TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Chapter 120

Final Regulation

Title of Regulation: **12VAC30-120. Waivered Services (adding 12VAC30-120-1000, 12VAC30-120-1005, 12VAC30-120-1010, 12VAC30-120-1020, 12VAC30-120-1030, 12VAC30-120-1040, 12VAC30-120-1060, 12VAC30-120-1070, 12VAC30-120-1080, 12VAC30-120-1088, 12VAC30-120-1090; repealing 12VAC30-120-211, 12VAC30-120-213, 12VAC30-120-215, 12VAC30-120-217, 12VAC30-120-219, 12VAC30-120-221, 12VAC30-120-223, 12VAC30-120-225, 12VAC30-120-227, 12VAC30-120-229, 12VAC30-120-231, 12VAC30-120-233, 12VAC30-120-235, 12VAC30-120-237, 12VAC30-120-241, 12VAC30-120-245, 12VAC30-120-247, 12VAC30-120-249).**

Statutory Authority: § 32.1-323 of the Code of Virginia; 42 USC § 1396 et seq.

Effective Date: July 4, 2013.

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Summary:

The amendments (i) require the use of a statewide Supports Intensity Scale form, an assessment instrument, to comprehensively assess individuals' needs for supports and services received through the waiver every three years; (ii) require case managers to conduct an annual risk assessment of individuals enrolled in waiver programs; (iii) require persons whose services do not start within 30 days to be referred back to the local departments of social services for redetermination of eligibility; (iv) make the utilization of a service facilitator by the recipient optional under the consumer-directed model; (v) allow involuntary disenrollment from the consumer-directed model if consumer-directed services are not working well for a recipient; (vi) modify the process currently used to fill waiver slots to ensure the uniformity of the statewide process; (vii) include provisions for electronic information exchange between the local departments of social services, the Department of Medical Assistance Services, and enrolled service providers for determination of the patient pay requirement for waiver services; (viii) reorganize the existing requirements, incorporate new terminology, and update name changes and definitions; and (ix) revise the prior authorization of respite services from once a year up to 720 hours to once every six months up to 360 hours.

Changes made since publication of the proposed regulation include the following: (i) references to "MR/ID" have been changed to "ID"; (ii) a definition has been added for "in-home residential support services"; (iii) in the definition for "services facilitator" reference is made to collaborating with the case manager; (iv) provider monitoring of the electronic system for patient pay information has been changed from periodically to monthly; (v) collaborative development of the Individual Support Plan between the individual and the case manager is emphasized; (vi) annual expenditure amounts for assistive technology and environmental modifications have been restored to $5,000; (vii) the six-month time blocks for respite services have been removed; (viii) community services board case managers, working with the individual and family/caregivers, will have only 30 days to initiate services before the individual will have to be referred back to the local department of social services for re-evaluation of eligibility; (ix) the knowledge, skills, and abilities

required for persons to enroll with the department as services facilitators (as now set out in 12VAC30-120-225) are being added back into these regulations rather than being incorporated by reference from a guidance document; and (x) respite assistants are being required to have two references in their work record, rather than one as was proposed, as is set out in the current regulations 12VAC30-120-233 D. Other clarifying text changes are made in response to commenters' questions and to improve clarity and readability. Finally, references to "Intermediate Care Facilities for the Mentally Retarded" (ICF/MR) have been replaced with "Intermediate Facilities for the Intellectually Disabled" (ICF/ID).

Summary of Public Comments and Agency's Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

EDITOR'S NOTE: Part IV, Mental Retardation Waiver, consisting of 12VAC30-120-211 through 12VAC30-120-249, is being repealed in its entirety and is not set out below. The full text of the repealed provisions was published at the proposed stage in 28:12 VA.R. 67-97 September 26, 2011.

Part IV

[~~Mental Retardation/Intellectual~~ Intellectual] Disability Waiver

Article 1

Definitions and General Requirements

12VAC30-120-1000. Definitions.

"Activities of daily living" or "ADLs" means personal care tasks, e.g., bathing, dressing, toileting, transferring, and eating/feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and service needs.

"Agency-directed model" means a model of service delivery where an agency is responsible for providing direct support staff, for maintaining individuals' records, and for scheduling the dates and times of the direct support staff's presence in the individuals' homes.

"ADA" means the American with Disabilities Act pursuant to 42 USC § 12101 et seq.

"Appeal" means the process used to challenge actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12VAC30-110 and 12VAC30-20-500 through 12VAC30-20-560.

"Applicant" means a person (or his representative acting on his behalf) who has applied for or is in the process of applying for and is awaiting a determination of eligibility for admission to a home and community-based waiver or is on the waiver waiting list waiting for a slot to become available.

"Assistive technology" or "AT" means specialized medical equipment and supplies, including those devices, controls, or appliances specified in the Individual Support Plan but not available under the State Plan for Medical Assistance, which enable individuals to increase their abilities to perform ADLs, or to perceive, control, or communicate with the environment in which they live, or that are necessary to the proper functioning of the specialized equipment.

"Barrier crime" means those crimes listed in §§ 32.1-162.9:1 and 63.2-1719 of the Code of Virginia.

"Behavioral health authority" or "BHA" means the local agency, established by a city or county under § 37.2-100 of the Code of Virginia that plans, provides, and evaluates mental health, [~~mental retardation/intellectual~~ intellectual] disability [~~(MR/ID)~~ (ID)], and substance abuse services in the locality that it serves.

"CMS" means the Centers for Medicare and Medicaid Services, which is the unit of the federal Department of Health and Human Services that administers the Medicare and Medicaid programs.

"Case management" means the assessing and planning of services; linking the individual to services and supports identified in the Individual Support Plan; assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources; coordinating services and service planning with other agencies and providers involved with the individual; enhancing community integration; making collateral contacts to promote the implementation of the Individual Support Plan and community integration; monitoring to assess ongoing progress and ensuring services are delivered; and education and counseling that guides the individual and develops a supportive relationship that promotes the Individual Support Plan.

"Case manager" means the person who provides case management services on behalf of the community services board or behavioral health authority [, as either an employee or a contractor,] possessing a combination of [~~(MR/ID)~~ (ID)] work experience and relevant education that indicates that the individual possesses the knowledge, skills, and abilities as established by DMAS in 12VAC30-50-450.

"Community services board" or "CSB" means the local agency, established by a city or county or combination of counties or cities under Chapter 5 (§ 37.2-500 et seq.) of Title 37.2 of the Code of Virginia, that plans, provides, and evaluates mental health, [~~MR/ID~~ ID], and substance abuse services in the jurisdiction or jurisdictions it serves.

"Companion" means a person who provides companion services for compensation by DMAS.

"Companion services" means nonmedical care, support, and socialization provided to an adult (ages 18 years and over). The provision of companion services does not entail [routine] hands-on care. It is provided in accordance with a therapeutic outcome in the Individual Support Plan and is not purely diversional in nature.

"Comprehensive assessment" means the gathering of relevant social, psychological, medical, and level of care information by the case manager and is used as a basis for the development of the Individual Support Plan.

"Congregate residential support" means those supports in which the residential support services provider renders primary care (room, board, general supervision) and residential support services to the individual in the form of continuous (up to 24 hours per day) services performed by paid staff who shall be physically present in the home. These supports may be provided individually or simultaneously to more than one individual living in that home, depending on the required support. These supports are typically provided to an individual living (i) in a group home, (ii) in the home of the [~~MR/ID~~ ID] Waiver services provider (such as adult foster care or sponsored residential), or (iii) in an apartment or other home setting.

"Consumer-directed model" means a model of service delivery for which the individual or the individual's employer of record, as appropriate, [~~are~~ is] responsible for hiring, training, supervising, and firing of the person or persons who render the direct support or services reimbursed by DMAS.

"Crisis stabilization" means direct intervention to [~~persons~~ individuals] with [~~MR/ID~~ ID] who are experiencing serious psychiatric or behavioral challenges that jeopardize their current community living situation, by providing temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement. This service shall be designed to stabilize the individual and strengthen the current living situation so the individual can be supported in the community during and beyond the crisis period.

"DBHDS" means the Department of Behavioral Health and Developmental Services.

"DBHDS staff" means persons employed by or contracted with DBHDS.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means persons employed by or contracted with DMAS.

"DRS" means the Department of Rehabilitative Services.

"Day support" means services that promote skill building and provide supports (assistance) and safety supports for the acquisition, retention, or improvement of self-help, socialization, and adaptive skills, which typically take place outside the home in which the individual resides. Day support services shall focus on enabling the individual to attain or maintain his highest potential level of functioning.

"Developmental risk" means the presence before, during, or after an individual's birth, of conditions typically identified as related to the occurrence of a developmental disability and for which no specific developmental disability is identifiable through existing diagnostic and evaluative criteria.

"Direct marketing" means either (i) conducting directly or indirectly door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; (ii) mailing directly; (iii) paying "finders' fees"; (iv) offering financial incentives, rewards, gifts, or special opportunities to eligible individuals and the individual's family/caregivers, as appropriate, as inducements to use the providers' services; (v) continuous, periodic marketing activities to the same prospective individual and the individual's family/caregiver, as appropriate - for example, monthly, quarterly, or annual giveaways as inducements to use the providers' services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of the providers' services or other benefits as a means of influencing the individual's and the individual's family/caregivers, as appropriate, use of the providers' services.

"Employer of record" or "EOR" means the person who performs the functions of the employer in the consumer directed model. The EOR may be the [~~waiver~~] individual [enrolled in the waiver], or a family member, caregiver or another person, as appropriate, when the individual is unable to perform the employer functions.

"Enroll" means that the individual has been determined by the case manager to meet the level of functioning requirements for the [~~MR/ID~~ ID] Waiver and DBHDS has verified the availability of a [~~MR/ID~~ ID] Waiver slot for that individual. Financial eligibility determinations and enrollment in Medicaid are set out in 12VAC30-120-1010.

"Entrepreneurial model" means a small business employing a shift of eight or fewer individuals who have disabilities and usually involves interactions with the public and coworkers who do not have disabilities.

