. Page 126 "Purchase services to obtain authorizations or change existing authorizations within seven days of the IDT meeting or team's approval of a service plan addendum"	
176	5/5/2026	513.17.4.1, page 108 Looks like a typo including 1:4 ratio for unlicensed residential homes	**Duplicate**
177	5/5/2026	513.19.1, page 127 CM procedure codes are listed as NF & SFC or ISS & Group Home. It was adjusted in the last manual that SFC could be purchased as ISS & Group Home code instead and can be found this way on the rate sheet. Is this still the case? If so, the services should be named to reflect that Change	**Duplicate**
178	5/5/2026	513.21.3, page 137 ""The maximum units of transportation trips cannot exceed two one-way trips per day or 520 trips annually" Policy Clarification states : Q41: In Section 513.21.3 Transportation Trips, the third bullet indicates that the service limit is 520 trips annually; however in the WV I/DD Waiver Services, Units, Rates and Limitations sheet, the limit is 730. Which one is correct? A41: [Updated 2/4/16] The policy manual is correct; the units on the Services, Units, Rates and Limitations sheet is an error and has been corrected. Please note, however, that, though the policy manual indicates that there is a 2 trips per day limit, this will not apply—only the annual limit of 520 will apply.	**No Change** The existing policy manual language states that transportation trips cannot exceed two one-way trips per day *or* 520 trips annually.

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		Is there a limit of 2 trips per day, or only the limit of 520 units per year? If it is only limited to 520 trips per year, this should be updated in the manual rather than putting it wrong in the manual and then correcting it with policy clarification."	
179	5/5/2026	“The effective date of transfer for Case Management services must be the first day of the selected month."" Need to update transfer for CM agency to include if the person has an anchor date that is not the first of the month. When is the transfer date for that person? First of the month or their anchor date? "	**No Change** The effective date of transfer for case management services is the first day of the month, regardless of anchor date. A transfer of service providers, including case management, does not impact a member’s annual IPP cycle.
180	5/5/2026	513.8.1.3, page 53 "New manual says: Unless prior approval is granted, no case management agency may provide other HCBS for a member, whether those services are funded by Medicaid or another funding source Policy clarifications from the last manual says: Q192: If an agency provides behavioral health services such as psychiatric or counseling services to a member, do CFCM policies prohibit that agency from providing behavioral health services and case management services to the same member? A192: [3/4/21] A member may receive case management and behavioral health services from the same agency. This would not be considered a conflict of interest. [Updated 3/18/21] This also includes ABA therapy and other outpatient therapies that are not available through the IDDW program.	**No Change** The referenced section of the policy manual was not updated. Behavioral health case management services, while considered HCBS, do not conflict with IDDW case management, as a behavioral health case manager is not responsible for the development, implementation, or delivery of services under the IDDW IPP.

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		Can you clarify this in the manual rather than the policy clarifications so it doesn't get confusing?	
181	5/5/2026	Direct care service caps – should include leap year as this was different for ISS than NF. Previously the leap year cap for ISS was 35,136 but the cap for NF was unaffected. Will this still be the case?	**No Change** Available units are adjusted during leap years and increases in units are authorized by the UMC and updated in the MMIS.
182	5/5/2026	513.8, 513.10.2, 513.20.3, pages 50, 64, 134 "Team members who attend by teleconference may not bill for the time spent in the IDT and the case manager must note on the signature sheet that they attended by phone." BUT "Professional must attend all planning meetings, either face-to-face or by teleconference, if billing the IPP code, the professional must be present for the entirety of IPP meeting" By "present" do they mean attending the meeting in one of these manners, or do they mean in person where they client is? If they are required to be in person where the client is, they should be able to bill travel time for that required service.	**Duplicate**
183	5/5/2026	Will BSPs and RNs still be able to bill for training over the phone? Or via video conference?	**Duplicate**
184	5/5/2026	513.21.3, page 139 Under "Limitations/Caps" the last bullet point states, "A trip may be billed concurrently with person-centered support services, crisis services, respite, and any day services. These services may not be provided by the driver of the vehicle." This is a significant concern as a provider. With a driver no longer permitted to bill trips concurrently with day hab or respite services, this rule would create a hardship for staffing and reimbursement for providers. As a provider, we would need to have a staff designated as only the driver, not counted in the staffing ratio, and only providing and receiving reimbursement for the trip itself.	**Duplicate**

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		Reimbursement rates do not support this practice. In some cases, there may only be one member on the van or bus, yet we would need to provide both a staff for that member as well as a driver in order to provide a trip.	
185	5/5/2026	513.1, page 14 "The policy clarification should be merged with the new manual and a new policy clarification started. If the intent is for this to function as an ongoing, living document, it would also be helpful to specify a process and timeline for periodic review to ensure continued accuracy and relevance."	**No Change** No proposed change to contents of the policy manual included in comment. The IDDW policy manual is updated as needed and in accordance with federal rules and requirements.
186	5/5/2026	513.2, page 21Due to the lack of qualified BSP supervisors, it would be beneficial for BSPs and CM's to share supervisory staff.	**Duplicate**
187	5/5/2026	513.3.1.1, page 25 I do not think this accurately reflects the process for POCs as it discusses receiving comments from the provider. They haven't been allowing comment. Is that coming back? The last two years we've only been able to push back on disallowances. We have to agree we will do something to address the POC in house but not on the POC. Josh R. Said he changed this process. In the prior manual 513.2.3.4 Plan of Correction also indicated we were supposed to do a similar process as what is in the draft manual. Interesting.	**No Change** Per current policy manual, IDDW providers are permitted to submit comments to address citations, along with any other necessary supporting information and documentation to the UMC for consideration.
188	5/5/2026	513.3.11, page 29 Six months may not always be a practical timeframe for a new BSP to complete the required 'approved WV APBS curriculum' training. Availability and scheduling of these trainings are often outside of the provider's control, as they rely on third-party programs. In addition, there may be variability in the depth and quality of available trainings; for example, some approved courses may not provide sufficient instruction on core competencies such as developing Positive Behavior Support Plans. As a result, meeting this requirement within the specified timeframe may present challenges despite good-faith efforts to	**No Change** This is not a new requirement. All BSP staff must be trained on all aspects of the BSP service and under the clinical supervision of a BSP during the first six months of hire if they do not have the required education or staff training. New hires or staff who transition into the BSP role without the requisite training or education who are unable to meet the

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		comply, and may not consistently ensure adequate preparation for the role.	training requirements may deliver services under a service code that matches their training and education until they are able to complete the required training.
189	5/5/2026	513.3.12, page 33 Allowing staff with five years of experience in the IDD field to serve as case managers raises concerns. Modifying the qualifications to permit this change may not fully align with the expectations and requirements of the IDD Waiver case management role. Additionally, reducing qualification standards to allow individuals without a relevant degree or license may negatively impact the quality and consistency of client care, given the typical expectations for training and preparation in case management positions. These roles often require complex responsibilities, such as developing person-centered treatment plans and managing or calculating service budgets, which typically rely on formal training and oversight. Best practices in the field generally support a combination of formal education and supervised experience to ensure high-quality service delivery. While practical experience in the IDD field is valuable, it may not, on its own, fully meet the competencies required to effectively perform the responsibilities of an IDD Waiver case manager.	**Duplicate**
190	5/5/2026	512.4, page 34 The OHFLAC fax number is incorrect. The current fax number is: 304-957-7615	**No Change** The phone number provided in this section is for reporting incidents of abuse, neglect, and/or exploitation, not the general phone number for OHFLAC.
191	5/5/2026	513.5, page 38 It would be beneficial to include the timeframe the CM Agency must store the ORIGINAL PHYSICAL copy of the Annual Assessment outside of the EHR, and what they are expected to do with the ORIGINAL PHYSICAL copy of the	**No Change** Section 513.5 (Documentation and Record Retention Requirements) states that IDDW providers must maintain required

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		document if the client transfers or is discharged from the CM agency.	documentation, which includes annual assessments, for at least five years.
192	5/5/2026	513.8, page 47 The member, themselves, is not listed as a person who needs to be included in the IDT in the second paragraph. I would recommend including the member in this list, or moving the 6th paragraph "The member must attend the IPP meeting" up stating before or after the list of other required IDT members.	**Change** This section of the policy manual will be revised to state that the IDT includes the member to further clarify the member's central role in the IDT.
193	5/5/2026	513.8, pages 48 and 50 The manual indicates on page 48 "If the member has a Medley Advocate, the Medley Advocate must attend the entire meeting." And then contradicts itself on page 50 stating "the Medley advocate may choose to only attend the six-month and the annual." Clarification on Medley participation, and agreement with the IPP to avoid confusion would be beneficial.	**Duplicate**
194	5/5/2026	513.10.1, page 64 "Limiting a BSP's ability to bill for travel inadvertently restricts the scope and effectiveness of services. Reduced travel capacity can limit opportunities for BSPs to conduct in-person observations of IHP implementation, particularly in situations involving regression, emerging behaviors, or discrepancies in reported data. Direct observation is often critical to ensuring fidelity of implementation, as well as to support accurate data collection and informed development of Functional Behavior Assessments (FBA) and Positive Behavior Support Plans (PBSP). Additionally, travel limitations may reduce the BSP's ability to provide timely on-site coaching and training to direct care staff, which is essential for maintaining consistency and quality in service delivery. It may also hinder responsiveness to urgent or complex behavioral concerns, delay necessary plan modifications, and limit engagement with interdisciplinary team members. Collectively, these constraints could negatively impact the quality,	**No Change** Administrative costs, including overhead costs such as travel, are calculated into each individual reimbursement rate. All IDDW reimbursement rates are reviewed on annual basis per WV legislative mandate.

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		effectiveness, and person-centered nature of services provided to individuals receiving support."	
195	5/5/2026	513.15.2, page 90 West Virginia no longer participates in sub-minimum wage programs. However, the fourth bullet under Limitations/Caps references a 'Department of Labor certificate,' indicating if agencies do not possess this certificate, individuals must be paid at least minimum wage. This language may be outdated or unclear and could benefit from revision or clarification to ensure alignment with current state and federal requirements.	**No Change** Per current policy manual, an agency must obtain and display the Department of Labor certificate if they do not pay individuals performing work at least minimum wage.
196	5/5/2026	513.20.2, pages 131 and 132 "Additional clarification is needed regarding how agency RNs should distinguish between medication administration and skilled nursing services. Guidance should also address appropriate use of the code for training new AMAPs, as well as meeting OHFLAC-required monitoring responsibilities. If this service is tied to specific individuals and their budgets, further direction is needed on how it applies when an AMAP, under AMAP RN supervision, serves multiple clients. Clarifying how costs and service units are allocated in these situations would be helpful. A list of RN Medication Admiration tasks is needed to reduce misuse of this service. Given the complexity of these requirements, it may be appropriate to separate RN medication administration into its own section to improve clarity and consistency in implementation"	**No Change** Additional guidance regarding implementation of the new Skilled Nursing Medication Administration service and billing code will be forthcoming and provided by BMS in partnership with the UMC.
197	5/5/2026	Pages 59, 139, 155, 156, and 154, No section: Please change from Service Coordinator/Service Coordination to Case Manager/Case Management.	**Duplicate**

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198	5/5/2026	When will the Annual Review Tool be changed to reflect the manual changes?	**No Change** Additional information regarding any forthcoming changes to the provider quality review tool will be provided by BMS in partnership with the UMC following the publication of Chapter 513.
199	5/5/2026	Is there a list of approved programs for obtaining electronic signatures?	**Duplicate**
200	5/5/2026	Page 10 Last sentence, “Case managers and direct-support professional staff must complete mandatory training on the Statewide Transition Plan. Members will receive educational information on the Statewide Transition Plan from their case manager” Is the HCBS Assessment adequate for the “educational information”?	**No Change** BMS does not mandate the content of training regarding the Statewide Transition Plan. However, case managers and direct support professional staff are expected to be knowledgeable of the requirements of the Statewide Transition Plan, including federal rules and requirements of the HCBS Settings Rule to help ensure continuing compliance.
201	5/5/2026	**No page / No section:** The mandatory training on the Statewide Transition plan, if still applicable, should also be included in the training requirement list and/or staff qualifications to stand out better.	**Duplicate**
202	5/5/2026	Page 16, Section 513.2: Administrative Standards, 7th bullet: Shouldn’t agencies that provide both CM and HCBS assign 2 agency IDDW contact persons? There is a lot of effort separating the two except here.	**Duplicate**
203	5/5/2026	Page 20, Section 513.2: Responsibilities to Agency Staff, top of page 20, first full bullet point on the page, last bullet for this section. How often is the agency required to have the written approval from the UMC for their online training?	**No Change** The current policy manual does not include a requirement for repeated approvals from the UMC. Providers are expected to obtain UMC

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			approval prior to using an internet-based provider for training purposes.
204	5/5/2026	Page 21, Section 513.2: 2nd bullet: If legal representative does not participate in the annual functional assessment, the legal representative must sign the Freedom of Choice within 10 days. However, if this is not possible, the form should be completed at or before the member's annual IPP meeting. Case Manager should document the circumstance which prohibited completion within 10 calendar days. When and where is the CM required to document this?	**No Change** BMS does not prescribe the way a case manager documents the inability to obtain the LAR's signature on the FOC form. The case manager may document the circumstances involved in any manner that effectively communicates the reason for the late FOC to the UMC.
205	5/5/2026	Page 26, Section 513.2.3.6: It states "IDDW agencies must submit evidence every calendar year to document continuing compliance will all certification requirements specified in this manual. Evidence reports must include a signed attestation from an appropriate official of the provider agency (e.g., executive director, Board Chair, etc.). Reports may be sent from a provider's human resources (HR) system. For example, providers may send an Excel spreadsheet or any other format that includes all applicable fields and documents training dates of employees." Providing training dates of employees was removed and is not listed on the excel form provided by Acentra (conference call 1/4/2024).	**Duplicate**
206	5/5/2026	Page 33, Section 513.3.10: Please amend to include the 8/1/2025 allowance for having the affidavit instead of maintaining the driver's license, insurance, etc.	**Duplicate**
207	5/5/2026	Page 34, Section 513.3.17: Transportation Services Agency Staff Qualifications: This states that the provider is "required to maintain documentation at all times verifying that agency staff…. have a valid driver's license, proof of current vehicle insurance, inspection and registration". Please change to reflect the 8/1/2025 allowance for having an affidavit.	**Duplicate**

