Comments for Chapter: 501, Aged and Disabled Waiver

Effective Date: June 1, 2026

Number	Date Received	Comment	Status Result
1	3/13/2026	Section 501.82 - This section states that specific training such as Competency-Based Personal Attendance Skills for PAs must be provided by a nurse, social worker/counselor etc. The current manual specifies that the training must be provided by the "agency RN." We are seeking clarification on whether the wording in the draft includes LPNs as well as RNs.	**No Change:** The manual was changed to no longer limit the role to an "agency" Registered Nurse (RN). Licensed Practical Nurses (LPNs) would not fall under that classification.
2	3/16/2026	Section 501.18.2 - While we may not completely understand what would prohibit an LPN from providing this training, we do understand the reason "agency" was removed. However, we worry that not specifying that it must be a registered nurse may lead to misinterpretation and potential compliance issues for some agencies. Do you think for transparency sake it would be possible to specify the type of nurse permitted to provide these specific trainings?	**Change:** Any reference to "nurse" will be replaced with "RN." Nurse will be defined in the glossary as an RN unless otherwise indicated to provide further clarify.
3	3/23/2026	501.3.3.7 – PCSP is not included in the glossary, it is assumed it stands for Person Centered Service Plan, but may be unclear to new providers/Case Managers/Nurses, the only explanation of PCSP acronym is on page 11 (safeguards).	**Change:** Person-Centered Service Planning (PCSP) will be defined in the glossary for increased clarity.
4	3/23/2026	501.6.1 – refers to CareConnection, which is no longer in use.	**Change:** References to CareConnection will be replaced with reference to the utilization management contractor (UMC) portal.
5	3/23/2026	501.11.1.6 – pg 33 – "The case management agency will be alerted by the UMC portal that the MNER needs to be updated." – The current portal system does not alert CM agencies, case managers/agencies must manually run reports to obtain this information.	**Change:** This statement will be changed to state the case manager (CM) must review the information from the UMC portal.
6	4/3/2026	Supports the decision to discontinue the provider continuation certification verification system web portal. Recognizes the importance of continuing certification (audits/reviews), program integrity, etc., but the web portal used for data entry became antiquated and unreliable. This was a necessary change that will lead to a more efficient continuing certification process. Thank you.	**No Change:** Comment does not include policy recommendations for changes.

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7	4/3/2026	Personal attendants (PAs) that live with ADW members should be required to use EVV. The current "live-in" exemption ignores the possibilities of fraud, waste, and abuse (FWA) in these situations, which is a weld documented concern, and frustrates the arbitrary 85% EVV compliance threshold by creating an unnecessary double-standard. If EVV is a reasonable and acceptable tool for preventing FWA, which we agree that it is, EVV should be used in all settings and situations to limit FWA and encourage transparency and consistency.	**No Change:** This was not a proposed change within this manual; however, with the implementation of electronic visit verification (EVV), the Bureau of Medical Services (BMS') goal was to choose the least restrictive options of the requirements to help ensure easier compliance with the process. Agencies have the option to require all in-home caregivers or only those that do not reside with the member to utilize EVV.
8	4/3/2026	Request removal of the 501.3.2 Office Criteria requirement that "[e]ach designated office must meet the following criteria: Physically located in West Virginia." Many home care agencies operate offices just outside of West Virginia's borders, in border states such as Kentucky, Ohio, Pennsylvania, Virginia, and Maryland. Many offices would like to participate in the ADW program, but cannot, due to this overly restrictive regulation. This regulation seems to be in direct conflict with Governor Patrick Morrisey's "Backyard Brawl" effort via executive order, which seeks to help West Virginia companies compete and thrive by relaxing burdensome regulations. This regulation limits ADW member access to home care. For agencies with border county offices, both inside and outside of West Virginia, this requirement is problematic and results in ADW members being undeserved, limiting choice. We request that BMS/BoSS consider one of the following approaches: Allow ADW (and PC) agencies domiciled (headquartered) in West Virginia (according to the West Virginia Secretary of State) to be exempt from this requirement entirely; and/or	**No Change:** BMS will review this policy and determine possible future actions related to offices not physically located in West Virginia.