"Environmental modifications" or "EM" means physical adaptations to a primary place of residence, primary vehicle, or work site (when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act) that are necessary to ensure the individual's health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards. Such EM shall be of direct medical or remedial benefit to the individual.

"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by DMAS for children under the age of 21 according to federal guidelines (that prescribe preventive and treatment services for Medicaid eligible children) as defined in 12VAC30-50-130.

"Fiscal employer/agent" means a state agency or other entity as determined by DMAS to meet the requirements of 42 CFR 441.484 and the Virginia Public Procurement Act (Chapter 43 (§ 2.2-4300 et seq.) of Title 2.2 of the Code of Virginia).

"Freedom of choice" means the right afforded an individual who is determined to require a level of care specified in a waiver to choose (i) either institutional or home and community-based services provided there are available CMS-allocated and state-funded slots; (ii) providers of services; and (iii) waiver services as may be limited by medical necessity.

"Health planning region" or "HPR" means the federally designated geographical area within which health care needs assessment and planning takes place, and within which health care resource development is reviewed.

"Health, safety, and welfare standard" means that an individual's right to receive a waiver service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria and a written individual plan for supports, and that services can be safely provided in the community.

"Home and community-based waiver services" or "waiver services" means the range of community services approved by the CMS, pursuant to § 1915(c) of the Social Security Act, to be offered to persons as an alternative to institutionalization.

["IDOLS" means Intellectual Disability Online System.

"In-home residential support services" means support provided in a private residence by a DBHDS-licensed residential provider to an individual enrolled in the waiver to include: (i) skill building and supports and safety supports to enable individuals to maintain or improve their health; (ii) developing skills in daily living; (iii) safely using community resources; (iv) being included in the life of the community and home; (v) developing relationships; and (vi) participating as citizens of the community. In-home residential support services shall not replace the primary care provided to the individual by his family and caregiver but shall be supplemental to it.]

"Individual" means the person receiving the services or evaluations established in these regulations.

"Individual Support Plan" means a comprehensive plan that sets out the supports and actions to be taken during the year by each service provider, as detailed in the provider's Plan for Supports, to achieve desired outcomes. The Individual Support Plan shall be developed by the individual [enrolled in the waiver], the individual's family/caregiver, as appropriate, other service providers such as the case manager, and other interested parties chosen by the individual, and shall contain essential information, what is important to the individual on a day-to-day basis and in the future, and what is important for the individual to be healthy and safe as reflected in the Plan for Supports. The Individual Support Plan is known as the Consumer Service Plan in the Day Support Waiver.

"Instrumental activities of daily living" or "IADLs" means tasks such as meal preparation, shopping, housekeeping, laundry, and money management.

["Intellectual disability" or "ID" means a disability as defined by the American Association on Intellectual and Developmental Disabilities (AAIDD) in the Intellectual Disability: Definition, Classification, and Systems of Supports (11th edition, 2010).]

[~~"ICF/MR"~~ "ICF/ID"] means a facility or distinct part of a facility certified by the Virginia Department of Health as meeting the federal certification regulations for an Intermediate Care Facility for the [~~Mentally Retarded~~ Intellectually Disabled] and persons with related conditions and that addresses the total needs of the residents, which include physical, intellectual, social, emotional, and habilitation providing active treatment as defined in 42 CFR 435.1010 and 42 CFR 483.440.

[~~"ISAR" means the Individual Service Authorization Request and is the DMAS form used by providers to request prior authorization for MR/ID Waiver services.~~]

"Licensed practical nurse" or "LPN" means a person who is licensed or holds multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia to practice practical nursing as defined.

"Medicaid Long-Term Care Communication Form" or "DMAS-225" means the form used by the case manager to report [~~, as required in agency's guidance documents.~~] information about changes in an individual's situation.

"Medically necessary" means an item or service provided for the diagnosis or treatment of an individual's condition consistent with community standards of medical practice as determined by DMAS and in accordance with Medicaid policy.

[~~"Mental retardation/intellectual disability" or "MR/ID" means a disability as defined by the American Association on Intellectual and Developmental Disabilities (AAIDD). For the purposes of this waiver and these regulations, "MR" and "ID" shall be synonymous terms.~~

"Parent" or "parents" means a person or persons who is or are biologically or naturally related, a foster parent, or an adoptive parent to the individual enrolled in the waiver.]

"Participating provider" means an entity that meets the standards and requirements set forth by DMAS and has a current, signed provider participation agreement with DMAS.

"Pend" means delaying the consideration of an individual's request for services until all required information is received by DBHDS.

"Person-centered planning" means a fundamental process that focuses on the needs and preferences of the individual to create an Individual Support Plan that shall contain essential information, a personal profile, and desired outcomes of the individual to be accomplished through waiver services and included in the providers' Plans for Supports.

"Personal assistance services" means assistance with ADLs, IADLs, access to the community, self-administration of medication or other medical needs, and the monitoring of health status and physical condition.

"Personal assistant" means a person who provides personal assistance services.

"Personal emergency response system" or "PERS" means an electronic device and monitoring service that enable certain individuals at high risk of institutionalization to secure help in an emergency. PERS services shall be limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision.

"Personal profile" means a point-in-time synopsis of what [~~a waiver~~ an] individual [enrolled in the waiver] wants to maintain, change, or improve in his life and shall be completed by the [~~waiver~~] individual and another person, such as his case manager or family/caregiver, chosen by the individual to help him plan before the annual planning meeting where it is discussed and finalized.

"Plan for Supports" means each service provider's plan for supporting the individual [enrolled in the waiver] in achieving his desired outcomes and facilitating the individual's health and safety. The Plan for Supports is one component of the Individual Support Plan. The Plan for Supports is referred to as an Individual Service Plan in the Day Support and Individual and Family with Developmental Disability Services (IFDDS) Waivers.

"Prevocational services" means services aimed at preparing an individual [enrolled in the waiver] for paid or unpaid employment. The services do not include activities that are specifically job-task oriented but focus on concepts such as accepting supervision, attendance at work, task completion, problem solving, and safety. Compensation for the [~~waiver~~] individual, if provided, shall be less than 50% of the minimum wage.

"Primary caregiver" means the primary person who consistently assumes the role of providing direct care and support of the individual [enrolled in the waiver] to live successfully in the community without compensation for providing such care.

[~~"Prior authorization" means the process of approving by either DMAS or its designated prior authorization contractor, for the purpose of DMAS' reimbursement, the service for the individual before it is rendered.~~]

"Qualified mental retardation professional" or "QMRP" for the purposes of the [~~MR/ID~~ ID] Waiver means [~~a professional possessing (i) at least one year of documented experience working directly with individuals who have MR/ID or developmental disabilities; (ii) at least a bachelor's degree in a human services field including, but not necessarily limited to, sociology, social work, special education, rehabilitation counseling, or psychology, or a bachelor's degree in another field in addition to an advanced degree in a human services field; and (iii) the required, as appropriate, Virginia or national license, registration, or certification in accordance with his professional standards~~ the same as defined at 12VAC35-105-20].

"Registered nurse" or "RN" means a person who is licensed or holds multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia to practice professional nursing.

"Residential support services" means support provided in the individual's home by a DBHDS-licensed residential provider or a VDSS-approved provider of adult foster care services. This service is one in which skill-building, supports, and safety supports are routinely provided to enable individuals to maintain or improve their health, to develop skills in daily living and safely use community resources, to be included in the community and home, to develop relationships, and to participate as citizens in the community.

"Respite services" means services provided to individuals who are unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those unpaid persons normally providing the care.

"Risk assessment" means an assessment that is completed by the case manager to determine areas of high risk of danger to the individual or others based on the individual's serious medical or behavioral factors. The required risk assessment for the [~~MR/ID~~ ID] Waiver shall be found in the state-designated assessment form which may be supplemented with other information. The risk assessment shall be used to plan risk mitigating supports for the individual in the Individual Support Plan.

"Safety supports" means specialized assistance that is required to assure the health and welfare of an individual.

["Service authorization" means the process of approving by either DMAS or its designated service authorization contractor, for the purpose of DMAS' reimbursement, the service for the individual before it is rendered.]

"Services facilitation" means a service that assists the individual or the individual's family/caregiver, or EOR, as appropriate, in arranging for, directing, and managing services provided through the consumer-directed model of service delivery.

"Services facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual or the individual's family/caregiver, or EOR, as appropriate, by [~~ensuring~~ collaborating with the case manager to ensure] the development and monitoring of the CD Services Plan for Supports, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed companion, personal assistance, and respite services.

"Significant change" means, but shall not be limited to, a change in an individual's condition that is expected to last longer than 30 days but shall not include short-term changes that resolve with or without intervention, a short-term acute illness or episodic event, or a well-established, predictive, cyclical pattern of clinical signs and symptoms associated with a previously diagnosed condition where an appropriate course of treatment is in progress.

"Skilled nursing services" means both skilled and hands-on care, as rendered by either a licensed RN or LPN, of either a supportive or health-related nature and may include, but shall not be limited to, all skilled nursing care as ordered by the attending physician and documented on the Plan for Supports, assistance with ADLs, administration of medications or other medical needs, and monitoring of the health status and physical condition of the [~~waiver~~] individual [enrolled in the waiver].

"Slot" means an opening or vacancy in waiver services for an individual.

"State Plan for Medical Assistance" or "Plan" means the Commonwealth's legal document approved by CMS identifying the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Supports" means paid and nonpaid assistance that promotes the accomplishment of an individual's desired outcomes. There shall be three types of supports: (i) routine supports that assist the individual in daily activities; (ii) skill building supports that help the individual gain new abilities; and (iii) safety supports that are required to assure the individual's health and safety.

"Supported employment" means paid supports provided in work settings in which persons without disabilities are typically employed. Paid supports include skill-building supports related to paid employment, ongoing or intermittent routine supports, and safety supports to enable an individual with [~~MR/ID~~ ID] to maintain paid employment.