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208	5/5/2026	Page 35, Section 513.4: In the current manual, if an incident happens on a weekend or holiday, it is acceptable to enter the incident the following business day. This is not stated in proposed manual. Please amend to allow this.	**Duplicate**
209	5/5/2026	Page 36, Section 513.4: First paragraph at the top of the page: "Staff who observe or is informed of the incident should report in WV IMS" – Please clarify. This allows the possibility of either duplicating reports or neglecting to report. The last sentence in this paragraph indicates that the CM is the responsible party for making the report, not the observer. If an agency staff observes or suspects abuse, shouldn't that individual complete the report? Taking the time to contact the CM, who may not be available (they could be out of the county/office, off work, etc., and this would delay or possibly prevent the report from being made.	**Duplicate**
210	5/5/2026	Page 36, Section 513.4: Especially with CFCM, there is a potential layer of bureaucracy and implication that the staff just needs to inform the CM.	**Duplicate**
211	5/5/2026	Page 36, Section 513.4: 1st paragraph: There should be no discussion of "in the event the individual receives Case Management from another agency" as the CFCM mandate was effective for all IDDW members in 2023. Since CFCM is now mandatory for all IDDW members, incident reports and IMS entry should be the responsibility of the service provider agency (traditional or self-directed option).	**Duplicate**
212	5/5/2026	Page 36, Section 513.4: Last paragraph of this section states the Case Manager must notify the UMC of a member's transfer to another Case Management provider or if the member chooses another delivery system within 2 working days. So, 2 working days from what? Is this referring to the DD2? Please clarify.	**Duplicate**
213	5/5/2026	Page 36, Section 513.4: Last two paragraphs and 2 bullet points seem out of place in this section. The CM is responsible for	**No Change** This section of the policy manual describes certain situations

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		ensuring that the information about the member is accurately depicted in the UMC website and notifying the UMC of transfer of CM or service delivery model.	requiring the case manager to submit reports to the UMC portal to maintain current, accurate information regarding the member's program status.
214	5/5/2026	Page 37, Section 513.5: Specific Requirements section, 3rd bullet: States all Waiver providers must maintain Case Management logs. Is this a new requirement for all IDDW members or is it only required to be documented when a member is on eligibility extension/hold status? Please clarify.	**Duplicate**
215	5/5/2026	Page 47, Section 513.8: It is stated that when the legal representative attends the IDT meeting via teleconference due to extenuating circumstances, the IPP must be signed electronically, and the signature must include a date and time stamp. What if the legal representative does not have the ability to sign electronically or the ability to include date and time stamp?	**Duplicate**
216	5/5/2026	Page 47, Section 513.8: With the Extension of Appendix K, all IDT members have been able to successfully participate in IPP meetings via teleconferencing. The new manual draft allows for the guardian, in extenuating circumstances. Can this be changed to allow team members to participate via teleconferencing? Concerning electronic signatures, the CM has 14 days to finalize, distribute, and upload (when applicable) so this should allow for the 14 days to obtain signatures when a person doesn't have the means to electronically sign.	**Duplicate**
217	5/5/2026	Page 47 and 51, Section 513.8.1: Page 47 states that if there is a legal representative, they must attend the meeting in person, however, can participate via teleconference in extenuating circumstances. Page 51 states that the IDT can agree to hold the meeting virtually other than the annual IPP.	**Duplicate**

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		Can it also extend that in extenuating circumstances, the IDT can agree to hold even the annually virtually?	
218	5/5/2026	Page 48, Section 513.8: Top of page 1st paragraph includes old language. Please clarify about the requirement to sign "agreement" that it reflects the new IPP signature page. There are members who still refuse to sign in agreement due to the old language. Additionally, within this same paragraph, last sentence is that the IPP is to be uploaded within 10 days of the IPP Meeting. Please amend to 14 days.	**Duplicate**
219	5/5/2026	Page 48, Section 513.8: After 2nd paragraph: All IPPs must be uploaded into the UMC's portal. Is this required for all IPPs or only IPPs which require purchase(s) and/or modification request(s)?	**Duplicate**
220	5/5/2026	Page 48, Section 513.8: IPP contents In case of a member's refusal to sign the IPP, the reason for the refusal must be documented in the IPP. Where is this to be documented? And who documents this? Please also clarify what language is acceptable as these have been doc requested for not using correct language.	**Duplicate**
221	5/5/2026	Page 49, Section 513.8: "If a finalized IPP needs changes,…" Is this referring to documentation requests? If so, can this addendum be part of the IPP and therefore not require an additional signature page?	**No Change** Any change to the IPP, including an addendum, requires agreement of the IDT evidenced by signatures.
222	5/5/2026	Page 50, Section 513.8: The first full paragraph regarding signatures conflicts with the new IPP (7.2024). The meeting minutes include a section on participation, and the signature page outlines specifics but total times are not included. Additionally, signing in real time isn't possible for those who participated by electronic means.	**Duplicate**

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223	5/5/2026	Page 50, Section 513.8: 1st paragraph A copy of the IPP is kept in all participating provider agency records and distributed, via secure electronic means, to all team members by the Case Manager within 7 calendar days of the date of the IDT meeting. Please amend to 14 days.	**Duplicate**
224	5/5/2026	Page 50, Section 513.8: 2nd paragraph In extenuating circumstances, IDT members may take part by teleconferencing. May IPPs still be conducted electronically or will all or some IPPs be required to be held in person? Please clarify but the electronic IPPs have been permitted and work well when needed. If required to be held in person, will a DD-12 be required to be submitted and approved before any team members can participate electronically? How will this impact the ability for team members to bill for time spent in the meeting? This paragraph also states Case Manager must obtain legal representative signature within 7 calendar days, which is not a reasonable time frame for cases where the legal representative does not live locally.	**Duplicate**
225	5/5/2026	Page 50, Section 513.8: 3rd paragraph: States spending plans are a required IPP attachment. Is it acceptable for the Case Manager to attach the email request sent to the assigned Palco RC for cases where the spending plan is not provided by the Palco RC as requested? Are Case Managers required to obtain utilization reports from the Palco RC for self-directed services for each IPP? If so, is it acceptable for the Case Manager to attach the email request sent to the assigned Palco RC for cases where the utilization report is not provided by the Palco RC as requested?	**Duplicate**
226	5/5/2026	Page 51, Section 513.8.1: 2nd paragraph States if all team members agree, meetings (other than annual) may be held virtually through a secure platform. Is this accurate? Will the annual IPP meeting be required to be held in person? If	**Duplicate**

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		so, will there be any acceptable extenuating circumstances? If so, will a DD-12 be required? If a DD-12 is not required, how will the Case Manager gain approval from BMS to hold the annual IPP meeting virtually?	
227	5/5/2026	Page 52, Section 513.8.1.1: Seven-Day IDT: Please clarify and expand "one day setting to another". Does this include if a member gets a job or is starting job exploration? Does this include when a member graduates high school even if they don't start a day program?	**Change** The policy manual will be revised to clarify that "day setting" refers to a Facility-Based Day Habilitation program.
228	5/5/2026	Page 53, Section 513.8.1.2: Please clarify if the 30 day is only required for new Waiver slot or change in residential setting and not the change in day setting.	**No Change** Seven-day IDT meetings continue to be required when a member transfers from one Facility-Based Day Setting to another.
229	5/5/2026	Page 53, Section 513.8.1.3: Service provider transfer States Case Manager responsible for submitting the transfer via the UMC's portal and attaching the DD-10 within 5 business days. So, 5 business days from what? The date of the meeting? The effective transfer date?	**Duplicate**
230	5/5/2026	Page 54, Section 513.8.3: Discharge from the IDDW program States Case Manager is responsible for completing and submitting the DD-10 to the UMC's portal within 7 calendar days. So, 7 calendar days from what? The date of the meeting? The effective discharge date?	**Duplicate**
231	5/5/2026	Pages 81-86, Section 513.14: EAA/PDGS, both traditional and PO: The request is to increase the $1000 cap. This could be done in a cost-effective way that would have parameters set that the assigned budget couldn't be exceeded for example and possibly offer a range, $1000.00 – 10,000.00.	**No Change** The amount of reimbursement for each IDDW service is based upon the reimbursement rates approved by CMS in the IDDW waiver application. BMS may consider further evaluation of the EAA and PDGS rates in the future.

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232	5/5/2026	Pages 94-97, Section 513.16: We see so many NF settings in which the assigned budget is higher than the individual could access just based on services they're accessing within and outside of the IDDW funding. Modifications to a vehicle making them accessible is very costly and $1000.00 doesn't stretch that far.	**Duplicate**
233	5/5/2026	Pages 84, 94, Section 513.16: EAA, PDGS: Change to reflect the 3/1/2025 changes that eliminate the DD8 and include the PO Payment Request from the Palco RC approving the item prior to authorizing EAA/PDGS	**Duplicate**
234	5/5/2026	Page 97, Section 513.17.1.1: FPCS - Thank you for the possibility of extending this to domestic partner of a member's parent.	**No Change**
235	5/5/2026	Page 97, Section 513.17.1.1: FPCS – The family member who is also the legally appointed guardian who lives with the member may provide FPCS, but the motion for authorization is a requirement. This isn't identified within the manual but it would be helpful to spell it out here or in the limitations section. Can this be addressed?	**No Change** The IDDW policy manual does not supersede nor document the requirements of the West Virginia Guardianship and Conservatorship Act.
236	5/5/2026	Page 99, Section 513.17.1.1: When a member turns 18 within a budget year (and if not in school), why can't the IDT plan for the 18th birthday and include the new cap starting on their birthday. So the CM could prorate the daily limit of 5 hrs/day from the first day of the new budget year until the day before the 18th birthday and beginning on the 18th birthday prorate the 8 hrs/day through the end of the budget year.	**Duplicate**
237	5/5/2026	Page 99, Section 513.17.1.1: Limitations/caps, 4th bullet: Many school age members receive in-home schooling and it's not a full 8 hours of day in school. In addition, there are days when school is closed to include the full summer. Why limit the FPCS for a member who is 18 and chooses to remain in school until they turn	**Duplicate**

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		21? The FPCS is still an assessed need and could be used up to 8 hours on many, if not most, days.	
238	5/5/2026	Page 106, Section 513.17.3: It is imperative that AMAPs are permitted to bill the AMAP modifier for the entire duration of their shift. Limiting the modifier to only the moments in which a medication is physically administered does not reflect the full scope of AMAP responsibilities. AMAPs are responsible for continuous monitoring, documentation, medication security, error prevention, and adherence to all medication-related protocols for the entirety of the shift, not just during the act of administration. In order to maintain safe and compliant medication administration across all shifts, it is essential that providers have enough AMAP-certified staff available at all times. Due to ongoing workforce turnover and the unpredictability of staffing patterns, we must train the majority of our direct support staff as AMAPs to ensure adequate coverage. If the AMAP modifier is limited or restricted, it becomes financially unsustainable to maintain the number of trained AMAPs required to safely staff programs. Providers cannot rely on a small subset of AMAPs when turnover is constant; the only viable model is to train most staff so that every shift has appropriate medication-certified personnel available.	**Duplicate**
239	5/5/2026	Page 124, Section 513.19.1: 9th bullet: Conflict of Interest Assurance Form: Is this developed by each agency and does it have to have this exact title?	**Duplicate**
240	5/5/2026	Page 125, Section 513.19.1: Please add that the CM will upload the lease agreement for members in an ISS/GH setting if this is still a requirement.	**Duplicate**
241	5/5/2026	Page 126, Section 513.19.1: 1st bullet: Purchase services.. “within 7 days”: Please change to 14 days.	**Duplicate**

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242	5/5/2026	Page 126, Section 513.19.1: 3rd bullet: Please change to "compile" not "coordinate". This was addressed in the public comments of the IDDW Application (Feb/Mar 2025).	**Change** This section of the policy manual will be revised to replace the reference to "compile" with "coordinate."
243	5/5/2026	Page 126, Section 513.19.1: 2nd bullet: Follow reporting requirements of the WV IMS for members on their caseload. Incident reports and IMS entry should be the responsibility of the service provider agency (traditional or self-directed option). Case Managers should receive a copy of the reports for record retention and IPP requirements but not be responsible for documenting the reports or entering the reports into IMS, especially incidents that are not observed by the CM.	**Duplicate**
244	5/5/2026	Page 126, Section 513.19.1: 11th bullet: Please clarify: Is the CM required to upload each IPP into CC?	**Duplicate**
245	5/5/2026	Page 127, Section 513.19.1: 4th bullet: Process the DD2 within 2 business days – This isn't consistent throughout the manual but also doesn't specify within 2 business days from when. The member/guardian may make the request but until the other agency accepts and there's an IPP, it wouldn't make sense to upload a DD2 prior to then.	**Duplicate**
246	5/5/2026	Page 127, Section 513.19.1: Procedure codes: G9002U3 Case Management Natural Family The procedure code G900U4 should be CM ISS/GH and include SFC – please amend.	**Duplicate**
247	5/5/2026	Page 128, Section 513.19.1: Documentation: A progress log for each service – is this a new expectation? Up until now, the CM log has been to document CM services for a member who is on member-hold, for example, but not a required document	**Duplicate**

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248	5/5/2026	Page 128, Section 513.19.1: 1st bullet: Limitations/Caps – there wouldn't be an exception because the cap is a pmpm rate. The first 2 bullets seem out of place and unnecessary.	**No Change** Case managers must continue to meet documentation requirements regardless of the reimbursement methodology.
249	5/5/2026	Page 138, Section 513.22: "…submitted to the UMC within 10 business days of the IDT meeting…" Please change to 14 days	**Duplicate**
250	5/5/2026	Page 145, Section 513.26: Please clarify the timelines on the due date for the CM to upload the DD10 – 7 days from when? If it's pretty straightforward and the member is electing or agreeing to the discharge and there's an IDT – is the DD10 uploaded within 7 days of that meeting? On the DD10, it states within 7 days of the transfer/discharge. If a member doesn't receive direct services within 30 days and isn't communicative with the CM, when does the DD10 get completed?	**No Change** Case management agencies may seek technical assistance from the UMC regarding the best practice to document the unique circumstances regarding a case manager's inability to obtain required documentation from an individual.
251	5/5/2026	Page 146, Section 513.27: Please clarify "within 7 days", from when?	**Duplicate**
252	5/5/2026	Page 148, Glossary: The last sentence in the definition of Critical Juncture is out of place. It just states, "Days: Calendar days unless otherwise specified" but there is no reference to the word "days" within the definition.	**Duplicate**
253	5/5/2026	Page 17, Section 513.2: Responsibilities to Agency Staff - Bullet 7 removes "except contracted extended professional staff". Does this mean contracted extended professional staff will now need the following trainings maintained by the agency; Crisis Intervention, Reporting Abuse/Neglect, First Aid, CPR and PBS?	**Duplicate**
254	5/5/2026	Page 18, Section 513.2: In addition, any staff person who provides transportation services must abide by local, state, and federal laws about vehicle licensing, registration, and inspections upon hire and checked annually thereafter. Responsibilities to Agency Staff - Bullet 6 refers to vehicle "inspections". We have received	**Duplicate**