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		Allow for a variance for ADW (and PC) agencies that have at least one ADW certified offices in West Virginia to operate ADW certified offices at out of state offices as long as the offices are within 30 miles of the border. Please note: this "30 miles" standard is found elsewhere in the ADW manual, relating to non-medical transportation services that may be provided within 30 miles of the West Virginia border, to people residing in a West Virginia county bordering another state. There is precedent for this type of approach; this is not a novel concept for ADW.	
9	4/10/2026	Two comments were received related to Provider-Owned/-Controlled Settings on page 7. This is concerning as a change in times has led to people frequently living with someone who is a friend or significant other, but who is not a relative by blood or marriage. If that kind of situation exists, is it going to have to be reviewed yearly and the Provider Owned Settings Assessment completed? If a member moves in with a friend who ends up working as their caregiver, does this mean the friend would have to take back keys they have given to other family in the event of an emergency?	**No Change:** Provider-owned/ controlled setting standards are set by the Centers for Medicare & Medicaid Services (CMS) promulgated under the 2014 Home and Community Based Services Final Rule CMS-2249-F and CMS 2296-F. Any time a setting is identified as provider-owned/controlled, it will be treated as such. The Settings Rule provider-owned/controlled settings standards do not apply to individuals who are not service providers or staff and therefore would not apply to family or friends who are not caregivers or residents.
10	4/10/2026	In relation to Page 12, *Only one provider agency or case management agency serves the geographical area within a 25- mile radius to the member, eliminating the member's opportunity for choice of case manager....* *There were no providers of personal attendant or case management services in a geographical area within a 25-mile radius to the member:*	**Change:** Language will be clarified by removing personal attendant agencies, as the intent is to include only case management agencies.

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		Do these statements mean CMs of conflicted cases will have to check mileage of all CMAs and PAAs for each person before assisting with an exception application. Although participants may have a difficult time giving up a CM they have been with for years when a new agency suddenly opens within 25 miles, generally it is more difficult to give up the caregiver who is with them on a daily basis. I always offer the option, but having to run the mileage for both would be even more time consuming.	
11	4/10/2026	In relation to Page 12, *Members will be given the opportunity to submit a Conflict-of-Interest Exception form if there are any geographical or linguistic exceptions.* The word "cultural" has been dropped here. Is the intent that the only reason someone can be in a conflicted relationship be because there is no other agency around or they speak another language? The idea that individuals signed up for service under one set of regulations and were told they could be "grandfathered in" and not have to adhere to the new regulations is becoming null by forcing transfers if a new agency opens. Forcing a member to choose from a selection of one, is the same as no choice. And if any other agencies are too far away to be able to provide timely service, one other agency within 25 miles, is a selection of one.	**Change:** Cultural exceptions are allowable, the manual will be updated to reflect this for better clarity.
12	4/10/2026	In relation to Page 12, *Informs agency employees that during an investigation, information on their personal cell phone is discoverable.* I understand this is becoming the norm as electronic use increases. Our cell phones are often the best way to reach us as we are so frequently on the road for work. However, that being said, it feels like a work phone becomes the better option as no one wants to give up their personal privacy. I have not done the research, but I'm curious whether it's possible for an employee to designate a cell phone as a "work phone" vs a "personal phone" if it is not provided by the business since I'm certain not all businesses can fund individual cell phones even though most businesses insist upon the contact information to contact employees.	**No Change:** Each agency may designate its own policy addressing the use of personally and agency owned electronic devices.
13	4/10/2026	In relation to Page 20, *All ADW agencies must send at least one representative to mandatory quarterly provider meetings, trainings, and calls. That representative is responsible for disseminating the information learned at the quarterly provider meeting to all other pertinent agency*	**No Change:** All meetings are currently conducted virtually, with materials distributed via email. Attendance at meetings is determined at the agency's

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		personnel. If it is determined that a representative was not present, it becomes the agency's responsibility to obtain the information shared and follow any directives provided. Continued and on-going non-participation may result in sanctions. ADW provider agencies are responsible for conducting their own staff clinical supervision. The OA is not responsible for this duty. I'm going to continue to assert that meetings should be open or notes/recordings available to the public. Requiring one person from an agency of 500 to attend, does not ensure the information is disseminated, particularly when the information may not be understood/appreciated because it is not something that employee deals with during their day to day tasks.	discretion. It is the responsibility of the attending staff to disseminate information to all other agency personnel.
14	4/10/2026	In relation to Page 23, *The personal attendant agency or case management agency staff may install the fixed object (FOB) device in the member's home to a stationary fixture if a personal attendant is unable or unwilling to download and use an app to meet check in/out requirements for EVV. The case manager is responsible to note the FOB was installed when applicable on the Monthly Contact form.* Is there a system in place to ensure the CM is aware a FOB was a need and being ordered? Because communication continues to be an issue at times. This isn't something related to what the CM would normally do. While we ask if they received services and are happy with them, we don't ask how those services were documented and reported for billing purposes. Side note, but along the line of communication: The fact that both entities can now see each other's information in Atrezzo is a step forward. However, not being notified when something is uploaded means you would have to know to go looking for it, and it's not realistic to expect CMs/RNs to have time to do that on a regular basis for everyone on their caseload.	**No Change:** When two agencies are proving care to an individual, it is essential that ongoing communication occurs to help ensure the individual receives services. The manual currently specifies that installation of the FOB may be completed by either the PA or CM agency, with the expectation that this activity is communicated between both entities.
15	4/10/2026	In relation to Page 25, *An Incident Report documenting the outcomes of the review must be completed and entered into the WV IMS within 14 calendar days of learning of the incident.*	**No Change:** If documentation cannot be completed within the required timeline, the agency must document