"Support plan" means the report of recommendations resulting from a therapeutic consultation.

"Therapeutic consultation" means covered services designed to assist the individual and the individual's family/caregiver, as appropriate, with assessments, plan design, and teaching for the purpose of assisting the [~~waiver~~] individual [enrolled in the waiver].

"Transition services" means set-up expenses as defined in 12VAC30-120-2010.

"VDSS" means the Virginia Department of Social Services.

12VAC30-120-1005. Waiver description and legal authority.

A. Home and community-based waiver services shall be available through a § 1915(c) waiver of the Social Security Act. Under this waiver, DMAS has waived § 1902(a) (10) (B) and (C) of the Social Security Act related to comparability of services. These services shall be appropriate and necessary to maintain the individual in the community.

B. Federal waiver requirements, as established in § 1915 of the Social Security Act and 42 CFR 430.25, provide that the average per capita fiscal year expenditures in the aggregate under this waiver shall not exceed the average per capita expenditures for the level of care provided in an [~~ICF/MR~~ ICF/ID], as defined in 42 CFR 435.1010 and 42 CFR 483.440, under the State Plan that would have been provided had the waiver not been granted.

C. DMAS shall be the single state agency authority pursuant to 42 CFR 431.10 responsible for the processing and payment of claims for the services covered in this waiver and for obtaining federal financial participation from CMS. The Department of Behavioral Health and Developmental Services (DBHDS) shall be responsible for the daily administrative supervision of the [~~MR/ID~~ ID] Waiver in accordance with the interagency agreement between DMAS and DBHDS.

D. [Any of the services covered under the authority of this waiver shall be required in order for the individual to avoid institutionalization.

E.] Waiver service populations. These waiver services shall be provided for the following individuals who have been determined to require the level of care provided in an [~~ICF/MR~~ ICF/ID]:

1. Individuals with [~~MR/ID~~ ID]; or

2. Individuals younger than the age of six who are at developmental risk. At the age of six years, these individuals must have a diagnosis of [~~MR/ID~~ ID] to continue to receive [these] home and community-based waiver services [~~specifically under this program~~].

[~~MR/ID Waiver individuals~~ Individuals enrolled in the waiver] who attain the age of six years of age, who are determined not to have a diagnosis of [~~MR/ID~~ ID], and who meet all Individual and Family Developmental Disability Support (IFDDS) Waiver eligibility criteria, shall be eligible [to apply] for transfer to the IFDDS Waiver for the period of time up to their seventh birthday. Psychological evaluations [or standardized development assessments] confirming [individuals'] diagnoses must be completed less than one year prior to transferring to the IFDDS Waiver. These individuals transferring from the [~~MR/ID~~ ID] Waiver will be assigned a slot in the IFDDS Waiver, [~~subject to the approval of the slot by CMS~~ if one is available]. The case manager shall submit the current Level of Functioning Survey, Individual Support Plan, and psychological evaluation (or standardized developmental assessment

for children under six years of age) to DMAS for review. Upon determination by DMAS that the individual is appropriate for transfer to the IFDDS Waiver and there is a slot available for the child, the [~~MR/ID~~ ID] case manager shall provide the family with a list of IFDDS Waiver case managers. The [~~MR/ID~~ ID] case manager shall work with the selected IFDDS Waiver case manager to determine an appropriate transfer date and shall submit a DMAS-225 to the local department of social services. The [~~MR/ID~~ ID] Waiver slot shall be held by the CSB until the child has successfully transitioned to the IFDDS Waiver. Once the child's transition into the IFDDS Waiver is complete, the CSB shall reallocate [~~, consistent with DBHDS guidance policies,~~] the [~~MR/ID~~ ID] slot to another individual on the waiting list. [~~If there is no IFDDS Waiver slot available for this child, then the child shall be placed on the IFDDS Waiver's waiting list. Such waiver individuals shall be dis-enrolled from the MR/ID Waiver.~~]

[~~E. MR/ID~~ F. ID] services shall not be offered or provided to an individual who resides outside of the physical boundaries of the United States or the Commonwealth. Waiver services shall not be furnished to individuals who are inpatients of a hospital, nursing facility, [~~ICF/MR~~ ICF/ID], or inpatient rehabilitation facility. Individuals with [~~MR/ID~~ ID] who are inpatients of these facilities may receive case management services as described in 12VAC30-50-450. The case manager may recommend waiver services that would promote exiting from the institutional placement; however, these waiver services shall not be provided until the individual has exited the institution.

[~~F.~~ G.] An individual shall not be simultaneously enrolled in more than one waiver [~~program~~].

[~~G.~~ H.] DMAS shall be responsible for assuring appropriate placement of the individual in home and community-based waiver services and shall have the authority to terminate such services for the individual who no longer qualifies for the waiver. Termination from this waiver shall occur when the individual's health and medical needs can no longer be safely met by waiver services in the community.

[~~H.~~ I.] No waiver services shall be reimbursed until after both the provider enrollment process and individual eligibility process have been completed.

12VAC30-120-1010. Individual eligibility requirements.

A. Individuals receiving services under this waiver must meet the following Medicaid eligibility requirements. The Commonwealth shall apply the financial eligibility criteria contained in the State Plan for the categorically needy. The Commonwealth covers the optional categorically needy groups under 42 CFR 435.211, 42 CFR 435.217, and 42 CFR 435.230.

1. The income level used for 42 CFR 435.211, 42 CFR 435.217 and 42 CFR 435.230 shall be 300% of the current Supplemental Security Income (SSI) payment standard for one person.

2. Under this waiver, the coverage groups authorized under § 1902(a)(10)(A)(ii)(VI) of the Social Security Act shall be considered as if they were institutionalized for the purpose of applying institutional deeming rules. All individuals under the waiver must meet the financial and nonfinancial Medicaid eligibility criteria and meet the institutional level-of-care criteria. The deeming rules shall be applied to waiver eligible individuals as if the individuals were residing in an institution or would require that level of care.

3. The Commonwealth shall reduce its payment for home and community-based waiver services provided to an individual who is eligible for Medicaid services under 42 CFR 435.217 by that amount of the individual's total income (including amounts disregarded in determining eligibility) that remains after allowable deductions for personal maintenance needs, other dependents, and medical needs have been made, according to the guidelines in 42

CFR 435.735 and § 1915(c)(3) of the Social Security Act as amended by the Consolidated Omnibus Budget Reconciliation Act of 1986. DMAS shall reduce its payment for home and community-based waiver services by the amount that remains after the deductions listed in this subdivision:

a. For individuals to whom § 1924(d) applies and for whom the Commonwealth waives the requirement for comparability pursuant to § 1902(a)(10)(B), DMAS shall deduct the following in the respective order:

(1) The basic maintenance needs for an individual under this waiver, which shall be equal to 165% of the SSI payment for one person. As of January 1, 2002, due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

(2) For an individual with only a spouse at home, the community spousal income allowance determined in accordance with § 1924(d) of the Social Security Act.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family determined in accordance with § 1924(d) of the Social Security Act.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles or coinsurance charges, and necessary medical or remedial care recognized under state law but not covered under the plan.

b. For individuals to whom § 1924(d) does not apply and for whom the Commonwealth waives the requirement for comparability pursuant to § 1902(a)(10)(B), DMAS shall deduct the following in the respective order:

(1) The basic maintenance needs for an individual under this waiver, which is equal to 165% of the SSI payment for one person. As of January 1, 2002, due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

(2) For an individual with a dependent child or children, an additional amount for the maintenance needs of the child or children, which shall be equal to the Title XIX medically needy income standard based on the number of dependent children.

(3) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles or coinsurance charges, and necessary medical or remedial care recognized under state law but not covered under the State Plan for Medical Assistance.

B. The following four criteria shall apply to all individuals who have [~~MR/ID~~ ID] who seek these waiver services:

[~~a.~~ 1.] Individuals qualifying for [~~MR/ID~~ ID] Waiver services shall have a demonstrated need for the service due to significant functional limitations in major life activities. The need for these waiver services shall arise from either (i) an individual having a diagnosed condition of [~~MR/ID~~ ID] or (ii) a child younger than six years of age being at developmental risk of significant functional limitations in major life activities;

[~~b.~~ 2.] Individuals qualifying for [~~MR/ID~~ ID] Waiver services shall meet the [~~ICF/MR~~ ICF/ID] level-of-care criteria;

[~~c.~~ 3.] The Individual Support Plan and services that are delivered shall be consistent with the Medicaid definition of each service; and

[~~d.~~ 4.] Services shall be recommended by the case manager based on [his documentation of the need for each specific service as reflected in] a current assessment using a DBHDS-approved [~~assessment~~ SIS] instrument, [~~as specified in DBHDS and DMAS guidance documents, by demonstrating need for each specific service~~ or for children younger than five years of age, an alternative industry assessment instrument, such as the Early Learning Assessment Profile, and authorized by DBHDS].

C. Assessment and enrollment.

1. To ensure that Virginia's home and community-based waiver programs serve only individuals who would otherwise be placed in an [~~ICF/MR~~ ICF/ID], home and community-based waiver services shall be considered only for individuals who are eligible for admission to an [~~ICF/MR~~ ICF/ID] due to their diagnoses of [~~MR/ID~~ ID], or individuals who are younger than six years of age and who are at developmental risk. For the case manager to make a recommendation for waiver services, [~~MR/ID~~ ID] Waiver services must be determined to be an appropriate service alternative to delay or avoid placement in an [~~ICF/MR~~ ICF/ID], or to promote exiting from [~~either~~] an [~~ICF/MR~~ ICF/ID] or other institutional placement.

2. The case manager shall recommend the individual for home and community-based waiver services after determining diagnostic and functional eligibility. This determination shall be mandatory before DMAS assumes payment responsibility of home and community-based waiver services and shall include:

a. The required level-of-care determination by applying the existing DMAS [~~ICF/MR~~ ICF/ID] criteria (Part VI (12VAC30-130-430 et seq.) of the Amount, Duration and Scope of Selected Services Regulation) to be completed no more than six months prior to enrollment. The case manager determines whether the individual meets the [~~ICF/MR~~ ICF/ID] criteria with input from the individual and the individual's family/caregiver, as appropriate, and service and support providers involved in the individual's support; and

b. A psychological evaluation or standardized developmental assessment for children who are younger than six years of age that reflects the current psychological status (diagnosis), current cognitive abilities, and current adaptive level of the individual's functioning.