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		clarification that Acentra no longer looks at inspection stickers. Are inspection stickers going to be a requirement? Additionally, under the same bullet it states, "…an affidavit, complete by the staff... attesting to the validity of their driver's license, current vehicle insurance, and registration may serve as evidence of compliance..." This sentence omits inspection stickers.	
255	5/5/2026	Page 18, Section 513.2: Responsibilities to Agency Staff - Bullet 6 pretaining to the affidavit states the affidavit is to be completed by the staff providing transportation. However, FAQ 231 states the affidavit is signed by the agency's leadership as well as the individual providing transportation. This seems to imply that the agency is also attesting to the validy of the individuals driver's license, insurance and registration and not just the staff providing transportation. The draft manual does not make this distinction. Who needs to attest and sign the affidavit; the staff, the agency, or both?	**Duplicate**
256	5/5/2026	Page 18, Section 513.2: Licensed RNs and LPNs are excluded from CPR training and certification requirements. Is this true that Licensed RNs and LPNs do not have to have CPR training?	**Duplicate**
257	5/5/2026	Page 19, Section 513.2: Responsibilities to Agency Staff - Direct care ethics training excludes, Person-Centered Support LPN. Are LPN's no longer required to have this training annually?	**Duplicate**
258	5/5/2026	Page 34, Section 513.3.17: In addition to meeting all IDDW staff requirements in Sections 513.2 - 513.2.1, the provider is required to maintain documentation at all times verifying that agency staff providing transportation services have a valid driver’s license, proof of current vehicle insurance, inspection and registration. Inspection Stickers are no longer required as long as there is a signed Affidavit. Refers to vehicle inspections and does not mention affidavit	**Duplicate**

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259	5/5/2026	Page 34-35, Section 513.4: Last bullet on page 34 added, "but does not require treatment beyond basic first aid provided at the location of the injury". Does that mean anyone taken for outside care, even if as a precaution and only found to have a sprain or other minor issue, or no problem at all, will need to be considered a critical incident and require investigation and subsequent reporting?	**Duplicate**
260	5/5/2026	Page 35, Section 513.4: Any incident involving a person utilizing IDDW services must be reported to the UMC by entering the incident into the WV IMS within 24 hours of learning of the incident. The following statement (effective 2/1/2028) has been removed: All incidents must be entered into the WV IMS within 24 hours of the provider becoming aware of the occurrence. If the provider becomes aware of the incident on a weekend or holiday, it is acceptable to enter the incident the following business day. Was this an oversight or is it truly being removed and we only have 24 hours to enter, even on a weekend or holiday? This puts uneccerssary and undue burden on staff to enter these reports on days when they are not scheduled to work. The prior reporting requirement timeline was adequate. PLease consider keepig it the same.	**Duplicate**
261	5/5/2026	Page 47, Section 513.8: If the member has a legal representative, the legal representative must attend the IPP in person. The legal representative may participate via teleconference in extenuating circumstances. Does the legal representative have to attend in person or can they participate via teleconference in extenuation circumstances? Needs to be clearly written. The guardian can attend via telephone but only in extenuating circumstances - Does a DD12 still need to be done?	**Duplicate**
262	5/5/2026	Page 48, Section 513.8: The IPP must be uploaded to the UMC portal within ten business days. Does the IPP need to be	**Duplicate**

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		uploaded to the UMC portal within ten business days or 14 business days?	
263	5/5/2026	Page 48, Section 513.8: All IPPs must be uploaded into the UMC's portal and given to all team members within 14 business days. Does the IPP need to be uploaded to the UMC portal within ten business days or 14 business days? Does the IPP need to be ditributed to all team members with 14 business days or within seven calendar days from the IDT meeting?	**Duplicate**
264	5/5/2026	Page 50, Section 513.8: A copy of the IPP is kept in all participating provider agency records and distributed, via secure electronic means, to all team members by the case manager within seven calendar days of the date of the IDT team meeting. The IPP must be uploaded into the UMC's portal within 14 calendar days of the IDT meeting to ensure timely authorization of services. Does the IPP need to be distributed to all team members within seven calendar days from the IDT meeting or within 14 days? Does the IPP need to be uploaded to the UMC portal within ten business days or 14 business days?	**Duplicate**
265	5/5/2026	Page 50, Section 513.8: An IPP includes the completed IPP (WV-BMS-IDD-5) and the following attachments: Crisis Response Plan, Behavior Support Plan/Protocols (if applicable), tentative weekly schedule, budgeted cost of planned services, spending plans (if the member self-directs eligible services), and meeting mintues. Should the CM submit/upload the IPP to avoid deadline expiration, if the member's Palco RC does not get them the spending plan on time?	**Duplicate**
266	5/5/2026	Page 52, Section 513.8.1.1: The intial meeting occurs within the first seven calendar days of admission/intake by a provider/case management agency… Does the seven days start when the client becomes active in CareConnection or when their chart becomes	**Duplicate**

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		active with the agency? Does this meeting have to be held face to face?	
267	5/5/2026	Page 59, Section 513.9.2: The Personal Options FMS acts as the fiscal/employer agent to the member, and is therefore responsible to: Monitor spening of budget funds following approved spending plans Do the PD - RCs have a timeline to upload Spending Plans to CareConnection?	**Duplicate**
268	5/5/2026	Page 59, Section 513.9.2: The Personal Options FMS acts as the fiscal/employer agent to the member, and is therefore responsible to: Make available a monthly utilization report to identify the members' use of budget funds. Is this given to the member, the PR, the provider or the CM?	**Duplicate**
269	5/5/2026	Page 87, Section 513.15.1: "Facility based day habilitation activities must be based at the licensed site, but the member may access community services and activities from the licensed site" Then at the bottom under "Site of Service:" The service may be provided in the community or in a licensed IDD Facility Based Day Program facility. Question: "This service may be provided in the community" is new to the manual. What is meant by "based" at the licensed site? Do they have to start or stop at the site? Is there a minimum number of hours they have to be "at" the site?	**Duplicate**
270	5/5/2026	Page 90, Section 513.15.3: The addition in the Site of Service "The provider's office is not considered a community setting." The definition is "to assist in getting and keeping competitive employment" Some tasks of "getting" competitive employment would be completed in an providers office. However, site of service now prevents that from being done. Can this be clarified? Added "supported Employment may not be billed without documentation of a referral to the Division of Rehab Services" What type of documentation is required?	**Duplicate**

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271	5/5/2026	Page 98, Section 513.17.1.1: Other relationships may be considered with prior approval by the BMS… What is the process of obtaining prior approval from the BMS?	**Duplicate**
272	5/5/2026	Page 98, Section 513.17.3: It has been added under Documentation requirements that The Case management provider name be on all Direct Support Service Logs for this service. Every DD-7 will now require the Case management provider's name?	**Duplicate**
273	5/5/2026	Page 126, Section 513.19.1: Disseminate copies of all IPPs, via secure electronic means, to the IDT members and PD service option providers…. Do we not have to send hard copies to all direct care providers (PCS and Day Hab)?	**Duplicate**
274	5/5/2026	Page 132, Section 213.20.2: T1003TE 1:1 ratio Does this mean the RN can only do 1:1 service?	**Duplicate**
275	5/5/2026	Page 134, Section 213.20.3: Staff provided Skilled Nursing RN IPP services may live in the member's home. Should this say "may not live in the member's home"?	**Duplicate**
276	5/5/2026	**No page** / Section 513.21.3: Added "A trip may be billed concurrently with person - centered support services, Crisis services, respite and any day services. These services may not be provided by the driver of the vehicle". We will need 2 staff at all times now? If an individual is going on an outing, we will either have to have 2 staff to bill the service and the trip or pick either the service of the trip to bill?	**Duplicate**
277	5/5/2026	Page 138, Section 513.22: Claims may be processed for less than a full unit of service - Is this accurate? Can we get clarifcation on the statement "billng must take place on the last date in the service range". At present, we consolidate services over a calendar month, capturing the first and last dates of service, with a total units billed (rounded down). Can you confirm if this date span approach is still correct, or if we should instead	**No Change** The IDDW policy manual does not prescribe the processes that each individual vendor may require for payment processing. IDDW providers may seek technical assistance from the vendor regarding permissible billing practices.

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		submit claims using only the last date of service ratha than a beginning and ending date? HHA has their rates configured to round up, which appears to be contributing to occasional payment mismatches, as we round down.	
278	5/5/2026	Page 139, Section 513.24: The member has or will go a calendar month without accessing a direct care service, the service coordinator…. Service Coordinator vs Case Manager	**Duplicate**
279	5/5/2026	Page 21, Section 513.2: The licensing board is still mentioned on the 3rd bullet. CM does not require a license so all the information regarding a licensing board should be removed.	**No Change** While there are no licensure requirements for case managers, many case managers are licensed professionals and would thereby be bound to any applicable licensing board rules and regulations regarding ethics violations.
280	5/5/2026	Page 34, **No section**: There is no section 513.3.1.7 and 513.3.17 is for transportation services Agency Qualifications.	**Duplicate**
281	5/5/2026	Page 36-38, Section 513.5: I do not see anything about CM monthly contracts. I don't know why this would even be in the manual	**Change** The Change Log will be revised to correctly reference “contacts” instead of “contracts.”
282	5/5/2026	Page 43, Section 513.6.3.2: Should be 513.6.2.3 but no mention of the requirements of the assessment	**Change** The Change Log will be revised to more accurately describe the changes to Section 513.6.2 regarding the annual assessment criteria.
283	5/5/2026	Page 47, Section 513.8: 7th Paragraph says that if a legal rep attends the IPP other than in person, they have to sign electronically with date/time stamp. Why can't the CM obtain a regular signature? That would be easier than sending it electronically. Up until now, both were allowed so can this be included in the section if it is still allowed to have either/or?	**No Change** The LAR signature must be obtained in real time, either in person or by electronic means, to safeguard the accuracy and timeliness of the member and LAR’s agreement to the IPP.

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284	5/5/2026	Page 48, Section 513.8: IPP must be uploaded in 14 business days and it says 10 business days so that needs to be one or the other. (1st paragraph, last sentence)	**Duplicate**
285	5/5/2026	Page 48, Section 513.8: 1st Paragraph says IPP must be uploaded to the UMC portal within 10 business days. 3rd Paragraph says IPPs must be uploaded into the UMC's portal and given to all team members within 14 business days. Currently, it is 14 calendar days. CM's would like the 14 business days but it needs to clarified and all match because otherwise CM's will be confused.	**Duplicate**
286	5/5/2026	Page 50, Section 513.8: Here it says in 1st paragraph that the CM has to distribute IPP to all team members in 7 calendar days. Sentence after that says the IPP must be uploaded to UMC portal within 14 calendar days to ensure timely authorization of services. So that is 4 different deadlines for IPP's. Please clarify in all 4 places.	**Duplicate**
287	5/5/2026	Page 50, Section 513.8: If a team member teleconferences in, they cannot bill for IDT. Why? I thought we were moving toward telehealth. This should be allowed. Especially with Nursing (and staffing in general). Nursing can provide the proper medical information via Telehealth with no issues. Sometimes, Nurses for agencies are hours away from members and it is not feasible for them to attend in person.	**Duplicate**
288	5/5/2026	Page 50, Section 513.8: Why must CM attain a signature for the IPP from the legal rep if the IPP is not due for 14 days? These seems like a ridiculous request that makes no sense. Shouldn't the deadline for signatures from the IDT be the date the IPP is due?	**Duplicate**
289	5/5/2026	Section 513.8: I do not see anything about (1) a timeline for discharge following an extended admission of a crisis site.	**Change** Section 513.8.1.4 will be revised to include discharge from a crisis site placement as a circumstance

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			under which a Critical Juncture IDT meeting should be held.
290	5/5/2026	Section 513.8: I do not see anything about (2) ability to transfer Transportation fund to ULR PCS.	**No Change** The Change Log includes a description of the revision of the graphic to depict the ability to transfer transportation funds to unlicensed residential person-centered support.
291	5/5/2026	Section 513.8: I do not see anything about (3) There is no graphic to explain this as indicated on the change log. Number 2 and Graphic found on page 58	**No Change** The Change Log includes a description of the revision of the graphic to depict ability to transfer transportation funds to unlicensed residential person-centered support.
292	5/5/2026	Page 50, Section 513.8: Why is a 180 day deadline needed for the time between IPPs? In other places it says 6 months.	**Change** The reference to the 180-day time between IPP updates will be revised to “six months” to help ensure internal consistency throughout this section of the policy manual.
293	5/5/2026	Page 61-62, Section 513.10.1: This is the BSP section so there is nothing about CM like the change log says.(2) First sentence says Functional Assessment. Change log says it was changed to Functional Behavior Assessment. It was not. (3) Change log says DSP responsibility to develop the tentative schedule. The manual says it is the BSP's responsiblity so that needs to be corrected in the Change log.	**Duplicate**
294	5/5/2026	Page 65, Section 513.10.2: BSP should be able to bill if they attend by phone. As long as they provide the information needed, they are still attending the meeting by phone/computer. This should be allowed as they cannot bill for transportation and it is more cost efficient and less time consuming as BSP's have large caseloads. Language here is confusing. Can the BSP bill if by	**Duplicate**