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		This necessitates BOSS reviewing Q1 and completing Q2 before the reporter can then complete Q3. I understand there is a backlog, but I've had members who were deceased for two months before I was able to close out their case b/c I was waiting on final documentation.	the reason for the delay in the case record.
16	4/10/2026	In relation to Page 25*, The incident report and Notification of Death form generated by the IMS must also be attached to the member's record in CareConnection by the agency that first learns of the death. The agency must also request a discharge of the member by changing the member's status in CareConnection, which sends a notification to the OA, who will process the discharge.* Just a note that this system is no longer in use. I'm not certain of the relevancy since the effective date of the manual is almost a year old.	**Change:** References to CareConnection will be replaced with reference to the UMC portal. The language will be updated in response.
17	4/10/2026	In relation to Page 34*, The case management agency is responsible for sending the Notice of Approved Continued Medical Eligibility to the personal attendant agency, Personal Options vendor when applicable, and the economic service worker.* Why is the CM responsible for forwarding the PAS/NOD to the PAA? They have access to the documentation in Atrezzo and actually receive a notification for those documents.	**Change:** With the implementation of Atrezzo, the personal attendant agency now has access to the case management agency information, and this requirement is no longer necessary. Updates will be made in policy to reflect this change.
18	4/10/2026	In relation to Page 42, *Documentation must then be uploaded into the UMC portal within seven business days upon completion of the document.* This timeline keeps shrinking. I understand the need in providing the documentation in a timely manner. However, we do not have regular scheduled activities each day. If this is lowered to within seven business days, that would mean any time someone is going to be out of the office for more than a couple of days, they aren't going to schedule visits immediately prior for fear of not being able to get the documentation uploaded within the policy timeframe. Anyone can print generic paperwork and upload it. That shouldn't be encouraged by reducing deadlines until there is no reasonable time to address necessary changes and individuality of documentation.	**No Change:** The purpose of the policy is to help ensure timely recording of documentation. These timeframes help ensure consistent documentation and communication across the program.

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19	4/10/2026	In relation to Page 43, *When the member has a change in needs, a Service Plan Addendum to the Plan must be developed and attached to the current PCSP to document any permanent Plan changes.* The participant signature requirement needs to be removed from the SPA. It's not required for a PAL change. The biggest reason for the request is that it either results in a delay in communication or communicating the same thing multiple times to insure it is relayed. Frequently when I take a SPA out to be signed saying home health services have started, they have already stopped…I'm not convinced this is a widely used form, mandated or not, or others would likely be voicing the same concern.	**Change:** Member signatures are required to be on all service plan related documents. Manual language will be updated to reflect that an addendum or an update to the current PCSP can be done.
20	4/10/2026	In relation to Page 44, *The Responsibility Agreement must be updated each time that a PCSP is reviewed.* What if the behavior has improved? I did not complete one just yesterday because the issue was cancelling appointments/not accepting calls. However, I feel the participant has made an attempt to improve and their informal supports have assisted with reminders.	**Change:** If the responsibility agreement has been met, the PCSP may be updated to reflect that one is no longer needed. Manual language will be updated to reflect this for further clarity.
21	4/10/2026	In relation to Page 44, *Agency staff can meet at different times with the member however all meetings must be scheduled within seven business days, and the Service Plan must be completed within 14 calendar days. Documentation must then be uploaded into the UMC portal within seven business days upon completion of the document*. This is in regarding to annual and six month reviews, so within 7 business days of what? Each other (CMA/PAA)? Or should that requirement just be removed and policy indicate that the assessments and service plan have to be completed within 14 days of each other?	**Change:** The meetings must occur within seven business days upon acceptance of the referral. Documentation must be uploaded into the UMC portal within seven business days of completion. Manual language will be updated to provide clarity.
22	4/10/2026	In relation to Page 45, *ADW services may not be provided in assisted/independent living residences, group residential facilities and provider owned/leased settings of paid caregivers. Qualified residences for ADW recipients, including ADW and TMH members, are defined as: • A home that is owned or leased by a nonfamily member that is not a paid caregiver. • A home owned by the member. • An apartment leased by the member. • A home or apartment that is owned or leased by the member's family.*	**Change:** BMS will review and revise the policy language to better reflect evolving household and family structures. Updates will clarify eligible living arrangements consistent with current policy intent and Section 1915c waiver program requirements.