3. The case manager shall provide the individual and the individual's family/caregiver, as appropriate, with the choice of [~~MR/ID~~ ID] Waiver services or [~~ICF/MR~~ ICF/ID] placement.

4. The case manager shall [~~send the appropriate forms to DBHDS to~~] enroll the individual in the [~~MR/ID~~ ID] Waiver or, if no slot is available, [~~to~~] place the individual on the waiting list. [~~DBHDS~~ The CSB] shall only enroll the individual [~~if~~ following electronic confirmation by DBHDS that] a slot is available. If no slot is available, then the individual's name shall be placed on either the urgent or [~~non-urgent~~ nonurgent] statewide waiting list, consistent with criteria established in this waiver in 12VAC30-120-1088, until such time as a slot becomes available. Once [~~notification has been received from DBHDS that the individual~~ the individual's name] has been placed on either the urgent or [~~non-urgent~~ nonurgent] waiting list, the case manager shall notify the individual in writing within 10 business days of his placement on either list and offer appeal rights. The case manager shall contact the individual and the individual's family/caregiver, as appropriate, at least annually while the individual is on the waiting list to provide the choice between institutional placement and waiver services.

D. Waiver approval process: authorizing and accessing services.

1. Once the case manager has determined an individual meets the functional criteria for [~~MR/ID~~ ID] Waiver services, has determined that a slot is available, and that the individual has chosen [~~MR/ID~~ ID] Waiver services, the case manager shall submit enrollment information [via the IDOLS] to DBHDS to confirm level-of-care eligibility [~~and the availability of a slot~~].

2. Once the individual has been enrolled by [~~DBHDS~~ the CSB], the case manager will submit a DMAS-225 along with a [~~written~~ computer-generated] confirmation [~~from DBHDS~~] of level-of-care eligibility to the local department of social services to determine financial eligibility for the waiver program and any patient pay responsibilities.

3. After the case manager has received written notification of Medicaid eligibility by the local departments of social services [~~and written confirmation of enrollment from DBHDS~~], the case manager shall so inform the individual and the individual's family/caregiver, as appropriate, to permit the development of the Individual Support Plan.

a. The individual and the individual's family/caregiver, as appropriate, shall meet with the case manager within 30 calendar days [of waiver enrollment] to discuss the individual's needs and existing supports, complete the DBHDS-approved assessment, obtain a medical examination completed no earlier than 12 months prior to the initiation of waiver services, begin to develop the Personal Profile, and complete all designated assessments, such as the Supports Intensity Scale (SIS), deemed necessary to establish and document the needed services.

b. The case manager shall provide the individual and the individual's family/caregiver, as appropriate, with choice of needed services available under the [~~MR/ID~~ ID] Waiver, alternative settings, and providers. Once the service providers are chosen, a planning meeting shall be arranged by the case manager to develop the person-centered Individual Support Plan based on the assessment of needs as reflected in the level of care and DBHDS-approved functional assessment instruments and the preferences of the individual and the individual's family/caregiver's, as appropriate.

c. Participants invited to participate in the person-centered planning meeting shall include the individual, case manager, service providers, the individual's family/caregiver, as appropriate, and others desired by the individual. The Individual Support Plan development process identifies the

services to be rendered to individuals, the frequency of services, the type of service provider or providers, and a description of the services to be offered. [The individual enrolled in the waiver, or the family/caregiver as appropriate, and case manager must sign the ISP.]

4. The individual or case manager shall contact chosen service providers so that services can be initiated within 30 [calendar] days of [~~receipt of~~] enrollment [~~confirmation from DBHDS~~]. The service providers in conjunction with the individual and the individual's family/caregiver, as appropriate, and the case manager shall develop Plans for Supports for each service. A copy of these plans shall be submitted to the case manager. The case manager shall review and ensure the Plan for Supports meets the established service criteria for the identified needs prior to submitting to the state-designated agency or its contractor for [~~prior~~ service] authorization. Only [~~MR/ID~~ ID] Waiver services authorized on the Individual Support Plan by the state-designated agency or its contractor according to DMAS policies may be reimbursed by DMAS. The Plan for Supports from each waiver service provider shall be incorporated into the Individual Support Plan along with the steps for risk mitigation as indicated by the risk assessment.

5. When the case manager obtains the DMAS-225 form from a local department of social services, the case manager shall designate and inform in writing a service provider to be the collector of patient pay when applicable. The designated provider shall [~~periodically~~ monthly] monitor the DMAS-designated system for changes in patient pay obligations and adjust billing, as appropriate, with the change documented in the record in accordance with DMAS policy. When the designated collector of patient pay is the consumer-directed [~~EOR~~ personal or respite assistant or companion], the case manager shall forward a copy of the DMAS-225 form to the [~~consumer-directed fiscal/employer agent and the~~] EOR [along with the case manager's designation described in 12VAC30-120-1060 S 2 a (6). In such cases, the case manager shall be required to perform the monthly monitoring of the patient pay system and shall notify the EOR of all changes].

6. The case manager shall submit the results of the comprehensive assessment and a recommendation to DBHDS staff for final determination of [~~ICF/MR~~ ICF/ID] level of care and authorization for community-based services. The state-designated agency or its contractor shall, within 10 working days of receiving all supporting documentation, review and approve, pend for more information, or deny the individual service requests. The state-designated agency or its contractor shall communicate in writing to the case manager whether the recommended services have been approved and the amounts and type of services authorized or if any services have been denied. Medicaid shall not pay for any home and community-based waiver services delivered prior to the authorization date approved by the state-designated agency or its contractor if [~~prior~~ service] authorization is required.

7. [~~MR/ID~~ ID] Waiver services may be recommended by the case manager only if:

a. The individual is Medicaid eligible as determined by the local departments of social services;

b. The individual has a diagnosis of [~~MR/ID~~ ID] as defined by the American Association on Intellectual and Developmental Disabilities, or is a child under the age of six at developmental risk, and who would in the absence of waiver services require the level of care provided in an [~~ICF/MR~~ ICF/ID] the cost of which would be reimbursed under the Plan; and

c. The contents of the Plans for Support [~~shall be~~ are] consistent with the Medicaid definition of each service.

8. All Individual Support Plans shall be subject to final approval by DMAS. DMAS is the single state agency authority responsible for the supervision of the administration of the [~~MR/ID~~ ID] Waiver.

9. If services are not initiated by the provider within 30 days of receipt of enrollment confirmation from DBHDS, the case manager shall notify the local department of social services so that a re-evaluation of eligibility as a noninstitutionalized individual can be made.

10. In the case of [~~a waiver individual~~ an individual enrolled in the waiver] being referred back to a local department of social services for a redetermination of eligibility and in order to retain the designated slot, the case manager shall submit [~~written~~] information to DBHDS [via IDOLS] requesting retention of the designated slot pending the initiation of services. A copy of the request shall be provided to the individual and the individual's family/caregiver, as appropriate. DBHDS shall have the authority to approve the slot-retention request in 30-day extensions, up to a maximum of four consecutive extensions, or deny such request to retain the waiver slot for that individual. DBHDS shall provide a [~~written~~] response to the case manager [via IDOLS] indicating denial or approval of the slot extension request. DBHDS shall submit this response within 10 working days of the receipt of the request for extension and include the individual's right to appeal its decision.

E. Reevaluation of service need.

1. The Individual Support Plan.

a. The Individual Support Plan, as defined herein, shall be [collaboratively] developed annually by the case manager with the individual and the individual's family/caregiver, as appropriate, other service providers, consultants, and other interested parties based on relevant, current assessment data.

b. The case manager shall be responsible for continuous monitoring of the appropriateness of the individual's services and revisions to the Individual Support Plan as indicated by the changing needs of the individual. At a minimum, the case manager must review the Individual Support Plan every three months to determine whether the individual's desired outcomes and support activities are being met and whether any modifications to the Individual Support Plan are necessary.

c. Any modification to the amount or type of services in the Individual Support Plan shall be prior authorized by the state-designated agency or its contractor.

d. All requests for increased waiver services by [~~MR/ID Waiver individuals~~ individuals enrolled in the waiver] shall be reviewed under the health, safety, and welfare standard and for consistency with cost effectiveness. This standard assures that an individual's ability to receive a waiver service is dependent on the finding that the individual needs the service, based on appropriate assessment criteria and a written Plan for Supports, and that services can safely and cost effectively be provided in the community.

2. Review of level of care.

a. The case manager shall complete a reassessment annually in coordination with the individual and the individual's family/caregiver, as appropriate, and service providers. The reassessment shall include an update of the level of care and Personal Profile, risk assessment, and any other appropriate assessment information. The Individual Support Plan shall be revised as appropriate.

b. At least every three years [for those individuals who are 16 years of age and older and every two years for those individuals who are ages birth through 15 years old,] or when the individual's support needs change significantly, the case manager, with the assistance of the individual and other

appropriate parties who have knowledge of the individual's circumstances and needs for support, shall complete the DBHDS-approved SIS form or [~~its~~ an] approved [~~substitute form~~ alternative instrument for children younger than the age of five years].

c. A medical examination shall be completed for adults based on need identified by the individual and the individual's family/caregiver, as appropriate, provider, case manager, or DBHDS staff. Medical examinations and screenings for children shall be completed according to the recommended frequency and periodicity of the EPSDT program.

d. A new psychological evaluation shall be required whenever the individual's functioning has undergone significant change (such as a loss of abilities or awareness that is expected to last longer than 30 days) and is no longer reflective of the past psychological evaluation. A psychological evaluation or standardized developmental assessment for children younger than six years of age must reflect the current psychological status (diagnosis), adaptive level of functioning, and cognitive abilities.