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		phone or in person? As long as they attend the whole meeting? please clarify (4th bullet)	
295	5/5/2026	Page 82, Section 513.14.1: 7th bullet is not changed as the change log says. Last bullet says the CM must not pay but it should say PDG&S should not pay.	**Change** This section of the policy manual will be revised to clarify that the Personal Options FMS vendor, not the case manager, is responsible for payment of the cost of the EAA services to the vendor of the EAA service.
296	5/5/2026	Page 86, Section 513.14.4: Only says car seats unless specifically adapted/modified for the person. There is no language about the types of carseats.	**No Change** The current policy manual states that *adapted or modified* car seats may be purchased through PDG&S.
297	5/5/2026	Page 126, Section 513.19.1: Manual says: Purchase service to obtain authorizations or change existing authorizations within 7 days of the IDT meeting… You cannot submit purchases until the IPP is complete. That was a 14 calendar day deadline, however this new manual states here-7days and previously in the manual, it says 10 business days, 14 business days, and 14 calendar days so I'm not sure which one is correct.	**Duplicate**
298	5/5/2026	Page 128, Section 513.19.1: Under limitations/caps section it says that CM can be done while on a member- hold. Please clarify because CM cannot be done while member is in another state but WV does not have the needed services in WV so there is a lot of CM that is done that can't be paid for.	**No Change** Federal rules and regulations prohibit the delivery of Medicaid-funded services to an individual residing out of state.
299	5/5/2026	Page 128, Section 513.19.1: No mention that CM cannot be provided if member is out of state. I think that should be added as many members go out of state because WV cannot provide the needed care so even though CM is needed usually in this circumstance, CM's should know they cannot provide this service out of state. (5th bullet under limitations)	**Duplicate**

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300	5/5/2026	Page 134, Section 513.20.3: It says Skilled RN IPP can live in the member's home. But everywhere else says they cannot. So you need to add NOT to the sentence so it all says the same thing. (5th bullet under limitations)	**Duplicate**
301	5/5/2026	Page 139, Section 513.24: Use the term service coordinator 2x's. Should be Case Manager. (1st full Paragraph)	**Duplicate**
302	5/5/2026	Page 140, Section 513.25.2: Change log says Revision of language to reflect new requirements and documentation requirements for CM in person visit frequency but it is not there as this is the Responsibilities (member/legal rep)	**No Change** Existing policy manual language describes the member's responsibility to follow all IDDW policies including routine home visits with their case manager.
303	5/5/2026	Page 17, Section 513.2: Bullet 3: Define Therapy. This should not include cognitive behavioral therapy or other therapy service not covered by this program.	**Change** This section will be revised to clarify that agency staff must ensure access to IDDW professional therapy services for members.
304	5/5/2026	Page 30, Section 513.31: "To qualify to train others using an approved curriculum, an individual must meet one of the following four criteria..." Please clarify "train others". Train new BSP hires? Train DSP's? In addition, please identify the acceptable method of obtaining approval for BSP training programs and or changes in trainers once the program has been approved.	**No Change** Provider qualifications for the BSP services are defined in the CMS-approved waiver application. BMS may consider re-evaluating BSP training qualifications, including qualifications to train others, in a future amendment.
305	5/5/2026	Page 66, Section 513.11.1: Discrepancy between authorization period between paragraphs one and two. Is the authorization valid for one year or six months?	**No Change** The first paragraph of this section refers to the timeline for the IDT to review the crisis service utilization. The second paragraph refers to the period of time for which crisis services may be authorized.
306	5/5/2026	The manual seems to take opposing positions on the use of teleconference for meeting or staff training and support throughout the document. Please add a section for teleconference and	**Duplicate**

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		outline when it is permitted, permitted but not billable and not permitted.	
307	5/5/2026	**No page**, Section 513.20.2: "RN Skilled Nursing Services are restricted to those nursing services that are outside the scope and practice of an LPN. If the RN provides a Skilled Nursing service that is within the scope of practice for an LPN, the RN must use the LPN code". Medication Administration is included in the LPN Scope of Practice per WV NPA. This manual clearly requires the use of AMAP trained staff for medication administration, as the current allowance for LPN medication administration as a skilled nursing task has been removed. Please reconsider this change, as reductions in direct nursing care will be harmful to this population. There are not enough RN's available to cover medication administration in place of AMAPs	**No Change** The addition of the AMAP codes with enhanced rates eliminates the current exception that allows LPNs to bill for medication administration.
308	5/6/2026	Page 16-17 & 146: DRWV appreciates the added language around provider accountability regarding discharge of Members. DRWV would like to see stronger language included that the provider will be subject to a targeted review, referral/enrollment hold, reduction in caseload and/or disenrollment as an IDDW provider.	**No Change** The current draft policy manual states that “providers may be subject to a targeted review, referral/enrollment hold, reduction in caseload and/or disenrollment as an IDDW provider.”
309	5/6/2026	Page 18: DRWV recommends Approved Protective Services Record Check be a requirement. DRWV is concerned that completion of an affidavit serves as the documentation needed for employers/employees to show as having the necessary transportation requirements.	**Change** This section of the policy manual will be revised to include the recommendation that providers obtain an Approved Protective Services Record Check and consider the results of this check. BMS anticipates the implementation of mandatory background checks in WV CARES (which includes an Approved Protective Services Record Check) in

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			the coming months as enhancements are made to this system to expedite search results and information sharing.
310		Page 18: Also, DRWV recommends Completion of the West Virginia Association for Positive Behavior Support (WV APBS) Overview of Positive Behavior Support or the West Virginia University's Center for Excellence in Disabilities (WVU CED) Positive Behavior Support Direct-Care Overview, be a required training component.	**No Change** BMS may consider changes to the training requirements for direct support staff in a future amendment.
311	5/6/2026	Page 20-21: DRWV would like to see enforcement of the conflict-of-interest policy in instances where case management and service provider agencies have clear and known affiliations.	**Change** This section of the policy manual will be revised to clarify that failure to comply with Conflict Free Case Management requirements may result in enforcement actions, including, but not limited to, a targeted review that may result in a referral/admissions ban or reduction in caseload size and/or disenrollment as an IDDW provider.
312	5/6/2026	Page 21: DRWV would like to see enforcement of the conflict-of-interest policy in instances where IDDW agencies serve as property owners/landlords for individuals living in Intensively Supported Settings (ISS).	**Duplicate**
313	5/6/2026	Page 25: DRWV disagrees with the proposed change to allow the Utilization Management Contractor (UMC) to provide the draft exit report within 120 days of exit summation. Current policy requires the draft exit report be provided within two weeks.	**Duplicate**
314	5/6/2026	Page 47-50: Individual Program Plan (IPP) To ensure the timely and accurate completion of a member's IPP, DRWV recommends having case managers complete the IPP as a "live" document.	**No Change** The current draft policy manual language requires that all IDT members sign the IPP in "real time."
315	5/6/2026	Page 62: DRWV is not in support of utilizing behavior guidelines/protocols. Although the manual states "Develop	**No Change** BMS may consider changes to the circumstances in which

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		Interactive Guidelines or Behavior Protocols for individuals who do not require a formal PBS Plan." It is DRWV's position that service providers do not consistently establish formal plans for members who need this level of support. The language suggests that BMS is in support of using guidelines/protocols. DRWV is aware of numerous members who had significant interfering behaviors, that were severe and frequent but only had guidelines/protocols. Often these members had multiple encounters with law enforcement, arrests, medical and psychiatric hospitalizations. DRWV does not believe that guidelines/protocols are a sufficient or acceptable replacement to keep members safe.	the development and implementation of a positive behavior support plan (PBS) may be required in a future amendment.
316	5/6/2026	Page 78-81: Electronic Monitoring (Traditional Option) Information in the change log conflicts with language in section 513.13.1. The change log states, "Revision of allowable units for electronic monitoring services for individuals over age 18 residing in natural family/specialized family care home settings for members aged 18 and older." In addition, the change log states, "Revision of language to reflect the correct number of units and hours available for the electronic monitoring service in natural family/specialized family care homes." However, in section 513.13.1 it includes limitations/caps that state, "the electronic monitoring/surveillance system may not be used in specialized family care homes."	**Change** The Change Log will be revised to remove the reference to specialized family care settings.
317	5/6/2026	Page 88-90: DRWV believes the existing policy allows for more integrated opportunities for members to participate in employment.	**No Change**
318	5/6/2026	Page 89: DRWV appreciates the clarification that a provider's office is not a community setting.	**No Change**
319	5/6/2026	Page 112-114: DRWV appreciates the increase and flexibility to crisis services.	**No change**
320	5/6/2026	Page 165: The change log states, "Addition of language added to reflect that initial training is required, and ongoing education is	**No Change** This language is included in the "HCBS Service Requirements" section of the policy manual.

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		encouraged." However, DRWV could not locate this language in the manual.	
321	5/6/2026	Page 166: 513.2.3.4 and 513.3.1.2 are included in the change log. However, there does not appear to be any changes to the language in the manual. Additionally, DRWV questions if Section 513.3.1.2 is referring to 513.3.12, Section 513.3.1.3 is referring to 513.3.13, and if Section 513.3.1.7 is referring to 513.3.17.	**Change** The Change Log will be revised to more accurately reflect each corresponding change within the policy manual.
322	5/6/2026	Page 167: Section 513.6.2.3 does not appear to be in the manual. DRWV is uncertain of what manual changes were made.	**Change** The Change Log will be revised to more accurately reflect each corresponding change within the policy manual.
323	5/6/2026	Page 172: DRWV questions what change related to case manager in person visit frequency is referenced in section 513.25.2.	**Change** The Change Log will be revised to more accurately reflect each corresponding change within the policy manual.
324	5/6/2026	There were several sections included in the change log that are missing from the manual. These sections include 513.1.3, 513.1.7, 513.6.2.3, 513.3.11.11, and 513.23.	**Change** The Change Log will be revised to more accurately reflect each corresponding change within the policy manual.
325	5/6/2026	Hi, I have reviewed the manual and appreciate the clarification of qualifications for BSP I and BSP II, as well as the ability of BSP to work in the home and a second to work in Day program or other setting. In other states, (for example, Minnesota) in order to be able to bill for Positive Behavior Support at BSP I or BSP II, an agency must have a BSP II (or equivalent) on staff or contracted to assure there is someone able to assist in plan design, training, or staff response by any other plan designer (BSP I). Without an agency having that oversight (to increase compliance with PBS	**No Change** BMS may consider revisions to the BSP service definition, including provider qualifications, in a future amendment.

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		implementation within an agency), agencies cannot bill PBS at any level. I wonder if this could help us better coordinate plan development, training, implementation, and effectiveness.	
326	5/6/2026	Case Management (CM) – Page 12First bullet under "The CM must, at a minimum, perform the following:" Please consider adding language indicating that these activities will be completed in collaboration with the member's residential agency, family, and/or payee, as applicable.	**No Change** While an individual member may have assistance and participation from various paid providers and natural supports, the case manager is responsible for performing the minimum requirements listed in this section of the policy manual.
327	5/6/2026	Case Management (CM) – Page 125 8th Bullet Point. The draft indicates units must be purchased within 7 days. Current manual language allows 14 days. Is this an intentional policy change or an oversight? If this is an intended change, additional guidance would be helpful regarding situations where required documentation from providers has not yet been received or is unavailable within that timeframe. It may also be beneficial to include language addressing timely responses to documentation requests by both Case Managers and residential providers.	**Duplicate**
328	5/6/2026	Case Management (CM) – Page 125 18th Bullet Point. This section appears inconsistent with the earlier policy language. Units are required to be purchased within 7 days; however, documentation is not required to be uploaded until 14 days afterward. Clarification and alignment of timelines would be appreciated.	**Duplicate**
329	5/6/2026	Case Management (CM) – Page 125 19th Bullet Point. Please consider adding clear timelines for required actions for both Case Managers and residential providers.	**No Change** Existing language in the policy manual requires IDDW service provider agencies to cooperate in the sharing of information and

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			documentation necessary to complete and finalize the IPP.
330	5/6/2026	Case Management (CM) – Page 125 23rd Bullet Point. Please note that the location requirement appears to indicate services must occur at the member's residence. Clarification would be appreciated unless this is an intentional policy Change	**No Change** Per policy, the case manager is required to conduct in-person visits at the individual's residence.
331	5/6/2026	Case Management (CM) – Page 125 Travel Billing for Case Managers. Please consider including a separate billing code for Case Manager travel.	**Duplicate**
332	5/6/2026	Case Management (CM) – Page 125 Procedure Codes. Please correct the procedure code descriptions: US = Natural Family U4 = ISS/GH/SFC	**Duplicate**
333	5/6/2026	Case Management (CM) – Page 125 Start/Stop Times. Please consider removing the requirement for start and stop times, as this has previously been discussed during provider calls and identified as not required.	**No Change** While start and stop times are no longer needed to support case management billing due to the change to per member/per month reimbursement, documenting the length of the case management contact is important for general documentation purposes.
334	5/6/2026	Case Management (CM) – Page 125 Limitations Section. Since Case Management is the only required service, the first bullet point in this section does not appear applicable and may need clarification or removal.	**Change** Case management is a mandatory IDDW service. This bullet will be removed for clarification purposes.
335	5/6/2026	Case Management (CM) – Page 125 One CM at a Time. Please clarify that exceptions exist to the policy requiring services to begin on the first day of the following month and clearly outline what those exceptions are. This area	**No Change** Any exceptions to policy are made on a case-by-case basis.

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		has historically created confusion and frustration for providers when exceptions are made that appear to circumvent policy. Additional clarity and consistency would be greatly appreciated.	
336	5/6/2026	Case Management (CM) – Page 125 Staffing Shortages / Service Flexibility. Due to ongoing staffing shortages, it would be helpful to allow Case Managers to provide respite and/or home-based PCS services to clients served by CM-only agencies, provided they are not the individual's assigned Case Manager.	**No Change** Existing policy manual language allows for a single agency to provide both case management and direct support services if all requirements for Conflict Free Case Management are met.
337	5/6/2026	RN Section DD-9 Timeline. Please clarify when the DD-9 must be provided to Case Managers. Ideally, it should be available at the time of the IPP meeting or immediately afterward if unit changes were made during the juncture process.	**Change** Section 513.20.3 will be revised to clarify that the RN must complete and submit the Request for Nursing Services form (DD-9) to the case manager within 10 business days of the IPP. In addition, related sections of the policy manual regarding documentation requirements for the BSP I and II services will be revised to reflect similar requirements for distribution of any Positive Behavior Support Plan, Interactive Guidelines, and/or Behavior Protocols to the case manager 10 business days prior to the IPP.
338	5/6/2026	RN Participation in IPPs Please clarify whether both a residential RN and an FBDH RN are prohibited from participating in and billing for annual and six-month IPPs at the same time. Additionally, please consider adding language stating that if IPP units are exhausted, the RN may utilize the standard RN billing code instead.	**No Change** Federal rules and regulations prohibit the provision of duplicate services. As existing policy language states, only one RN may bill for this service during an IDT meeting.