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		Again, I think this is identifying people as provider owned, who do not exist solely in a provider relationship. The idea of family is evolving and this policy puts a limitation on some situations that I don't think are reasonable. I understand the idea, but I feel like the wording needs revisited.	
23	4/10/2026	In relation to Page 46, *The case manager must complete the Initial Contact form for a member new to the program.* This form needs updated. Policy has changed since it was developed and portions of it are not relevant (related to financial eligibility/initial contact).	**No Change:** BMS will review the form and revise it as needed to help ensure alignment with current policy and procedures, including updating any sections related to financial eligibility and initial contact.
24	4/10/2026	In relation to Page 48, *Quarterly home visits must be documented on the monthly contact forms but marking the form as being a face-to-face quarterly visit.* This may be moot if the form is changing. However, I literally never check "face to face" because when I asked previously I was told that all quarterly home visits have to be in the home. I check "quarterly home visit" for all 4 yearly home visits. If it isn't their other 8 telephonic visits and I run into or speak with someone, I just use a log note.	**No Change:** Both monthly and quarterly contacts can be documented on this form. Quarterly home visits should be marked as face-to-face to clearly indicate compliance with quarterly visit requirements, even when they occur in the member's home.
25	4/10/2026	In relation to Page 48-49, *If a member (or legal representative) cannot be reached by telephone for the monthly contact, the case manager must attempt to reach the individual(s) listed on the member's 24-Hour Emergency Backup Plan within one business day of not being able to reach the member.* TOO restrictive. We do a lot in a day and we may not even be able to remember all the people we tried to reach the previous day or be in the office to make the required call the following day. I do tell my people that if I cannot reach them or their representative within 3 days a welfare check will have to be requested. However, if we have no reason to be concerned about an individual's well being it's asking a lot that they accept/return calls within a day.	**No Change:** The purpose of the policy is to help ensure timely confirmation of member health and safety when routine contact is unsuccessful, while outlining graduated steps that rely on backup contacts and service providers before escalating concerns. These timeframes help ensure consistent documentation and prompt follow-up to confirm services are not disrupted and that the member remains safe, even when there is no immediate indication of risk.
26	4/10/2026	In relation to Page 49, *At a minimum, upload the following documents into the UMC web portal…West Virginia Personal Care Dual Services Request Form (if applicable)*	**Change:** This form is no longer in use; manual language will be updated to reflect this.

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		Is this form still being utilized? I had been told it was no longer a requirement. It is never requested when the PC MNER and selection forms are sent to Acentra.	
27	4/10/2026	In relation to Page 50, *Follow up on all service delivery concerns within two business days and document in the WV IMS.* As we're aware of them…the manual states the PAA has to notify the CMA if they can't provide staff within 90 days… When PA services start is still an issue that I struggle to obtain from PAAs even though I've been around forever and am familiar with most staff.	**No Change:** When more than one agency is providing services to an individual, the agencies are expected to maintain ongoing communication and coordination to help ensure the individual receives timely, appropriate, and uninterrupted care.
28	4/10/2026	In relation to Pages 56 and 57, *A family-paid personal attendant could not bill to take the member to visit their parent in their own residence, nursing home, or hospital. However, a non-family member paid personal attendant could bill to take the member on such visits. Visiting a family member/friend in a long-term-care facility or hospital or visiting a cemetery are not Community activities reimbursable by Medicaid.* They seem like contradictory statements to me. I'm not sure how taking someone to the hospital or nursing home isn't a community activity unless the purpose is not to participate in their community but to contribute financially to it… I do understand the reason for limiting family-paid personal attendants to do so, but I also think that you are thereby limiting the individual's likelihood of receiving the transportation.	**Change:** Manual language will be updated to clarify that visiting a family member or friend in a long-term-care facility or hospital is a community activity reimbursable by Medicaid when done by a non-family member paid personal attendant.
29	4/10/2026	In relation to Page 60, *The Service Level Request form must be signed by both the RN and the ADW recipient (or legal representative).* This was noted under the CM responsibilities although it was not as spelled out…but the form currently states "CM or RN signature".	**Change:** The Service Level Request form must be signed by either the RN or the case manager. Manual language will be updated to clarify this.
30	4/10/2026	In relation to Page 69, *Case managers are not expected to go into a member's home for home visits, service planning and assessments when infestations have been identified. A phone meeting must be conducted to complete an addendum to the members' Service Plan to develop a plan to address the infestation. The addendum would need to reflect changes in the personal attendant services provided and shared with the personal attendant agency.*	**Change**: Case managers have a choice to enter the member's home or to provide alternative services until the pest eradication is completed. If the landlord indicates that pest eradication is not their responsibility, the participant can receive the service. Manual language will be updated to