3. The case manager shall monitor the service providers' Plans for Supports to ensure that all providers are working toward the desired outcomes of the individuals.

4. Case managers shall be required to conduct monthly onsite visits for all [~~MR/ID Waiver~~] individuals [enrolled in the waiver] residing in VDSS-licensed assisted living facilities or approved adult foster care homes. Case managers shall conduct a minimum of quarterly [~~on-site~~ onsite] home visits to individuals receiving [~~MR/ID~~ ID] Waiver services who [~~also~~] reside in [~~all~~] DBHDS-licensed sponsored residential homes.

12VAC30-120-1020. Covered services; limits on covered services.

A. Covered services in the [~~MR/ID~~ ID] Waiver include: assistive technology, companion services (both consumer-directed and agency-directed), crisis stabilization, day support, environmental modifications, personal assistance services (both consumer-directed and agency-directed), personal emergency response systems (PERS), prevocational services, residential support services, respite services (both consumer-directed and agency-directed), services facilitation (only for consumer-directed services), skilled nursing services, supported employment, therapeutic consultation, and transition services.

1. There shall be separate supporting documentation for each service and each shall be clearly differentiated in documentation and corresponding billing.

2. [~~Each waiver individual's~~ The] need [of each individual enrolled in the waiver] for each service shall be clearly set out in the Individual Support Plan containing the providers' Plans for Supports.

3. Claims for payment that are not supported by their related documentation shall be subject to recovery by DMAS or its designated contractor as a result of utilization reviews or audits.

4. [~~Waiver individuals~~ Individuals enrolled in the waiver] may choose between the agency-directed model of service delivery or the consumer-directed model when DMAS makes this alternative model available for care. The only services provided in this waiver that permit the consumer-directed model of service delivery shall be: (i) personal assistance services; (ii) respite services; and (iii) companion services. [~~A waiver individual~~ An individual enrolled in the waiver] shall not receive consumer-directed services if at least one of the following conditions exists:

(a) The [~~waiver~~] individual [enrolled in the waiver] is younger than 18 years of age or is unable to be the employer of record and no one else can assume this role;

(b) The health, safety, or welfare of the [~~waiver~~] individual [enrolled in the waiver] cannot be [~~guaranteed~~ assured] or a back up emergency plan cannot be developed; or

(c) The [~~waiver~~] individual [enrolled in the waiver] has medication or skilled nursing needs or medical/behavioral conditions that cannot be safely met via the consumer-directed model of service delivery.

5. Voluntary/involuntary disenrollment of consumer-directed services. Either voluntary or involuntary disenrollment of consumer-directed services may occur. In either voluntary or involuntary situations, the [~~waiver~~] individual [enrolled in the waiver] shall be permitted to select an agency from which to receive his personal assistance, respite, or companion services.

a. An individual who has chosen consumer direction may choose, at any time, to change to the agency-directed services model as long as he continues to qualify for the specific services. The services facilitator or case manager, as appropriate, shall assist the individual with the change of services from consumer-directed to agency-directed.

b. The services facilitator or case manager, as appropriate, shall initiate involuntary disenrollment from consumer direction of the [~~waiver~~] individual [enrolled in the waiver] when any of the following conditions occur:

(1) The health, safety, or welfare of the [~~waiver~~] individual [enrolled in the waiver] is at risk;

(2) The individual or EOR, as appropriate, demonstrates consistent inability to hire and retain a personal assistant; or

(3) The individual or EOR, as appropriate, is consistently unable to manage the assistant, as may be demonstrated by, but shall not necessarily be limited to, a pattern of serious discrepancies with timesheets.

c. Prior to involuntary disenrollment, the services facilitator or case manager, as appropriate, shall:

(1) Verify that essential training has been provided to the individual or EOR, as appropriate, to improve the problem condition or conditions;

(2) Document in the individual's record the conditions creating the necessity for the involuntary disenrollment and actions taken by the services facilitator or case manager, as appropriate;

(3) Discuss with the individual or the EOR, as appropriate, the agency directed option that is available and the actions needed to arrange for such services while providing a list of potential providers; and

(4) Provide written notice to the individual and EOR, as appropriate, of the right to appeal [, pursuant to 12VAC30-110,] such involuntary termination of consumer direction. Such notice shall be given at least 10 business days prior to the effective date of this action.

[d. If the services facilitator initiates the involuntary disenrollment from consumer direction, then he shall inform the case manager.]

6. [~~Coordination of waiver services with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medicaid benefit. When the definition of this waiver's service is the same as that for EPSDT, then reimbursement for the waiver service shall first be made through the Medicaid EPSDT benefit~~ All requests for this waiver's services shall be submitted to either DMAS or the service authorization contractor for service (prior) authorization].

B. Assistive technology (AT). Service description. This service shall entail the provision of specialized medical equipment and supplies including those devices, controls, or appliances, specified in the Individual Support Plan but which are not available under the State Plan for Medical Assistance, that (i) enable individuals to increase their abilities to perform activities of daily living (ADLs); (ii) enable individuals to perceive, control, or communicate with the environment in which they live; or (iii) are necessary for life support, including the ancillary supplies and equipment necessary to the proper functioning of such technology.

1. Criteria. In order to qualify for these services, the individual shall have a demonstrated need for equipment or modification for remedial or direct medical benefit primarily in the individual's home, vehicle, community activity setting, or day program to specifically improve the individual's personal functioning. AT shall be covered in the least expensive, most cost-effective manner.

2. Service units and service limitations. AT shall be available to individuals who are receiving at least one other waiver service and may be provided in a residential or nonresidential setting. Only the AT services set out in the Plan for Supports shall be covered by DMAS. AT shall be prior authorized by the state-designated agency or its contractor for each calendar year with no carry-over across calendar years.

a. [~~Effective July 1, 2011, the~~ The] maximum funded expenditure per individual for all AT covered procedure codes (combined total of AT items and labor related to these items) shall be [~~$3,000~~ $5,000] per calendar year for individuals regardless of waiver for which AT is approved. [~~Requests made for reimbursement between January 1, 2011, and June 30, 2011, shall be subject to a $5,000 annual maximum; requests made for reimbursement between July 1, 2011, and December 31, 2011, shall be subject to $3,000 annual maximum and shall consider, against the $3,000 limit, any relevant expenditure from the first six months of the calendar year. Expenditures made in the first six months of calendar year 2011 (under the $5,000 limit) shall count against the $3,000 limit applicable in the second six months of calendar year 2011. For subsequent calendar years, the limit shall be $3,000 throughout the time period.~~] The service unit shall always be one for the total cost of all AT being requested for a specific timeframe.

b. Costs for AT shall not be carried over from calendar year to calendar year and shall be prior authorized by the state-designated agency or its contractor each calendar year. AT shall not be approved for purposes of convenience of the caregiver or restraint of the individual.

3. An independent professional consultation shall be obtained from staff knowledgeable of that item for each AT request prior to approval by the state-designated agency or its contractor. Equipment, supplies, or technology not available as durable medical equipment through the State Plan may be purchased and billed as AT as long as the request for such equipment, supplies, or technology is documented and justified in the individual's Plan for Supports, recommended by the case manager, prior authorized by the state-designated agency or its contractor, and provided in the least expensive, most cost-effective manner possible.

[~~4. Medical equipment and supplies required for individuals under age 21 that are covered both under the State Plan for Medical Assistance and outside the State Plan shall be furnished through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program.~~

~~5.~~ 4.] All AT items to be covered shall meet applicable standards of manufacture, design, and installation.

[~~6.~~ 5.] The AT provider shall obtain, install, and demonstrate, as necessary, such AT prior to submitting his claim to DMAS for reimbursement. The provider shall provide all warranties or guarantees from the AT's manufacturer to the individual and family/caregiver, as appropriate.

[~~7.~~ 6.] AT providers shall not be the spouse or parents of the [~~waiver~~] individual [enrolled in the waiver].

C. Companion (both consumer-directed and agency-directed) services. Service description. These services provide nonmedical care, socialization, or support to an adult (ages 18 or older). Companions may assist or support the [~~waiver~~] individual [enrolled in the waiver] with such tasks as meal preparation, community access and activities, laundry, and shopping, but companions do not perform these activities as discrete services. Companions may also perform light housekeeping tasks (such as bed-making, dusting and vacuuming, laundry, grocery shopping, etc.) when such services are specified in the individual's Plan for Supports and essential to the individual's health and welfare in the context of providing nonmedical care, socialization, or support, as may be needed [~~by the waiver individual~~] in order to maintain the individual's home environment in an orderly and clean manner. Companion services shall be provided in accordance with a therapeutic outcome in the Plan for Supports and shall not [~~purely~~] be [purely] recreational in nature. This service may be provided and reimbursed either through an agency-directed or a consumer-directed model.

1. In order to qualify for companion services, the [~~waiver~~] individual [enrolled in the waiver] shall have demonstrated a need for assistance with IADLs, light housekeeping (such as cleaning the bathroom used by the [~~waiver~~] individual, washing his dishes, preparing his meals, or washing his clothes), community access, reminders for medication self-administration, or support to assure safety. The provision of companion services shall not entail [routine] hands-on care.

2. Individuals choosing the consumer-directed option shall meet requirements for consumer direction as described herein.

3. Service units and service limitations.

a. The unit of service for companion services shall be one hour and the amount that may be included in the Plan for Supports shall not exceed eight hours per 24-hour day regardless of whether it is an agency-directed or consumer-directed service model, or both.

b. A companion shall not be permitted to provide nursing care procedures such as, but not limited to, ventilators, [~~continuous~~] tube feedings, suctioning of airways, or wound care.

c. The hours that can be authorized shall be based on documented individual need. No more than two unrelated individuals who are receiving waiver services and who live in the same home shall be permitted to share the authorized work hours of the companion.

4. This consumer directed service shall be available to [~~waiver~~] individuals [enrolled in the waiver] who receive congregate residential services. These services shall be available when [~~waiver~~] individuals [enrolled in the waiver] are not receiving congregate residential services such as, but not necessarily limited to, when they are on vacation or are visiting with family members.