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339	5/6/2026	Case Management Qualifications Last Bullet Point. I would strongly recommend removing this proposed Change I have concerns about lowering the qualification standards for Case Managers due to the broad scope of responsibilities required within this role. Case Managers are responsible for coordinating with multiple providers, adhering to strict timelines, chairing meetings, assessing members' needs, and helping ensure the health, safety, and overall well-being of the individuals they serve. I am concerned that removing the degree requirement could negatively impact the quality and consistency of services provided statewide. I would strongly support maintaining the current requirement of a four-year human services degree for Case Managers.	**No Change** The changes to the case management provider qualifications were included in the July 1, 2025, waiver renewal application and approved by CMS.
340	5/6/2026	BSP Section Documentation Timelines. I would like to see additional language included in the BSP section clarifying timelines for providing documentation to Case Managers. Ideally, documentation should be provided at the time of the meeting unless new programming objectives are requested and still need to be developed. It can be very frustrating for Case Managers to repeatedly follow up with agencies to obtain required paperwork after meetings have occurred. Clear policy expectations and timelines would help improve consistency, accountability, and communication between providers and Case Managers.	**Change** Section 513.10.1 will be revised to include a requirement that the BSP provide the PBS Plan, Interactive Guidelines, Individual Habilitation Plan, Tentative Schedule(s) and/or Behavior Protocols (as applicable) to the case manager at least 10 business days prior to the IPP meeting.
341	5/6/2026	Page 1: Seems like the footer could be better filled out to include chapter name and number.	**No Change** The formatting of the draft policy manual, including any needed edits to footers, will be finalized prior to publication.
342	5/6/2026	Page 10: "Case managers and direct-support professional staff must complete mandatory training on the Statewide Transition	**Duplicate**

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		Plan". This does not seem to specify whether or not the training would be completed just once or annually. This has been included in the Tabled section of PC Calls for some time. In other waiver programs, this is an annual requirement. So, we need a directive on which way BMS wants to proceed with this training.	
343	5/6/2026	Page 11 – last sentence: This would be a good place to reference the site change document.	**Change** This section of the policy manual will be revised to reference the Direct Support Services- Living Arrangement Assessment form.
344	5/6/2026	Page 11 - Last bullet under Provider-Owned/Controlled Settings. This is the first reference to the CSED Waiver. Most people are not going to recognize it since it's been given as an abbreviation. It should be identified by name first with abbreviations after.	**Change** This section of the policy manual will be revised to provide the full name of the Children with Serious Emotional Disorders Waiver.
345	5/6/2026	Page 14 - Second bullet, top of page: "The BMS will additionally notify members five business days following the provider notification to ensure all parties." Incomplete sentence.	**Change** This section of the policy manual will be revised to note that notification of the setting noncompliance and expectations regarding remediation are shared with all parties by BMS within five business days.
346	5/6/2026	Page 15 – "NOTE" under the first bullet of the Licensure and Certification Standards: We don't actually check for this for the purposes of the IDDW Reference Guide. We've recently confirmed that BMS is ok with Acentra just confirming the correct counties since some CONs don't seem to list some or any IDDW services. Will this need to change moving forward?	**No Change** While the Certificate of Need (CON) may not be subject to provider quality reviews, the requirement for providers to receive a CON from the West Virginia Health Care Authority remains in effect.
347	5/6/2026	Page 15, 2nd para. and 4th. Just seems like these are saying the same thing, just differently, which could be confusing to others.	**No Change** A behavioral health license through the Office of Health Facility Licensure and Certification (OHFLAC) is not the same as provider certification through the UMC.

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348	5/6/2026	For consistency - last word on the page. So far, policy has used "providers" when referencing the agency. Here it's using "agencies" instead. Same for top bullet on page 16. Should be consistent.	**No Change** The terms “provider,” “agency,” and “provider agency” are used throughout the policy manual and are commonly understood as interchangeable.
349	5/6/2026	I like under Administrative Standards, page 16, the part about the Provider would assign a person who would be responsible for X, Y, and Z - basically saying you have to create a position for someone to do the following. Although, I can see some providers complaining about having to hire specifically for this new, required position because of the added cost. I realize this is just language for 'supervisor’, but it may need some clarification. It could be helpful to clarify whether tasks have to be given to 1 person only, or if providers can divvy up oversight responsibilities, provided compliance can be demonstrated for each specific topic area.	**No Change** The existing policy language does not direct how providers choose to ensure the availability of assigned staff to perform the duties outlined in this section.
350	5/6/2026	Page 17, 3rd bullet down: Does this mean habilitation is now required for all members? Will BSP's be required for everyone as a result of required, specific goals? That was my thought when reading this statement. This may need a bit of explanation.	**No Change** This section of the policy manual does not include any mandate to provide habilitation to all members.
351	5/6/2026	About the affidavit being allowed by the staff providing transportation (pg. 18). I recommend sub-bullets that say something like the affidavit needs to include: 1) signature of supervisor /agency verification, 2) the date, 3) describe how often the affidavit has to be updated (annually, bi-annually, only as needed), 4) answer what should happen when vehicle changes happen mid-affidavit cycle.	**Duplicate**
352	5/6/2026	Page 18 - can we please say that the documented training on the crisis intervention has to be waived through some kind of documentation? Looking at QP files, we're not looking at treatment plans so knowing if that's been agreed to or not by the team, we'll never know. We would have nothing to review if it were	**No Change** The requirement to document required trainings, including training on an individual’s crisis plan, remains in effect.

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		found. All the provider has to say is "oh, well, the team waived it", to cover themselves, regardless of the member's actual need.	
353	5/6/2026	Page 18 - How to report Abuse, Neglect and Exploitation isn't mentioned. It doesn't really talk about mandated reporting, or saying training must include how to report, like before. This one just says staff need training on documentation and recognition. Documentation could be someone filling out an incident report but then doing nothing else. That's not actually reporting to the required people.	**No Change** Information regarding reporting requirements for incidences of suspected abuse, neglect, and/or exploitation is covered in Section 513.4, "Reporting Requirements" and includes required documentation.
354	5/6/2026	Someone could recognize the abuse and do an internal Incident Report, leaving it in the home notebook, then do nothing else the way this is worded. It feels incomplete in the way it's written and had created a verbiage loophole here that providers could exploit if they really wanted to	**No Change** WV Code mandates that all IDDW provider staff report suspected incidences of abuse, neglect, or exploitation. These requirements are included in Section 513.4, "Reporting Requirements" of the policy manual.
355	5/6/2026	Page 18 – 2nd to last bullet: RNs, LPNs, and others that may have specialized medical training (EMS) still must have proof of CPR unless it is expressly writing in their certification. First Aid is different because it is a basic part of their certification/credentialing.	**Duplicate**
356	5/6/2026	Top of page 19 – if possible, add a link to the WV Public Learning Center System in this section.	**No Change** Additional links will not be included to help ensure the most accurate and up-to-date information is provided and prevent confusion due to "broken" links. Any interested person may conduct an internet search to locate the most current link.
357	5/6/2026	Page 19 – 3rd bullet: define more specifically by adding something like, 80% or higher must be indicated on the training….	**No Change** Existing language in this section of the policy manual states that a "score of 80% or higher" is needed to prove competence.

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358	5/6/2026	Page 31 – Occupational Therapist Agency Staff Qualifications, second paragraph: for DT, OT, and PT, there appears to be some inconsistencies noted. For DT, this indicates, "if they are not staff but are contracted" then they must be individually enrolled…..So if the DT is agency staff, then they don't need to be enrolled as a registered dietician? I don't think that is the intention here, but it does seem to read that way as currently written. Might be worth revising to be consistent with the other therapy providers….maybe just outdated language?	**No Change** The included reference to Sections 513.2 – 513.2.1 indicates the need for Dietary Therapist licensure.
359	5/6/2026	Page 32 – QSW Qualifications (PO), 5th bullet: I think the frequency requirements in the 5th bullet (about crisis plans training) was meant for the bullet above (Emergency Procedures/CI training). CP training annually, EP/CI upon hire and as needed after. Right? Same with 9th bullet for member-specific needs.	**No Change** The referenced bullet points in this section of the policy manual reference distinct trainings regarding training on general policies versus trainings on member specific trainings.
360	5/6/2026	Page 37 – first bullet. Adding link to Chapters 100 and 300 could be helpful. Consider adding them.	**No Change** Additional links will not be included in order to help ensure the most accurate and up to date information is provided and prevent confusion due to "broken" links.
361	5/6/2026	The term "service coordinator" used again on page 139 in the section discussing situations where a member is jailed or imprisoned.	**Duplicate**
362	5/6/2026	Page 41 – 513.6.3.1 Initial FE under Assets: I think this would be a great place to somehow reference WVABLE accounts as a viable option/consideration. This truly needs to be common knowledge.	**No Change** WVABLE information is not IDDW policy related.
363	5/6/2026	Page 46 – 513.7.2 Redeterm FE, 3rd sentence: This would be a good point to add in the policy handbook and/or any other place where member/LR responsibilities are defined.	**No Change** Member/LAR responsibilities are defined in Section 513.25.2 and include the responsibility to provide information necessary to

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			allow the case manager to monitor financial eligibility.
364	5/6/2026	Page 47 – 2nd to last sentence says the LR must sign electronically: What if the agency only uses physical signatures? If, under these circumstances, the LR signs & scans a physical, would this not be acceptable? I would think it would be, but if not consider revising this language. Seems like adding an acceptable timeframe here (within 7 days as defined later in the manual, perhaps?) would be useful as well…..	**No Change** Real-time, electronic signatures are only required for LARs who attend the IPP via teleconference.
365	5/6/2026	Conflicting information on page 48. One place lists 10 days and another lists 14 days to upload IPPs to web portal.	**Duplicate**
366	5/6/2026	Page 53 – 513.8.1.2 30-Day IDT: add “or from one day setting to another” since this section currently only specifies residential services.	**Duplicate**
367	5/6/2026	On page 59, under the section that states “as the common law employer, the member is responsible to,” the final bullet still references “service coordinator.”	**Duplicate**
368	5/6/2026	The BSP sections are that it does not seem to reference which portions of BSP activities can be provided remotely/occur electronically. You could say the same for RNs. For example, IPP Meetings, we know that they can attend IPP Meetings electronically, but I don’t see that listed in caps/limitations, site of service, or any other applicable areas of policy. This actually is spelled out in the RN IPP Planning section, so maybe add similar language throughout. (page 134) “Professional must attend all planning meetings, either face-to-face or by teleconference, if billing the IPP code, the professional must be present for the entirety of IPP meeting. IPP cannot be billed for preparation prior, or follow-up performed after the IPP meeting.” This is not currently included in the BSP IPP section.	**Duplicate**

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369	5/6/2026	The "therapist's office or location of practice" is not included in the site of service for OT/PT/ST (or any of the PO versions) but is included in the site of service for DT-Traditional. Is this intentional? Seems inconsistent one way or another.	**Change** These sections of the policy manual will be revised to clarify that the therapist's office or location of practice is an approved site of service for all specialized therapy services.
370	5/6/2026	Electronic Monitoring section does not specify the need for annual completion of DD-15 & DD-16 forms and that this process is overseen by the UMC.	**Change** This section of the policy manual will be revised to describe the processes required to perform and document the Remote Monitoring Risk Assessment on the IDD-17, prepare and submit the Remote Monitoring Application on the IDD-15, and prepare, certify, and submit the Remote Monitoring Equipment on IDD-16.
371	5/6/2026	Maybe add a link to this: "WV Code Ch.16B-10 and on the OHFLAC website", which is listed in section 513.17.3 Licensed Group Home Person-Centered Support (Traditional Option). A link to OHFLAC is present in other sections (page 108 for example), but not for the state code. Maybe update each of these for consistency….?	**Change** This section of the policy manual will be revised to include the requirements for medication administration under the AMAP program and help ensure consistency.
372	5/6/2026	Towards the bottom of page 113 OHFLAC is mis-spelled.	**Change** This section of the policy manual will be revised to reflect the correct spelling of OHFLAC.
373	5/6/2026	Sites of service for OOH Respite Traditional and PO do not match. PO does not include FBDH/PVT sites. Is this intentional?	**No Change** Services provided at Facility-Based Day Habilitation or Prevocational Training sites are not available via *Personal Options* and may only be delivered through the traditional option.

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374	5/6/2026	Page 124 notes ASO, which is outdated terminology. Change to UMC.	**Change** This section of the policy manual will be revised to reference the UMC.
375	5/6/2026	Page 129 – consider adding link to Nurse Practice Act and the specified code.	**No Change** Additional links will not be included in order to help ensure the most accurate and up-to-date information is provided and prevent confusion due to "broken" links.
376	5/6/2026	Page 133: RN IPP Planning – why does the site of service indicate public community locations? Doesn't seem appropriate for an IPP-type of setting….	**Change** This section of the policy manual will be revised to remove the reference to public community locations as a permissible site of service for RN IPP Planning.
377	5/6/2026	Page 134: Transportation – maybe add links and/or more info about the states NEMT provider and how to access these miles.	**No Change** Additional links will not be included in order to help ensure the most accurate and up-to-date information is provided and prevent confusion due to "broken" links.
378	5/6/2026	Page 137: Trans-Trips – might want to better define "two one-way trips" since it does get rec'd for DIS routinely for some providers….there are related FAQs to build off of.	**No Change** Specific nuances regarding the provision of the Transportation Miles service are better addressed through the issuance of policy clarifications.
379	5/6/2026	Page 138: Billing Procedures – This statement is bolded: The billing period cannot overlap calendar months. How does BMS plan on monitoring/enforcing this? Will Gainwell deny IDDW claims that overlap calendar months?	**No Change** Processes to monitor billing claims and practices are not the subject matter of Chapter 513.
380	5/6/2026	Sections 513.25.2 (Responsibilities), 513.8.1.3 (Transfer/Discharge IDT Meeting), & 513.27 (Transfer) add finalized FAQ 234 (currently draft) answer to these sections.	**No Change** The comment refers to draft FAQs that are not currently available for review and distribution.