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		First let me say THANK YOU. But second, I kind of hate that it's allowing agencies to pull out when the treatment period can take time, especially for ongoing infestations…and some may be so extensive as to not be covered by $1,700/year.. I am very grateful for this moving forward, but I think there are some issues that have ben ongoing and will be harder to resolve. What if it is a rental property, but there is no written agreement between the landlord and tenant? Is there going to be a pre-approval application for this service?	provide clarity on the pest eradication process.
31	4/10/2026	Two questions were received regarding billing ADW services while an individual is inpatient in a nursing home, hospital, rehabilitation facility, or other inpatient medical facility on page 74. Why no CM or RN billing on the day of admission/discharge? We are often the ones who insist the individual call EMS, so we may have been doing a contact. So we can't bill the same day they are discharged, but we can bill while they are still admitted… I'm confused by this section. And if the CM can, then surely the RN would need to be able to do so as well since it's the PAA's staff that will be going in to provide care.	**No Change:** The PA may bill for allowable services. The case manager may not bill for case management services while an individual is inpatient due to the potential for duplication of services; however, the case manager may bill for approved transition services with Take Me Home members.
32	4/10/2026	In relation to Page 75, *ADW members cannot be unpaid or paid caregivers in another waiver program, the Personal Care Services program for another program participant, or in any other capacity for a family member (children, grandchildren, spouses, etc.).* I'm not sure I 100% understand the elimination of paid caregivers. But I'm more concerned about the unpaid caregiver. Is this to say that if an adult child receives I/DD service and their aging parent starts to need assistance of their own, they cannot apply for ADW service unless the I/DD individual is relocated?	**Change:** This policy does not mean that an individual on another waiver needs to be relocated. To support the safety of waiver members, a member cannot be the documented unpaid or paid caregiver of another member in any Home and Community Based Services (HCBS) waiver during service plan time. Manual language will be updated to provide more clarity.
33	4/10/2026	In relation to Page 76, *For initial PC requests, the PC applicant, ADW case manager, personal attendant agency, resource consultant or referent will submit an Initial PC-MNER to the UMC via fax or mail. If Waiver requirements are met (member assessed at a level D), the UMC will key the ADW PAS previously completed into the PC web portal and reach out to the PC applicant to acquire their choice of PC agency within their catchment area. If approved for PC, the UMC will refer the new PC member to their chosen PC agency via the PC web portal. If Waiver requirements*	**No Change:** The Atrezzo portal does not have the capability to provide this notification; however, the CM is responsible for reviewing the information in the portal regularly.

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		are not met, the UMC will close the request, and the person may reapply for PC if/when the person meets the waiver requirements. It's not in the policy for ADW. I'm not sure if it's in Acentra's, BUT CMs really need to receive a notification of some sort if the request is denied or on hold for some reason AND if/when approved.	
34	4/10/2026	In relation to Page 77, *Home health agency services provided to the ADW member must be coordinated by the ADW case manager and in general, may only include skilled nursing care or therapy services for posthospitalization stays or acute episodes of chronic conditions. The provision of case management via home health agencies is considered duplication of services and should not occur. The need for home health services must be documented in the members' Service Plan and/or Service Plan Addendum. Documentation of the referral from the member's attending physician is the responsibility of the home health agency. If a copy is available, it may be maintained in the member's ADW file. The need for home health services must be documented on the ADW Person Centered Plan or the Service Plan Addendum and must be maintained in the members' record of both the ADW agency and home health agency.* This is generally learned when I do my monthly contact. So, I often don't know about home health until the service is almost over. HH agencies do not reach out to provide information voluntarily. If that is something that should be happening, maybe that needs to be addressed with HHAs.	**Change:** Case managers should work with the home health agency to help ensure no duplication of services occur once they are made aware of those services being utilized. Manual language will be updated for clarity.
35	4/10/2026	In relation to Page 82, *Transferring Agency Responsibilities…Maintain all original documents for monitoring purposes.* I understand it does not apply for newer cases. However, older cases that transfer frequently do not have the DHS2/MECN in Atrezzo.	**Change:** Documents must be maintained by the agency if they are available. Manual language will be updated for clarity.