D. Crisis stabilization. Service description. These services shall involve direct interventions that provide temporary intensive services and support that avert emergency psychiatric hospitalization or institutional placement of individuals with [~~MR/ID~~ ID] who are experiencing serious psychiatric or behavioral problems that jeopardize their current community living situation. Crisis stabilization services shall have two components: (i) intervention and (ii) supervision. Crisis stabilization services shall include, as appropriate, neuropsychiatric, psychiatric, psychological, and other assessments and

stabilization techniques, medication management and monitoring, behavior assessment and positive behavioral support, and intensive service coordination with other agencies and providers. This service shall be designed to stabilize the individual and strengthen the current living situation, so that the individual remains in the community during and beyond the crisis period.

1. These services shall be provided to:

a. Assist with planning and delivery of services and supports to enable the individual to remain in the community;

b. Train family/caregivers and service providers in positive behavioral supports to maintain the individual in the community; and

c. Provide temporary crisis supervision to ensure the safety of the individual and others.

2. In order to receive crisis stabilization services, the individual shall:

a. Meet at least one of the following: (i) the individual shall be experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning; (ii) the individual shall be experiencing an increase in extreme emotional distress; (iii) the individual shall need continuous intervention to maintain stability; or (iv) the individual shall be causing harm to himself or others; and

b. Be at risk of at least one of the following: (i) psychiatric hospitalization; (ii) emergency [~~ICF/MR~~ ICF/ID] placement; (iii) immediate threat of loss of a community service due to a severe situational reaction; or (iv) causing harm to self or others.

3. Service units and service limitations. Crisis stabilization services shall only be authorized following a documented face-to-face assessment conducted by a qualified mental retardation professional (QMRP).

a. The unit for either intervention or supervision of this covered service shall be one hour. This service shall only be authorized in 15-day increments but no more than 60 days in a calendar year shall be approved. The actual service units per episode shall be based on the documented clinical needs of the individual being served. Extension of services, beyond the 15-day limit per authorization, shall only be authorized following a documented face-to-face reassessment conducted by a QMRP.

b. Crisis stabilization services shall be provided directly in the following settings, but shall not be limited to:

(1) The home of an individual who lives with family, friends, or other primary caregiver or caregivers;

(2) The home of an individual who lives independently or semi-independently to augment any current services and supports; or

(3) Either a community-based residential program, a day program, or a respite care setting to augment ongoing current services and supports;

4. Crisis supervision shall be an optional component of crisis stabilization in which one-to-one supervision of the individual who is in crisis shall be provided by agency staff in order to ensure the safety of the individual and others in the environment. Crisis supervision may be provided as a component of crisis stabilization only if clinical or behavioral interventions allowed under this service are also provided during the authorized period.

Crisis supervision must be provided one-to-one and face-to-face with the individual. Crisis supervision, if provided as a part of this service, shall be separately billed in hourly service units.

5. Crisis stabilization services shall not be used for continuous long-term care. Room, board, and general supervision shall not be components of this service.

6. If appropriate, the assessment and any reassessments may be conducted jointly with a licensed mental health professional or other appropriate professional or professionals.

E. Day support services. Service description. These services shall include skill-building, supports, and safety supports for the acquisition, retention, or improvement of self-help, socialization, community integration, and adaptive skills. These services shall be typically offered in a nonresidential setting that provides opportunities for peer interactions, community integration, and enhancement of social networks. There shall be two levels of this service: (i) intensive and (ii) regular.

1. Criteria. For day support services, individuals shall demonstrate the need for skill-building or supports offered primarily in settings other than the individual's own residence that allows him an opportunity for being a productive and contributing member of his community.

2. Types of day support. The amount and type of day support included in the individual's Plan for Supports shall be determined by what is required for that individual. There are two types of day support: center-based, which is provided primarily at one location/building; or noncenter-based, which is provided primarily in community settings. Both types of day support may be provided at either intensive or regular levels.

3. Levels of day support. There shall be two levels of day support, intensive and regular. To be authorized at the intensive level, the individual shall meet at least one of the following criteria: (i) the individual requires physical assistance to meet the basic personal care needs (such as but not limited to toileting, eating/feeding); (ii) the individual requires additional, ongoing support to fully participate in programming and to accomplish the individual's desired outcomes due to extensive disability-related difficulties; or (iii) the individual requires extensive constant supervision to reduce or eliminate behaviors that preclude full participation in the program. In this case, written behavioral support activities shall be required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation. Individuals not meeting these specified criteria for intensive day support shall be provided with regular day support.

4. Service units and service limitations.

a. This service shall be limited to 780 [~~unit~~] blocks, or its equivalent under the DMAS fee schedule, per Individual Support Plan year. A block shall be defined as a period of time from one hour through three hours and 59 [~~seconds~~ minutes]. [Two blocks are defined as four hours to six hours and 59 minutes. Three blocks are defined as seven hours to nine hours and 59 minutes.] If this service is used in combination with prevocational, or group supported employment services, or both, the combined total units for day support, prevocational, or group supported employment services shall not exceed 780 units, or its equivalent under the DMAS fee schedule, per Individual Support Plan year.

b. Day support services shall be billed according to the DMAS fee schedule.

c. Day support shall not be regularly or temporarily provided in an individual's home setting or other residential setting (e.g., due to inclement weather or individual illness) without prior written approval from the state-designated agency or its contractor.

d. Noncenter-based day support services shall be separate and distinguishable from either residential support services or personal assistance services. The supporting documentation shall provide an estimate of the amount of day support required by the individual.

5. Service providers shall be reimbursed only for the amount and level of day support services included in the individual's approved Plan for Supports based on the setting, intensity, and duration of the service to be delivered.

F. Environmental modifications (EM). Service description. This service shall be defined [, as set out in 12VAC30-120-1000,] as those physical adaptations to the [~~waiver~~ individual's] primary home [~~or.~~] primary vehicle [, or work site] that shall be required by the [~~waiver~~] individual's Individual Support Plan, that are necessary to ensure the health and welfare of the individual, or that enable the individual to function with greater independence [~~and without which the individual would require institutionalization~~]. [Environmental modifications reimbursed by DMAS may only be made to an individual's work site when the modification exceeds the reasonable accommodation requirements of the Americans with Disabilities Act.] Such adaptations may include, but shall not necessarily be limited to, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the individual. Modifications may be made to a primary automotive vehicle in which the individual is transported if it is owned by the individual, a family member with whom the individual lives or has consistent and ongoing contact, or a nonrelative who provides primary long-term support to the individual and is not a paid provider of services. [~~Environmental modifications reimbursed by DMAS may only be made to an individual's work site when the modification exceeds the reasonable accommodation requirements of the Americans with Disabilities Act.~~]

1. In order to qualify for these services, the [~~waiver~~] individual [enrolled in the waiver] shall have a demonstrated need for equipment or modifications of a remedial or medical benefit offered in an individual's primary home, the primary vehicle used by the individual, community activity setting, or day program to specifically improve the individual's personal functioning. This service shall encompass those items not otherwise covered in the State Plan for Medical Assistance or through another program.

2. Service units and service limitations.

a. Environmental modifications shall be provided in the least expensive manner possible that will accomplish the modification required by the [~~waiver~~] individual [enrolled in the waiver] and shall be completed within the [~~Plan of Support~~ calendar] year consistent with [~~such plan's~~ the Plan of Supports'] requirements.

b. [~~Effective July 1, 2011, the~~ The] maximum funded expenditure per individual for all EM covered procedure codes (combined total of EM items and labor related to these items) shall be [~~$3,000~~ $5,000] per calendar year for individuals regardless of waiver for which EM is approved. [~~Requests made for reimbursement between January 1, 2011, and June 30, 2011, shall be subject to a $5,000 annual maximum; requests made for reimbursement between July 1, 2011, and December 31, 2011, shall be subject to $3,000 annual maximum, and shall consider, against the $3,000 limit, any relevant expenditure from the first six months of the calendar year. Expenditures made in the first six months of calendar year 2011 (under the $5,000 limit) shall count against the $3,000 limit applicable in the second six months of calendar year 2011. For subsequent calendar years, the limit shall be $3,000 throughout the time period.~~] The service unit shall always be one, for the total cost of all EM being requested for a specific timeframe.

EM shall be available to individuals [~~who are receiving at least one other waiver service in addition to MR/ID targeted case management pursuant to 12VAC30-50-450~~ enrolled in the waiver who are receiving at least one other waiver service and may be provided in a residential or nonresidential setting]. EM shall be prior authorized by the state-designated agency or its contractor for each calendar year with no carry-over across calendar years.

c. Modifications shall not be used to bring a substandard dwelling up to minimum habitation standards.

d. Providers shall be reimbursed for their actual cost of material and labor and no additional mark-ups shall be permitted.

e. Providers of EM services shall not be the spouse or parents of the [~~waiver~~] individual [enrolled in the waiver].

f. Excluded from coverage under this waiver service shall be those adaptations or improvements to the home that are of general utility and that are not of direct medical or remedial benefit to the [~~waiver~~] individual [enrolled in the waiver], such as, but not necessarily limited to, carpeting, roof repairs, and central air conditioning. Also excluded shall be modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act, and the Rehabilitation Act. Adaptations that add to the total square footage of the home shall be excluded from this service. Except when EM services are furnished in the individual's own home, such services shall not be provided to individuals who receive residential support services.

3. Modifications shall not be prior authorized or covered to adapt living arrangements that are owned or leased by providers of waiver services or those living arrangements that are sponsored by a DBHDS-licensed residential support provider. Specifically, provider-owned or leased settings where residential support services are furnished shall already be compliant with the Americans with Disabilities Act.

4. Modifications to a primary vehicle that shall be specifically excluded from this benefit shall be:

a. Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual;

b. Purchase or lease of a vehicle; and

c. Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications that were covered under this waiver benefit.

G. Personal assistance services. Service description. These services may be provided either through an agency-directed or consumer-directed (CD) model.