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381	5/6/2026	Add to the giant list of CM responsibilities something that specifically outlines that they need to maintain current/accurate member information in the UMC portal	**No Change** The responsibility of the case manager to submit and maintain accurate and current data in the UMC's portal is addressed in Section 513.4.
382	5/6/2026	513.8 Individual Program Plan (IPP) Pg 48: All IPPs must be uploaded into the UMC's portal and given to all team members within 14 business days and must include:	**Duplicate**
383	5/6/2026	513.8 Individual Program Plan (IPP) Pg 50: A copy of the IPP is kept in all participating provider agency records and distributed, via secure electronic means, to all team members by the case manager within seven calendar days of the date of the IDT team meeting.	**Duplicate**
384	5/6/2026	513.8.1.1 Initial and Seven-Day IDT meeting Pg 52: Disseminating the completed IPP within 14 calendar days	**Duplicate**
385	5/6/2026	513.8.1.3 Transfer/Discharge IDT Meeting Pg 53: Sending the completed IPP to the transfer to agency within 14 calendar days	**Duplicate**
386	5/6/2026	513.8.1.3 Transfer/Discharge IDT Meeting Pg 54: Disseminating the completed IPP within 14 calendar days	**Duplicate**
387	5/6/2026	513.19 Case Management Pg 126: Disseminate copies of all IPPs, via secure electronic means, to the IDT members and Participant Directed service Option providers (if applicable) within 14 calendar days of the IDT meeting.	**Duplicate**
388	5/6/2026	Uploading IPP to UMC portal (conflicting information) 513.8 Individual Program Plan (IPP) Pg 48: Last sentence of first paragraph: The IPP must be uploaded to the UMC portal within ten business days.	**Duplicate**
389	5/6/2026	Uploading IPP to UMC portal (conflicting information) 513.8 Individual Program Plan (IPP)	**Duplicate**

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		Pg 48: Third paragraph: All IPPs must be uploaded into the UMC's portal and given to all team members within 14 business days and must include	
390	5/6/2026	Uploading IPP to UMC portal (conflicting information) 513.8 Individual Program Plan (IPP) Pg 50: The IPP must be uploaded into the UMC's portal within 14 calendar days of the IDT meeting to ensure timely authorization of services.	**Duplicate**
391	5/6/2026	513.8.1.3 Transfer/Discharge IDT Meeting Pg 53: Sending completed IPP to transfer agency within 14 calendar days	**Duplicate**
392	5/6/2026	513.19 Case Management Pg 126: Upload any required documentation into the UMC's portal within 14 calendar days of the IDT meeting. NOTE: No services will be prior authorized until the current IPP is loaded into the portal.	**Duplicate**
393	5/6/2026	Electronic Signatures – Chapter 100, General Information of BMS policy manual doesn't have information regarding electronic signatures but is mentioned as where to find this information. 513.2 Provider Enrollment and Responsibilities Pg 20: Note: Electronic signatures must comply with the documentation and record retention requirements described in Chapter 100, General Information of the BMS policy manual.	**Duplicate**
394	5/6/2026	Electronic Signatures – Chapter 100, General Information of BMS policy manual doesn't have information regarding electronic signatures but is mentioned as where to find this information. 513.5 Documentation and Record Retention Requirements Pg 37: IDDW Program provider agencies must follow the documentation and maintenance of records requirements	**Duplicate**

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		described in Chapter 100, General Information; and Chapter 300, Provider Participation Requirements of the BMS policy manual.	
395	5/6/2026	Electronic Signatures – Chapter 100, General Information of BMS policy manual doesn't have information regarding electronic signatures but is mentioned as where to find this information. 513.8 Individual Program Plan (IPP) Pg 47: Note: Electronic signatures must follow the documentation and record retention requirements described in Chapter 100, General Information of the BMS policy manual.	**Duplicate**
396	5/6/2026	Order to purchase services (conflicting information) 513.8 Individual Program Plan (IPP) Pg 49: Case management services must be purchased first, followed by direct-care services in the following order: person-centered support services, crisis services, day services, electronic monitoring, direct-licensed practical nurse services and respite services. Professional services may be purchased in any order that meets the individual's unique support needs.	**No Change** Existing language in this section of the policy manual is intended to help ensure individual choice in the selection of services, including the choice to forgo other services in order to maximize access to professional services that meet the individual member's needs.
397	5/6/2026	Order to purchase services (conflicting information) 513.8.1 The Interdisciplinary Team (IDT) Pg 51: All direct support and case management services must be purchased first before professional services. This is to ensure the health and safety of the member. The direct-care support services must be purchased in any order necessary to meet the individual's unique support needs: all types of person-centered supports, facility-based day habilitation, pre-vocational, job development, supported employment, electronic monitoring, LPN services and respite services.	**Duplicate**
398	5/6/2026	Signing the IPP (conflicting information) 513.8 Individual Program Plan (IPP) Pg 47: The legal representative may participate via teleconference in extenuating circumstances. If the legal	**Duplicate**

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		representative attends via teleconference, the IPP must be signed electronically, and the signature must include a date and time stamp.	
399	5/6/2026	Signing the IPP (conflicting information) 513.8 Individual Program Plan (IPP) Pg 50: The IPP must be signed in real time, by all IDT members who attended the meeting prior to the conclusion of the IPP meeting. In addition, the IDT must write down their agreement/disagreement with the IPP, date of the meeting, and the total time spent in the meeting for each team member.	**Duplicate**
400	5/6/2026	Signing the IPP (conflicting information) 513.8.1 The Interdisciplinary Team (IDT) Pg 52 All members of the IDT must sign the IPP signature sheet and indicate their participation in the meeting and must sign indicating agreement or disagreement with the IPP. All members of the IDT who attend the IPP meeting must sign the IPP in real time, prior to the conclusion of the IPP meeting.	**Duplicate**
401	5/6/2026	Signing the IPP (conflicting information) 513.8 Individual Program Plan (IPP) Pg 50 If the legal representative attends via teleconference the case manager must obtain their signature within seven calendar days	**Change** This section of the policy manual will be revised to reflect the requirement for real-time signatures from an LAR participating in the meeting via teleconference.
402	5/6/2026	Agreement with the IPP (conflicting information) 513.8 Individual Program Plan (IPP) Pg 50: The member, or their legal representative, a representative from each provider agency, and the Medley Advocate (if applicable) must agree with the plan and sign the IPP for it to be considered a valid IPP, per 42 CFR 441.301(c)(2). Agreement with the IPP (conflicting information) 513.8 Individual Program Plan (IPP) 513.8.1 The Interdisciplinary Team (IDT)	**No Change** The sections of the policy manual referenced in this comment are consistent. While each member of the IDT must document agreement with the plan by signature, only the member or LAR's disagreement with the IPP renders the IPP invalid.

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		Pg 52: If the member or their legal representative disagrees with the IPP, the IPP is not valid.	
403	5/6/2026	CM Transfer – Manual has must be first day of the month but Policy Clarification 230 has: Transfer should be effective on the first of the month following the transfer meeting; however, if that's not possible, the transfer may occur at any time following the IPP meeting. In these cases, the change in CM agency must be clearly documented and agreed upon by the IDT (which CM agency will complete the HV during the transition month, correct agency and code agreed upon, etc.). 513.8.1.3 Transfer/Discharge IDT Meeting Pg 53: The effective date of transfer for Case Management	**Change** This section of the policy manual will be revised to clarify that the effective date of transfer for case management services must be the first day of the month following the Transfer IDT Meeting.
404	5/6/2026	513.19 Case Management Pg 123: The member/legal representative may choose to transfer to a different case management provider for any reason, and the transfer will be effective on the first of the following month.	**Change** This section of the policy manual will be revised to clarify that the effective date of transfer for case management services must be the first day of the month following the Transfer IDT Meeting.
405	5/6/2026	Pg 128: A member may only have one case manager assigned at one time. In case of a transfer from one case management provider to another case management provider, the effective date of the transfer must fall on the 1st day of the month following the "transfer-to" agency's acceptance of the referral. The "transfer from" agency must finalize documentation related to member services but will not be able to bill during this time.	**Duplicate**
406	5/6/2026	513.8.1.2 30-Day IDT Meeting Pg 53: This meeting is only required if a full range of planned services were not finalized at the seven-day IPP meeting for the Initial IPP and the IPP for members who've transferred residential providers. Comment: Shouldn't this include those who've transferred day providers, too?	**No Change** The section of the policy meeting describing the requirements of a Transfer/Discharge IDT Meeting does not reference any requirement for an additional 30-Day IDT Meeting.

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407	5/6/2026	513.8.1.4 Critical Juncture IDT Meeting Pg 54: 2nd bullet of A face-to-face meeting may be held under any of the following circumstances: If the individual and/or members of the IDT do not have a reliable internet connection and/or audio capability. Comment: This bullet item list is for reasons to have a Critical Juncture meeting, and the 2nd bullet is not a reason to have a Critical Juncture meeting.	**Change** The policy manual will be revised to remove this reference to a circumstance that may indicate the need for a face-to-face meeting.
408	5/6/2026	513.9.2 Participant-Directed Service Delivery Model Pg 57: (Note that participant-directed goods and services and transportation can only be participant-directed if at least one of either a person-centered support and/or a respite service is also participant-directed.) Comment: Need to add EA & therapies; Should read: (Note that participant-directed goods and services, Environmental Accessibility, therapies, and transportation can only be participant-directed if at least one of either a person-centered support and/or a respite service is also participant-directed.) Pg 57: The maximum amount of a participant-directed budget is the equivalent monetary value of person-centered support service units, respite service units, participant-directed goods and services, and transportation service units available, based on the age, residential setting, needs of the member, and units available. When a member is accessing person-centered support, respite, participant-directed goods and services, and/or transportation services, whether via the Traditional or Participant-Directed Service Option, the total dollar amount of the services must be added together and may not exceed the service limits in both Service Options combined. Comment: Need to add EA & therapies to both of these sentences.	**Change** This section of the policy manual will be revised to clarify that environmental adaptations and professional therapies are included in the participant-directed services array.
409		513.9.2 Participant-Directed Service Delivery Model	**Duplicate**

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		Pg 57: (Note that participant-directed goods and services and transportation can only be participant-directed if at least one of either a person-centered support and/or a respite service is also participant-directed.) Comment: Need to add EA & therapies; Should read: (Note that participant-directed goods and services, Environmental Accessibility, therapies, and transportation can only be participant-directed if at least one of either a person-centered support and/or a respite service is also participant-directed.) Pg 58: However, Respite: Personal Options monies may not be transferred into the following: Person-Centered Support: Personal Options or Transportation Miles: Personal Options. Participant-Directed Goods and Services into Respite: Personal Options. Comment: need to add EA & therapies with Goods and Services	
410		513.9.2 Participant-Directed Service Delivery Model Pg 57: (Note that participant-directed goods and services and transportation can only be participant-directed if at least one of either a person-centered support and/or a respite service is also participant-directed.) Comment: Need to add EA & therapies; Should read: (Note that participant-directed goods and services, Environmental Accessibility, therapies, and transportation can only be participant-directed if at least one of either a person-centered support and/or a respite service is also participant-directed.) Family Person-Centered Supports: Personal Options or Transportation Miles: Personal Options. Participant-Directed Goods and Services. Comment: need to add EA & therapies	**Duplicate**
411	5/6/2026	513.11 Crisis Services Pg 66: Under Prior Authorization: however, the IDT must closely monitor the use of intermittent crisis-site person-centered support	**Change** This section of the policy manual will be revised to reference the proper service category.

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		to ensure that services are provided following the person-centered plan and behavior support plan. Comment: This should say Crisis Services not crisis site pcs – this section isn't Crisis Site PCS, it's Crisis Services (2:1); two different services.	
412	5/6/2026	513.12.8 Speech Therapy (Participant-Directed Option, Personal Options Model) Comment: SD ST caps ages are incorrect, should be 24 like traditional ST on pg. 72; this is what SD ST currently has in Limitations/Caps: • 96 units or 96 events per member's annual IPP year for members below age 22. • 48 units or 48 events per member's annual IPP year for members age 22 and over.	**Change** Section 513.12.4 will be revised to reflect the correct limitation that the provision of this service is limited to members below age 22.
413	5/6/2026	513.13 Electronic Monitoring Pg 80 Comment: Service Units has "unit = 1 event" but this service has always been unit = 1 hour. Then, in Limitations/Caps has "The maximum units of electronic monitoring service available for members living in unlicensed residential settings cannot exceed 23,360 units or 5,840 hours (average 16 hours per day) per member's IPP year." That math for 23,360 units means that 1 unit = 15 minutes so that is different than this cap which is unit = 1 event (or unit = 1 hour as it has always been). If the number of 15-minute units of 23,360 is to remain in this section, it should say "23,360 15-minute units" to avoid confusion.	**Change** This section of the policy manual will be revised to reflect the correct service unit of one hour.
414	5/6/2026	513.14 Environmental Accessibility Adaptations Pg 82 (EAA Home) & pig 83 (EAA Vehicle): The case management agency must not pay EAA funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service. Comment: This should say "the agency with the authorization must not pay EAA	**Duplicate**

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		funds…" not just specifically the CM agency as CM agency most often wouldn't have the EAA auth due to CFCM unless a COI was done.	
415		513.14.3 Environmental Accessibility Adaptations Home (Participant Directed Option, Personal Options Model Comment: EAA Home PO has a nice list of items not allowed, why isn't it included in EAA Home Traditional? Here is the list that is in the PO section: Computers, communication devices, tablets, and other technologies, landline telephones or cell phones, swimming pools, hot tubs or spas or any accessories, repairs or supplies for these items, railing for decks or porches, appliances that are not adapted/modified, yard work, household cleaning supplies, utility payments, household furnishings such as comforters, linens, drapes, etc. Furniture unless it is a lift chair for someone with documented mobility issues, outdoor recreational equipment unless specifically adapted for the person's needs, driveway or walkway repairs or supplies unless specifically to exit or enter home to and from vehicle, covered awnings.	**No Change** BMS may consider inclusion of a list of disallowed items for EAA Home Traditional in a future amendment.
416	5/6/2026	513.14.4 Environmental Accessibility Adaptations Vehicle (Participant Directed Option, Personal Options Model Pg 86 Limitations/Caps: EAA Vehicle PO: $1,000 available per member's annual IPP year in combination with Traditional and Personal Options EAA – Home and/or participant-directed goods and services. Comment: Need to add Trad EAA vehicle here with Traditional and Personal Options EAA Home.	**Change** This section of the policy manual will be revised to include Traditional and *Personal Options* EAA.
417	5/6/2026	513.15.1 Facility Based Day Habilitation (Traditional Option) Pg 88: The maximum annual units of facility-based day habilitation cannot exceed 6,240 units or 1560 hours (average six hours/day) per member's IPP year. Comment: This calculation of 1560 hours is an average of six hours/weekday as six hours/day for a full year	**No Change** Facility-Based Day Habilitation is intended to be provided only during weekdays.