1. Personal assistance shall be provided to individuals in the areas of activities of daily living (ADLs), instrumental activities of daily living (IADLs), access to the community, monitoring of self-administered medications or other medical needs, monitoring of health status and physical condition, and work-related personal assistance. Such services, as set out in the Plan for Supports, may be provided and reimbursed in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. When specified, such supportive services may include assistance with IADLs. Personal assistance shall not include either practical or professional nursing services or those practices regulated in Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia, as

appropriate. This service shall not include skilled nursing services with the exception of skilled nursing tasks that may be delegated pursuant to 18VAC90-20-420 through 18VAC90-20-460.

2. Criteria. In order to qualify for personal assistance, the individual shall demonstrate a need for assistance with ADLs, community access, self-administration of medications or other medical needs, or monitoring of health status or physical condition.

3. Service units and service limitations.

a. The unit of service shall be one hour.

b. Each individual [~~and family/caregiver~~, family, or caregiver] shall have a back-up plan for the individual's needed supports in case the personal assistant does not report for work as expected or terminates employment without prior notice.

c. Personal assistance shall not be available to individuals who (i) receive congregate residential services or who live in assisted living facilities, (ii) would benefit from ADL or IADL skill development as identified by the case manager, or (iii) receive comparable services provided through another program or service.

d. The hours to be authorized shall be based on the individual's need. No more than two unrelated individuals who live in the same home shall be permitted to share the authorized work hours of the assistant.

H. Personal Emergency Response System (PERS). Service description. This service shall be a service that monitors [~~waiver~~] individuals' safety in their homes, and provides access to emergency assistance for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the individuals' home telephone system. PERS may also include medication monitoring devices.

1. PERS may be authorized when there is no one else in the home with the [~~waiver~~] individual [enrolled in the waiver] who is competent or continuously available to call for help in an emergency.

2. Service units and service limitations.

a. A unit of service shall include administrative costs, time, labor, and supplies associated with the installation, maintenance, monitoring, and adjustments of the PERS. A unit of service is the one-month rental price set by DMAS. The one-time installation of the unit shall include installation, account activation, individual and caregiver instruction, and removal of PERS equipment.

b. PERS services shall be capable of being activated by a remote wireless device and shall be connected to the individual's telephone system. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The activating device must be waterproof, automatically transmit to the response center an activator low battery alert signal prior to the battery losing power, and be able to be worn by the individual.

c. PERS services shall not be used as a substitute for providing adequate supervision for the [~~waiver~~] individual [enrolled in the waiver].

I. Prevocational services. Service description. These services shall be intended to prepare [~~a waiver~~ an] individual [enrolled in the waiver] for paid or unpaid employment but shall not be job-task oriented. Prevocational services shall be provided to individuals who are not expected to be able to join the general work force without supports or to participate in a transitional sheltered workshop within one year of beginning waiver services. Activities included in this service shall not be directed at teaching specific job skills but at underlying habilitative outcomes such as accepting supervision, regular job attendance, task completion, problem solving, and safety. There shall be two levels of this covered service: (i) intensive and (ii) regular.

1. In order to qualify for prevocational services, the [~~waiver~~] individual [enrolled in the waiver] shall have a demonstrated need for support in skills that are aimed toward preparation of paid employment that may be offered in a variety of community settings.

2. Service units and service limitations. Billing shall be in accordance with the DMAS fee schedule.

a. This service shall be limited to 780 [~~unit~~] blocks, or its equivalent under the DMAS fee schedule, per Individual Support Plan year. [A block shall be defined as a period of time from one hour through three hours and 59 minutes. Two blocks are defined as four hours to six hours and 59 minutes. Three blocks are defined as seven hours to nine hours and 59 minutes.] If this service is used in combination with day support or group-supported employment services, or both, the combined total units for prevocational services, day support and group supported employment services shall not exceed 780 [~~unit~~] blocks, or its equivalent under the DMAS fee schedule, per Individual Support Plan year. A block shall be defined as a period of time from one hour through three hours and 59 [~~seconds~~ minutes].

b. Prevocational services may be provided in center-based or noncenter-based settings. Center-based settings means services shall be provided primarily at one location or building and noncenter-based means services shall be provided primarily in community settings.

c. For prevocational services to be authorized at the intensive level, the individual must meet at least one of the following criteria: (i) require physical assistance to meet the basic personal care needs (such as, but not limited to, toileting, eating/feeding); (ii) require additional, ongoing support to fully participate in services and to accomplish desired outcomes due to extensive disability-related difficulties; or (iii) require extensive constant supervision to reduce or eliminate behaviors that preclude full participation in the program. In this case, written behavioral support activities shall be required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation. Individuals not meeting these specified criteria for intensive prevocational services shall be provided with regular prevocational services.

4. There shall be documentation regarding whether prevocational services are available in vocational rehabilitation agencies through § 110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA). If the individual is not eligible for services through the IDEA due to his age, documentation shall be required only for lack of DRS funding. When these services are provided through these alternative funding sources, the Plan for Supports shall not authorize prevocational services as waiver expenditures.

5. Prevocational services shall only be provided when the individual's compensation for work performed is less than 50% of the minimum wage.

J. Residential support services. Service description. These services shall consist of skill-building, supports, and safety supports, provided primarily in an individual's home or in a licensed or approved residence, that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Service providers shall be reimbursed only for the amount and type of residential support services that are included in the individual's approved Plan for Supports. There shall be two types of this service: congregate

residential support and in-home supports. Residential support services shall be authorized for Medicaid reimbursement in the Plan for Supports only when the individual requires these services and when such needs exceed the services included in the individual's room and board arrangements with the service provider, or if these services exceed supports provided by the family/caregiver. [~~Residential~~ Only in exceptional instances shall residential] support services [~~shall not~~] be routinely reimbursed up to a 24-hour period.

1. Criteria.

a. In order for DMAS to reimburse for congregate residential support services, the individual shall have a demonstrated need for supports to be provided by staff who shall be paid by the residential support provider.

b. To qualify for this service in a congregate setting, the individual shall have a demonstrated need for continuous skill-building, supports, and safety supports for up to 24 hours per day.

c. Providers shall participate as requested in the completion of the DBHDS-approved SIS form or its approved substitute form.

d. The residential support Plan for Supports shall indicate the necessary amount and type of activities required by the individual, the schedule of residential support services, and the total number of projected hours per week of waiver reimbursed residential support.

[e. In-home residential supports shall be supplemental to the primary care provided by the individual, his family member or members, and other caregivers. In-home residential supports shall not replace this primary care.

f. In-home residential supports shall be delivered on an individual basis, typically for less than a continuous 24-hour period. This service shall be delivered with a 1:1 staff-to-individual ratio except when skill building supports require interaction with another person.]

2. Service units and service limitations. Total billing shall not exceed the amount authorized in the Plan for Supports. The provider must maintain documentation of the date and times that services have been provided, and specific circumstances that prevented provision of all of the scheduled services, should that occur.

a. This service shall be provided on an individual-specific basis according to the Plan for Supports and service setting requirements;

b. Congregate residential support shall not be provided to any [~~waiver~~] individual [enrolled in the waiver] who receives personal assistance services under the [~~MR/ID~~ ID] Waiver or other residential services that provide a comparable level of care [~~as described in the agency's guidance documents~~]. Residential support services shall be permitted to be provided to [~~waiver individuals~~ the individual enrolled in the waiver] in conjunction with respite services for unpaid caregivers;

c. Room, board, and general supervision shall not be components of this service;

d. This service shall not be used solely to provide routine or emergency respite care for the family/caregiver with whom the individual lives; and

e. Medicaid reimbursement shall be available only for residential support services provided when the individual is present and when an enrolled Medicaid provider is providing the services.

K. Respite services. Service description. These services may be provided either through an agency-directed or consumer-directed (CD) model.

1. Respite services shall be provided to individuals in the areas of activities of daily living (ADLs), instrumental activities of daily living (IADLs), access to the community, monitoring of self-administered medications or other medical needs, and monitoring of health status and physical condition in the absence of the primary caregiver or to relieve the primary caregiver from the duties of care-giving. Such services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. When specified, such supportive services may include assistance with IADLs. Respite assistance shall not include either practical or professional nursing services or those practices regulated in Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia, as appropriate. This service shall not include skilled nursing services with the exception of skilled nursing tasks that may be delegated pursuant to 18VAC90-20-420 through 18VAC90-20-460.

2. Respite services shall be those that are normally provided by the individual's family or other unpaid primary caregiver. These covered services shall be furnished on a short-term, episodic, or periodic basis because of the absence of the unpaid caregiver or need for relief of [~~those~~ the] unpaid caregiver or caregivers who normally provide care for the individual [~~in order to prevent the breakdown of the unpaid caregiver~~].

3. Criteria.

a. In order to qualify for respite services, the individual shall demonstrate a need for assistance with ADLs, community access, self-administration of medications or other medical needs, or monitoring of health status or physical condition.

b. Respite services shall only be offered to individuals [~~, in order to avoid institutionalization of the individual,~~] who have an unpaid primary caregiver or caregivers who require temporary relief. Such need for relief may be either episodic [~~or,~~] intermittent [, or periodic].

4. Service units and service limitations.

a. The unit of service shall be one hour. Respite services shall be limited to 480 hours per individual per [state fiscal] year [~~, to be prior authorized in six-month increments not to exceed 240 hours per six months~~]. If an individual changes waiver programs, this same maximum number of respite hours shall apply. No additional respite hours beyond the 480 maximum limit shall be approved for payment. [~~Individuals who do not use all of their allowed respite hours in the first six month prior authorization period shall not be permitted to carry over any unused portion of hours to the second prior authorization period.~~] Individuals who are receiving respite services in this waiver through both the agency-directed and CD models shall not exceed 480 hours per year combined.

b. Each individual [~~and family/caregiver~~, family, or caregiver] shall have a back-up plan for the individual's care in case the respite assistant does not report for work as expected or terminates employment without prior notice.

c. Respite services shall not be provided to relieve staff of either group homes, pursuant to 12VAC35-105-20, or assisted living facilities, pursuant to 22VAC40-72-10, where residential supports are provided in shifts. Respite services shall not be provided for DMAS reimbursement by adult foster care providers for an individual residing in that foster home.