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		is 2,190 hours and this cap was created with the thinking of FBDH being provided only on weekdays	
418	5/6/2026	513.16 Goods and Services Pg 95: To access participant-directed goods and services, the member must also access at least one other type of participant-directed service during the budget year, i.e. participant-directed support or respite. Comment: That should say Person Centered Support not Participant directed support	**No Change** This section of the policy manual clarifies that in order to access Participant-Directed Goods and Services, a member must access at least one other participant-directed service during the budget year.
419	5/6/2026	513.17.1 Family Person Centered Support Pg 99 for FPCS Trad & pg 101 for PCS PO Limitations/Caps: If the person is aged 18 or older and still attending public school, then the limits of 7,320 15- minute units per IPP year will apply. Comment: How will this be monitored? RCs need this information to be made clearly available in the IPP to know what limit the member will receive. What about homeschool or private school	**Duplicate**
420	5/6/2026	513.17.2 Home Based Agency Person Centered Support Pg 104: Home-based agency person-centered support is not available while the member is hospitalized in a Medicaid-certified hospital, except for members who live in an unlicensed residential home, licensed group home or specialized family care home when behavioral needs of the member arise due to the temporary change in environment. Comment: Remove the information regarding those who live in an unlicensed residential home or licensed group home as those that live in those settings cannot have HBPCS services.	**No Change** This section of the policy manual is clarifying the types of settings a person may live in and continues to receive services when hospitalized and in need of supports to meet their behavioral health needs. This includes individuals receiving Home-Based Agency Person Centered Supports in specialized family care homes.
421	5/6/2026	513.17.3 Licensed Group Home Person Centered Support (Traditional Option) Pg 107 Limitations/Caps: The maximum annual units of licensed group home person-centered support services cannot exceed 35,040 units or 8,760 hours (based upon average of 24 hours per day) per IPP year. This is in combination with all other types of	**Duplicate**

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		person-centered support, LPN, crisis intervention, facility-based day habilitation, pre-vocational, job development, supported employment, and electronic monitoring. Comment: Add leap year cap 35,136 as application had it included and shouldn't wait until the leap year comes to do a Policy Clarification to address it.	
422	5/6/2026	513.17.4 Unlicensed Residential Person Centered Support Pg 108 Procedure Codes: remove S5125U4 1:4 code as that is an LGHPCS code and this is the URPCS section and there is not a 1:4 ratio for URPCS	**Duplicate**
423	5/6/2026	Pg 109 Limitations/Caps: Add leap yr cap 35,136 to 4th bullet of limitations/caps as it was in application and shouldn't wait until leap year to do a Policy Clarification to address it	**Duplicate**
424	5/6/2026	513.17.4.2 Unlicensed Residential Person-Centered Support (Personal Options Model) Pg 112 Limitations/Caps: All direct support services cannot exceed the equivalent monetary value of an average of 12 hours per day on days when facility-based day habilitation, job development, pre-vocational, and/or supported employment services are provided. Comment: This bullet needs removed as this is a 24/7 setting service so the direct support services should add up to 24 hours per day and not be limited to 12 hours per day.	**No Change** This section of the policy manual provides the circumstances in which members residing in these settings may not receive the direct support services for 24 hours a day, such as attendance at facility-based day habilitation or participation in job development, pre-vocational, and/or supported employment services.
425	5/6/2026	513.17.5 Crisis Site Person Centered Support (Traditional Option) Pg 114: Crisis Site PCS Limitations/caps 3rd bullet down: Prior authorization may be provided for up to 17,520 units or 4380 hours (based upon an average of 24 hours per day for 180 calendar days) at a time. Comment: This should be 17,280 units as that is the cap of this service and how many 15-minute units 4380 hours is equivalent to.	**Change** This section of the policy manual will be revised to reflect the correct amount of 17,280 units.

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426	5/6/2026	513.18.2 Out of Home Respite Pg 119 Traditional & pg 121 Personal Options: Comment: first sentence "Out-of-home respite services are provided out of the home where the individual lives…" Could be written more clearly as In-home Respite is also provided out of the home where the individual live; a better explanation of the service should be here to avoid confusion OR just take that part out completely as site of service goes over where the service can be provided.	**No Change** The service descriptions for both In-Home and Out-of-Home Respite provide information regarding the types of settings in which these services may be delivered.
427	5/6/2026	513.19 Case Management Pg 127 Procedure Codes: G9002U3 Case Management Natural Family & SFC. Comment: those in SFC are allowed to purchase the G9002U4 code, so should SFC be removed from the procedure code name for G9002U3 and added to G9002U4? Currently, the purchase of G9002U3 or G9002U4 for those in SFC is allowed as current manual has SFC as G9002U3 but BMS has allowed CM to those in SFC to purchase the G9002U4 code.	**Duplicate**
428	5/6/2026	513.20.1 Skilled Nursing Licensed Practical Nurse (Traditional Option) Pg 129: Reviewing and verifying physician orders are current, properly documented and communicated to direct-care staff and others per IDDW provider policy. Comment from Acentra RNs: communicating physician's orders to direct care staff is only allowed to be done by an RN so that part of this should be removed.	**Change** This section of the policy manual will be revised to remove this as a permissible service provided by an LPN.
429	5/6/2026	513.20.2 Skilled Nursing Licensed Registered Nurse (Traditional Option) Pg 132: Limitations and caps: 480 units or 120 hours per member's annual IPP year. Comment: specify that 480 units or 120 hours is T1002HI cap as there is another code here now. The T1003TE cap would be 365 as it's noted to be 1x/day maximum	**No Change** Changes in permissible amount of service unit authorizations due to the occurrence of a leap year are addressed at the system level, rather than individual program-level policy.

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		for non-leap year, 366 for leap year (leap year was noted in application).	
430	5/6/2026	513.21.2 Transportation Miles (Participant Directed Option, Personal Options Model) Pg 136: 6th bullet limitations/caps The equivalent monetary value for transportation miles: Personal Options may be used to increase access to Person-Centered Support: Personal Options and Respite: Personal Options, but not participant-directed goods and services. Comment: add EAA and therapies to goods and services here. Comment: Miles PO limitations/caps: Should add a bullet to state which services can be billed concurrently with Miles PO: PCS PO, In-Home Respite PO, Out-of-Home Respite PO.	**Change** The suggested revisions will be incorporated into the section.
431	5/6/2026	513.21.3 Transportation Trips (Traditional Option) Pg 138 limitations/caps: A trip may be billed concurrently with person-centered support services, crisis services, respite and any day services. These services may not be provided by the driver of the vehicle. Comment: What if there's only 1 staff driving the members out to an outing, they would be the staff providing the direct care svc and billing for the trip.	**Duplicate**
432	5/6/2026	513.25.4.2 Service Authorization Process Pg 145 Exceptions Process Comment: Letter of Denial was updated to Letter of Decision (exceptions decision letter when BMS determines requested additional service and funding is not warranted)	**Change** This section of the policy manual will be revised to reflect the change in the titles of the letter.
433	5/6/2026	AMAP – Cross reference updates (reduce conflicting standards) Add one AMAP "governing authority" anchor: When AMAP is used, require compliance with 71CSR17 (as amended/succeeded) and the OHFLAC AMAP manual & curriculum rather than restating AMAP standards in Chapter 513.	**No Change** Existing language in the policy manual states that the AMAP program is governed by OHFLAC policy.

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434	5/6/2026	AMAP – Cross reference updates (reduce conflicting standards) Add AMAP RN oversight cross reference: Insert a brief clause confirming RN delegation/monitoring expectations follow 71CSR17 (delegation decision model, minimum monitoring expectations, RN availability requirements). This prevents "shadow standards" inside the waiver manual. Add MAR/TAR cross reference: Clarify that when AMAP is used, MAR/TAR content and reconciliation must meet 71CSR17 minimum elements, aligning with Chapter 513's requirement that current physician orders and MARs be available in the home.	**No Change** Existing language in the policy manual states that RN responsibilities within the AMAP program are governed by OHFLAC policy.
435	5/6/2026	AMAP – Cross reference updates (reduce conflicting standards) Add PRN delegation cross reference: Add one line stating PRNs delegated under AMAP must meet 71CSR17 requirements (i.e., parameters that preclude independent judgment) and the RN must be notified of any change of status requiring a PRN medication.	**No Change** Existing language in the policy manual states that the AMAP program is governed by OHFLAC policy, which includes delegation of medication administration.
436	5/6/2026	AMAP – Cross reference updates (reduce conflicting standards) Align medication error follow up: Link Chapter 513 incident reporting expectations (WV IMS timelines and medication error examples) to 71CSR17 expectations for review of medication error reports/med related incidents (avoid conflicting standards).	**No Change** Existing language in the policy manual states that the AMAP program is governed by OHFLAC policy, which includes medication error review and reporting requirements.
437	5/6/2026	Behavioral Health licensure (where applicable only) Add one sentence stating that sites subject to 71CSR25 must comply with its medication control/rights/HRC provisions, including its explicit AMAP linkage to 71CSR17—without expanding Chapter 513 into a behavioral health licensure rule.	**No Change** Existing language in the policy manual states that the AMAP program is governed by OHFLAC policy.
438	5/6/2026	HCBS settings + rights restrictions (member dignity and least restrictive living) Add a "rights restriction" bridge in the HCBS settings section: Clarify that limits on privacy, visitors, food access, locks, communication, or freedom of movement must be documented as	**Change** This section of the policy manual will be revised to indicate that any restrictions of rights outlined in the HCBS Settings Rule must be documented on the IPP and include attempts to remediate via less restrictive

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		rights restrictions in the IPP (least restrictive alternatives attempted, consent, review; HRC when applicable).	means and review by the Human Rights Committee (HRC), when applicable.
439	5/6/2026	EVV clarification (reduce denials and confusion) Add an EVV vs MAR statement: Explicitly state EVV verifies visit/time/location and does not replace clinical documentation requirements (orders, MAR/TAR).	**No Change** Electronic Visit Verification records document time in and time out for direct support staff and bear no relationship to medication administration records.
440	5/6/2026	Section: HCBS Settings (Background / All HCBS Settings / Member Controlled & Provider Controlled Settings) Suggested language: "Any limitation on privacy, visitors, access to food, communication, or freedom of movement constitutes a rights restriction and must be documented in the IPP with justification, least restrictive alternatives attempted, informed consent, and required review/approval processes (including HRC when applicable)." Rationale: Chapter 513 already describes HCBS expectations (privacy/lockable doors, visitors, food access, autonomy), but does not explicitly link limitations to IPP rights restriction documentation and review; behavioral health standards also require rights limitations be clinically justified in writing.	**Duplicate**
441	5/6/2026	Section 513.2 – Provider Enrollment and Responsibilities Staff qualifications (AMAP mention) Suggested language: "When an IDDW provider utilizes Approved Medication Assistive Personnel (AMAP), the provider must comply with 71CSR17 (Delegation of Medication Administration and Health Maintenance Tasks to AMAP), as amended or succeeded."	**Duplicate**

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		Rationale: Chapter 513 references AMAP certification/education but does not establish the controlling AMAP authority in one place. "As amended/succeeded" prevents future manual conflicts if the rule changes.	
442	5/6/2026	Section 513.2 / 513.3 – Staff Training Requirements (AMAP oversight clarity) Suggested language: "RN delegation oversight, monitoring, competency validation, and retraining expectations for AMAP must follow 71CSR17 requirements." Rationale: 71CSR17 specifies RN delegation and monitoring/supervision expectations; cross referencing avoids inconsistent waiver only standards.	**Duplicate**
443		Section 513.5 – Documentation and Record Retention Requirements (orders/MAR in the home) Suggested language: "When AMAP is used, MAR/TAR documentation must meet the minimum content elements and record requirements in 71CSR17, including required prescriber orders and reconciliation expectations." Rationale: Chapter 513 requires current physician orders and MARs in the home; 71CSR17 defines required MAR/TAR elements. Cross referencing reduces disputes and inconsistent checklists.	**Duplicate**
444	5/6/2026	Section 513.4 – Reporting Requirements (Medication errors/incidents)	**Duplicate**

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		Suggested language: "Medication errors must be addressed consistent with IDDW incident reporting requirements and 71CSR17, including review of medication error reports and medication related incident reports." Rationale: Chapter 513 requires WV IMS reporting and includes medication errors as reportable; 71CSR17 requires review of medication error reports and related medication incidents.	
445	5/6/2026	Section 513.8 – IPP Requirements (restrictive measures/HRC attachments) Suggested language: "Restrictions related to HCBS setting qualities (e.g., food access, privacy/locks, visitors, communication) must be documented as rights restrictions in the IPP with supporting justification, consent, review requirements, and HRC approval when applicable." Rationale: Chapter 513 already requires HRC approval for restrictive measures within behavior plans; this clarifies that setting related restrictions also require person centered justification and review.	**Duplicate**
446	5/6/2026	Section 513.13 – Electronic Monitoring Suggested language: "Electronic monitoring parameters and any rights limitations must be documented in the IPP consistent with rights restriction documentation requirements and HRC approval/monitoring expectations."	**No Change** Existing policy manual language requires that any member wishing to access the Electronic Monitoring services must be assessed and approved by the HRC, and documentation of HRC approval must be documented and attached to the IPP.

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		Rationale: Chapter 513 requires HRC approval and informed consent for electronic monitoring; this ensures any rights impacts are treated consistently with other restrictions.	
447	5/6/2026	Section: Provider Enrollment/Operations (general "where applicable" clause) Suggested language: "Where providers are subject to Behavioral Health Centers Licensure requirements, providers must comply with 71CSR25 consumer rights, HRC, and medication control standards, including its requirement that AMAP use complies with 71CSR17." Rationale: 71CSR25 contains consumer rights/HRC/medication control standards and explicitly links AMAP compliance to 71CSR17; this narrow clause prevents conflicting guidance without expanding waiver policy into a licensure rule.	**No Change** Existing policy manual language addresses the requirements regarding consumer rights, HRC, medication standards, AMAP, and general Behavioral Health Center Licensure requirements within each relevant section of the policy manual.
448	5/6/2026	Additional concerns (Electronic Monitoring – dignity/institutional risk + copyediting) Items that may interfere with dignity/privacy 1. Video oversight has no explicit privacy boundaries • Concern: Could allow surveillance in bedrooms/bathrooms or personal care areas without clear limits. • Suggested fix: Add language prohibiting monitoring in bathrooms/bedrooms except with documented clinical justification, informed consent, and IPP rights restriction safeguards. 2. Visitor privacy not addressed • Concern: No requirement to notify visitors about audio/video monitoring.	**No Change** Current policy manual language is dictated by the Electronic Monitoring service definition in the CMS-approved waiver application. BMS may consider further revisions to the service description, and any related limitations, in a future amendment. Backup planning is required for all services to document alternative plans when a service or service provider is unavailable, including the Electronic Monitoring service.

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		• Suggested fix: Add a requirement for visitor notification (signage or verbal disclosure). 3. Member can turn system on/off – safety/billing ambiguity • Concern: Unclear what happens when the system is off (backup plan, safety response, billing implications). • Suggested fix: Require an IPP documented backup plan for when monitoring is off (who responds, how, timeframe).	
449	5/6/2026	Items that could enforce an institutionalized way of living All or nothing model (no paid staff + no other direct care billed) Concern: May limit individualized flexibility and person centered choice. Suggested fix: Clarify whether monitoring can be used as a time limited supplement (e.g., overnight) while preserving service integrity; if not allowed, state why and outline alternatives. Stand by response time (20 minutes) may be unrealistic in rural areas Concern: Could restrict access to the service or create noncompliance. Suggested fix: Allow member specific response times based on geography with documented risk mitigation (not only “shorter”). “Emergency response generated = WV IMS incident” may over capture Concern: “Emergency response” isn’t defined, increasing risk of unnecessary reporting burden.	**No Change** Current policy manual language is dictated by the Electronic Monitoring service definition in the CMS-approved waiver application. BMS may consider further revisions to the service description, and any related limitations, in a future amendment. Backup planning is required for all services to document alternative plans when a service or service provider is unavailable, including the Electronic Monitoring service.

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		Suggested fix: Define "emergency response" (e.g., stand by deployment, 911 activation, smoke/heat event) and align with WV IMS categories.	
450	5/6/2026	Format/grammar issues to flag "prom pt" → prompt Broken spacing: "servi ce," "sett ings" Inconsistent hyphenation: "stand by," "off site," "person centered," "pre vocational" Awkward phrasing: "ensure the need for independence and privacy" → "ensure independence and privacy" Capitalization inconsistency: "licensed Group Home" vs "licensed group home"	**Change** Various revisions will be made throughout the policy manual to promote consistency, as well as resolve any inadvertent typographical errors.
451	5/6/2026	Pg 11 – Member-Controlled Settings – Remediation: "Any member living in a setting which does not meet the above standards must begin remediation by their case management agency to achieve compliance. Remediation attempts will be monitored by the BMS, and assistance provided if needed." Comment: Predominately these settings in the IDDW program are natural family. Therefore, no agency or provider has much authority to make changes to the setting themselves. Suggest considering inclusion of language such as facilitated or documented by their case management agency instead.	**No Change** As stated in existing policy language, BMS monitors all remediation attempts and provides assistance, including guidance regarding documentation necessary for these unique situations.
452	5/6/2026	Pg 11 – Provider-Owned/Controlled Settings: Comment: Unlike the member-controlled section this one does not have it's own formatted header to separate it from the member-controlled section.	**Change** This section of the policy manual will be revised to correct formatting and increase clarity.
453	5/6/2026	Pg 11 – Provider-Owned/Controlled Settings:	**No Change** A camera in an individual's home and/or bedroom is a restrictive

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		Comment: Is there going to be any specific language addressing cameras in the home or in the member's bedroom? Either here or elsewhere in policy.	measure that is governed by the rules regarding restrictive practices.
454	5/6/2026	Pg 18 - 513.2 PROVIDER ENROLLMENT AND RESPONSIBILITIES - Responsibilities to Agency Staff "Documented training in Cardiopulmonary Resuscitation (CPR) by an approved agency listed on the IDDW website to include always having current CPR certification upon hire and as indicated per expiration date on the card (this training and refresher trainings must include manual demonstration and be specific to the ages of the members supported by the agency staff). NOTE: In-person or virtual skills demonstrations are acceptable with a valid certificate from an approved vendor. Licensed RNs and LPNs are excluded from CPR training and certification requirements." Per the current policy clarifications, RN/LPN staff are excluded ONLY from First Aid requirements, not CPR. Q229: Section 513.3.13 Skilled Nursing Agency Staff Qualifications states, "The nursing license must include a CPR/First Aid component, or the nurse must have a separate and current CPR/First Aid card." Does this mean that a current/valid nursing license will demonstrate compliance for CPR/First Aid training requirements? A229: [3/6/25] A valid/current nursing license or proof of advanced medical training would suffice as evidence of compliance for the First Aid training requirements; however, this license/certification alone would not necessarily meet the requirements necessary to demonstrate compliance for the CPR training requirements. Regardless of the medical staff's license or certification, providers must be able to demonstrate that all nursing staff, or those with advanced medical training, have documentation to support current/valid CPR training requirements as outlined in policy. Any	**Change** The nursing qualifications section will be revised to reflect that nurses are required to maintain CPR certification and are exempt from basic first aid certification.

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		questions related to these requirements should be directed to your agency's assigned Provider Educator, as necessary, for further review.	
455	5/6/2026	Pg 25 - 513.2.3.3 IDDW Provider Reviews: "If the IDDW provider disagrees with the final report, the IDDW provider may request a document/desk review (DDR) within 30 days of receipt of the final report pursuant to the procedures in Chapter 100, General Information of the West Virginia Medicaid policy manual. The IDDW provider must still complete the written repayment arrangement within 30 days of receipt of the final report, but scheduled repayments will not begin until after the DDR decision." Comment: We were told that this changed with changes to Chapter 800 that payments are no longer delayed by requesting a DDR. This may warrant additional review?	**Change** Pursuant to Chapter 800, providers that disagree with the finalized findings must submit a completed Audit Appeal Request form seeking a document/desk review (DDR) and completed repayment agreement. Scheduled repayments will begin 30 days after Finalized Findings are issued. Any findings overturned during the appeal process will be returned to the provider following the appeal decision.
456	5/6/2026	Pg 29 513.3.1.1 Behavior Support Professional I (BSP I) Agency Staff Qualifications & Pg 33 513.3.12 Case Management Agency Staff Qualifications: Comment: CM/BSP Staff Qualifications: Consider requiring standardized documentation of supervision activities. This will be easier to tie back to any recommended disallowances if agencies are not able to produce corresponding documentation. Right now, some agencies only show 'proof' of supervision by having a supervisor signature on documents without any further documentation of issues being addressed, etc.	**No Change** BMS will partner with the UMC to develop any necessary guidelines regarding acceptable billing practices for BSP supervision activities. BMS may consider revisions to the BSP service descriptions and provider qualifications in a future amendment.
457	5/6/2026	Pg 64 - 513.10 BEHAVIOR SUPPORT PROFESSIONAL SERVICES - Limitations/Caps	**No Change** This section of the policy manual has not changed. BSP providers may only bill for the level of

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		"BSP Level II services may only be provided by a staff person who meets the criteria in Sections 513.2 - 513.2.1, and Section 513.3.1.2." Comment: Currently, policy allows the higher BSP II reimbursement rate to be billed for any BSP activities if the staff is BSP II credentialed including the same activities that could be completed by a BSP I. Unsure if that was the original intent & whether it is a good idea to allow this practice to continue or whether the limitations should be related to certain types of activities being billed at that higher rate.	services for which they are qualified to deliver.
458	5/6/2026	Pg 105 - 513.17.3 Licensed Group Home Person-Centered Support (Traditional Option) "Staff members administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent GED. Information about the AMAP program requirements may be found in WV Code Ch.16B-10 and on the OHFLAC website. Staff members administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent GED. licensed group, person-centered support services must be assessment based and outlined on the IPP. Activities must allow the member to reside and participate in the most integrated setting appropriate to their needs" Comment: Highlighted section is duplicated from the first sentence in this paragraph. It also creates an incomplete sentence after it. Looks like a find & replace error potentially? Which could be present in other sections as well if so.	**Change** The final sentences of this paragraph will be removed for clarity and conciseness.
459	5/6/2026	Pg 105 - 513.17.3 Licensed Group Home Person-Centered Support (Traditional	**Duplicate**

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		Option) “Staff members administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent GED. Information about the AMAP program requirements may be found in WV Code Ch.16B-10 and on the OHFLAC website. Staff members administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent GED. licensed group, person-centered support services must be assessment based and outlined on the IPP. Activities must allow the member to reside and participate in the most integrated setting appropriate to their needs” Comment: AMAP Codes (this will be applicable to the UR PCS section as well): Is the use of AMAP codes intended solely for medication passes, or can they be billed for the entire shift? Clarifying this is important, as billing for full shifts may incentivize providers to certify more staff as AMAPs, potentially increasing both availability and service costs—especially if reimbursed at a higher rate.	
460	5/6/2026	Pg 105 - 513.17.3 Licensed Group Home Person-Centered Support (Traditional Option) “Staff members administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent GED. Information about the AMAP program requirements may be found in WV Code Ch.16B-10 and on the OHFLAC website. Licensed group, person-centered support services must be assessment based and outlined on the IPP. Activities must allow the member to reside and participate in the most integrated setting appropriate to their needs”	**No Change** BMS will partner with the UMC to determine the best practice for verifying and enforcing AMAP qualifications, including disallowances for unqualified providers of the AMAP service, and provide additional guidance.

Comments for Chapter 513, Intellectual and Developmental Disabilities Waiver

Effective Date: August 1, 2026

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		Additionally, is there an expectation that annual provider reviews will verify AMAP qualifications? ISS reviews have identified widespread noncompliance with AMAP certification requirements. Consideration should be given to disallowing billing for services provided by unqualified AMAP staff.	
461	5/6/2026	Pg 105 - 513.17.3 Licensed Group Home Person-Centered Support (Traditional Option) "Staff members administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent GED. Information about the AMAP program requirements may be found in WV Code Ch.16B-10 and on the OHFLAC website. Staff members administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent GED. licensed group, person-centered support services must be assessment based and outlined on the IPP. Activities must allow the member to reside and participate in the most integrated setting appropriate to their needs" Finally, the billing scope - medication pass only vs full shift - may impact how services are authorized, purchased, and tracked. It would be helpful to clarify how the modifier will function (e.g., as a distinct service or similar to the UK modifier used for PO PCS services).	**Duplicate**
462	5/6/2026	Pg 108 - 513.17.4 Unlicensed Residential Person-Centered Support Comment: Procedure Code included for 1:4 ratio in this section. This is not applicable in a setting where only up to 3 people can reside.	**Change** The 1:4 ratio procedure code will be removed from this section of the policy manual.

Comments for Chapter 513, Intellectual and Developmental Disabilities Waiver

Effective Date: August 1, 2026

Number	Date Received	Comment	Status Result
463	5/6/2026	Pg 129 - 513.20.1 Skilled Nursing Licensed Practical Nurse (Traditional Option) Comment: "W. Va. CSR §64-60-1 et seq." referenced twice in this section. The CSR has been reassigned. Link: WV SOS - Administrative Law - Code of State Rules - Online Data Services	**No Change** The citation to W.VA CSR §64-60-1 remains valid. There is no external link included in this section of the draft policy manual.
464	5/6/2026	Pg 131 - 513.20.1 Skilled Nursing Licensed Practical Nurse (Traditional Option) "LPN services may not be billed for completing administrative activities, including but not limited to:" Comment: Formatting - bullets immediately below this statement should probably be sub-bullets	**Change** Sub-bullets will be added to increase clarity of this section.
465	5/6/2026	Pg 132 - 513.20.2 Skilled Nursing Licensed Registered Nurse (Traditional Nurse) Comment: Are LPNs not allowed to bill the Skilled Nursing Medication Administration service for passing medication - having it under the RN service makes it sound that way? Shouldn't this be its own section instead of jammed into the RN service? Also, it's unclear when they would bill this for supervising AMAP staff. If they are an AMAP RN they are just billing this daily for the whole year for every person, they serve even if no specific supervision of AMAP activities occurs on that day? How is the claim to be substantiated? Additionally, is this service allowed to be billed concurrently with DCS if it is utilized for a medication pass or would purchasing this require a decrease in the DCS to be within caps? If it's also used for AMAP oversight that's not a direct member service this may be hard to track/verify. Sticking a second code in here without well defining the differentiation between the 15-minute existing RN units & the new event code is confusing & unclear what the caps are for each of these codes.	**Duplicate**

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Effective Date: August 1, 2026

Number	Date Received	Comment	Status Result
466	5/6/2026	Pg 136 – 513.21.2 Transportation Miles (Participant-Directed Option, Personal Options Model) – Limitations/Caps "May be used within 30 miles of the West Virginia border when the member is a resident of a county bordering the state of West Virginia." Comment: This sounds so weird when read. Maybe use the same language as traditional: May be utilized up to 30 miles beyond the West Virginia border by members living in a West Virginia county bordering another state.	**Change** This section of the policy manual will be revised for increased clarity.
467	5/6/2026	Pg 137: 513.21.3 Transportation Trips (Traditional Option) Comment: There are a couple of FAQs about billing trips that may need to be included in policy here: Q19 & Q41	**Change** This section of the policy manual will be revised to include additional information and clarify what constitutes a "trip" for billing purposes.