[d.] Skill development shall not be provided with respite services.

[~~d.~~ e.] The hours to be authorized shall be based on the individual's need. No more than two unrelated individuals who live in the same home shall be permitted to share the authorized work hours of the respite assistant.

5. Consumer-directed [and agency-directed] respite services shall meet the same standards [~~as agency-directed respite services~~] for service limits [~~,~~ and] authorizations [~~, provider restrictions~~].

L. Services facilitation and consumer-directed service model. Service description. [~~Waiver individuals~~ Individuals enrolled in the waiver] may be approved to select consumer directed (CD) models of service delivery, absent any of the specified conditions that precludes such a choice, and may also receive support from a services facilitator. Persons functioning as services facilitators shall be enrolled Medicaid providers. This shall be a separate waiver service to be used in conjunction with CD personal assistance, respite, or companion services and shall not be covered for an individual absent one of these consumer directed services.

1. Services facilitators shall train [~~waiver~~] individuals [enrolled in the waiver], family/caregiver, or EOR, as appropriate, to direct (such as select, hire, train, supervise, and authorize timesheets of) their own assistants who are rendering personal assistance, respite services, and companion services.

2. The services facilitator shall [~~be responsible for assessing~~ assess] the individual's particular needs for a requested CD service, assisting in the development of the Plan for Supports, [~~providing~~ provide] management training for the individual or the EOR, as appropriate, on his responsibilities as [~~employers~~ employer], and [~~providing~~ provide] ongoing support of the CD model of services. The [~~prior~~ service] authorization for receipt of consumer directed services shall be based on the approved Plan for Supports.

3. The services facilitator shall make an initial comprehensive home visit to collaborate with the individual and the individual's family/caregiver, as appropriate, to identify the individual's needs, assist in the development of the Plan for Supports with the individual and the individual's family/caregiver, as appropriate, and provide employer management training [~~using DMAS' agency guidance documents~~ to the individual and the family/caregiver, as appropriate, on his responsibilities as an employer, and providing ongoing support of the consumer-directed model of services.] Individuals or EORs who are unable to receive employer management training at the time of the initial visit shall receive management training within seven days of the initial visit.

a. The initial comprehensive home visit shall be completed only once upon the individual's entry into the CD model of service regardless of the number or type of CD services that an individual requests.

b. If an individual changes services facilitators, the new services facilitator shall complete a reassessment visit in lieu of a comprehensive visit.

[c. This employer management training shall be completed before the individual or EOR may hire an assistant who is to be reimbursed by DMAS.]

4. After the initial visit, the services facilitator shall continue to monitor the individual's Plan for Supports quarterly (i.e., every 90 days) and more often as-needed. If CD respite services are provided, the services facilitator shall review the utilization of CD respite services either every six months or upon the use of [~~100~~ 240] respite services hours, whichever comes first.

5. A face-to-face meeting shall occur between the services facilitator and the individual at least every six months to reassess the individual's needs and to ensure appropriateness of any CD services received by the individual. During these visits with the individual, the services facilitator shall observe,

evaluate, and consult with the individual, EOR, and the individual's family/caregiver, as appropriate, for the purpose of documenting the adequacy and appropriateness of CD services with regard to the individual's current functioning and cognitive status, medical needs, and social needs. The services facilitator's written summary of the visit shall include, but shall not necessarily be limited to:

a. Discussion with the individual and EOR or family/caregiver, as appropriate, whether the particular consumer directed service is adequate to meet the individual's needs;

b. Any suspected abuse, neglect, or exploitation and to whom it was reported;

c. Any special tasks performed by the assistant and the assistant's qualifications to perform these tasks;

d. Individual's and EOR's or family/caregiver's, as appropriate, satisfaction with the assistant's service;

e. Any hospitalization or change in medical condition, functioning, or cognitive status;

f. The presence or absence of the assistant in the home during the services facilitator's visit; and

g. Any other services received and the amount.

6. The services facilitator, during routine visits, shall also review and verify timesheets as needed to ensure that the number of hours approved in the Plan for Supports is not exceeded. If discrepancies are identified, the services facilitator shall discuss these with the individual or the EOR to resolve discrepancies and shall notify the fiscal/employer agent. If an individual is consistently identified as having discrepancies in his timesheets, the services facilitator shall contact the case manager to resolve the situation.

7. The services facilitator shall maintain a record of each individual containing elements as [~~described in DMAS' guidance documents~~ set out in 12VAC30-120-1060].

8. The services facilitator shall be available during standard business hours to the individual or EOR by telephone.

9. If a services facilitator is not selected by the individual, the individual or the family/caregiver serving as the EOR shall perform all of the duties and meet all of the requirements, [~~as set out in the agency's guidance documents~~ including documentation requirements], identified for services facilitation. However, the individual or family/caregiver shall not be reimbursed by DMAS for performing these duties or meeting these requirements.

10. If an individual enrolled in consumer-directed services has a lapse in services facilitator duties for more than 90 consecutive days, and the individual or family/caregiver is not willing or able to assume the service facilitation duties, then the case manager shall notify DMAS or its designated prior authorization contractor and the consumer-directed services shall be discontinued [once the required 10 days notice of this change has been observed]. [The individual whose consumer-directed services have been discontinued shall have the right to appeal this discontinuation action pursuant to 12VAC30-110.] The individual shall be given his choice of an agency for the alternative personal care, respite, or companion services that he was previously obtaining through consumer direction.

11. The CD services facilitator, who is to be reimbursed by DMAS, shall not be the [~~waiver~~] individual [enrolled in the waiver], the individual's case manager, a direct service provider, the individual's spouse, a parent of the individual who is a minor child, or [~~a family/caregiver~~ the EOR] who is employing the assistant/companion.

12. The services facilitator shall document what constitutes the individual's back-up plan in case the assistant [/companion] does not report for work as expected or terminates employment without prior notice.

13. Should the assistant [/companion] not report for work or terminate his employment without notice, then the services facilitator shall, upon the individual's or EOR's request, provide management training to ensure that the individual or the EOR is able to recruit and employ a new assistant [/companion].

14. The limits and requirements for individuals' selection of consumer directed services shall be as follows:

a. In order to be approved to use the CD model of services, the [~~waiver~~] individual [enrolled in the waiver], or if the individual is unable, the [~~family/caregiver~~ designated EOR], shall have the capability to hire, train, and fire his own assistants and supervise the assistants' performance. Case managers shall document in the Individual Support Plan the individual's choice for the CD model and whether or [not] the individual chooses services facilitation. [~~For the individual not selecting SF, the~~ The] case manager shall document in this individual's record that the individual can serve as the EOR or if there is a need for another person to serve as the EOR on behalf of the individual.

b. [~~A waiver~~ An] individual [enrolled in the waiver] who is younger than 18 years of age shall be required to have [~~someone function~~ an adult responsible for functioning in the capacity of an EOR.

c. Specific employer duties shall include checking references of assistants, determining that assistants meet specified qualifications, [timely and accurate completion of hiring packets,] training the assistants, supervising assistants' performance, and submitting complete and accurate timesheets to the fiscal/employer agent on a consistent and timely basis.

[~~d. Once the individual is authorized for CD services, the individual or the EOR shall successfully complete management training conducted by the services facilitator using DMAS guidance documents before the individual may hire an assistant for Medicaid reimbursement.~~]

M. Skilled nursing services. Service description. These services shall be provided for [~~waiver~~] individuals [enrolled in the waiver] having serious medical conditions and complex health care needs who do not meet home health criteria but who require specific skilled nursing services which cannot be provided by non-nursing personnel. Skilled nursing services may be provided in the [~~waiver~~] individual's home or other community setting on a regularly scheduled or intermittent basis. It may include consultation, nurse delegation as appropriate, oversight of direct support staff as appropriate, and training for other providers.

1. In order to qualify for these services, the [~~waiver~~] individual [enrolled in the waiver] shall have demonstrated complex health care needs that require specific skilled nursing services as ordered by a physician that cannot be otherwise provided under the Title XIX State Plan for Medical Assistance, such as under the home health care benefit.

2. Service units and service limitations. Skilled nursing services [~~to~~ shall] be rendered by a registered nurse or licensed practical nurse as defined in 12VAC30-120-1000 and shall be provided in hourly units in accordance with the DMAS fee schedule as set out in DMAS guidance documents. The services shall be explicitly detailed in a Plan for Supports and shall be specifically ordered by a physician as medically necessary [~~to prevent institutionalization~~].

N. Supported employment services. Service description. These services shall consist of [~~intensive.~~] ongoing supports that enable individuals to be employed in [~~a regular~~ an integrated] work setting and may include assisting the individual to locate a job or develop a job on behalf of the individual, as well as activities needed to sustain paid work by the individual including skill-building supports and safety supports on a job site. These services shall be provided in work settings where persons without disabilities are employed. [~~It is~~ Supported employment services shall be] especially designed for individuals with developmental disabilities, including individuals with [~~MR/ID~~ ID], who face severe impediments to employment due to the nature and complexity of their disabilities, irrespective of age or vocational potential (i.e., [the] individual's ability to perform work).

1. Supported employment services shall be available to individuals for whom competitive employment at or above the minimum wage is unlikely without ongoing supports and who because of their disabilities need ongoing support to perform in a work setting. The individual's assessment and Individual Support Plan must clearly reflect the individual's need for employment-related skill building.

2. Supported employment shall be provided in one of two models: individual or group.

a. Individual supported employment shall be defined as [~~intermittent~~] support, usually provided one-on-one by a job coach to an individual in a supported employment position. For this service, reimbursement of supported employment shall be limited to actual documented interventions or collateral contacts by the provider, not the amount of time the [~~waiver~~] individual [enrolled in the waiver] is in the supported employment situation.

b. Group supported employment shall be defined as continuous support provided by staff to eight or fewer individuals with disabilities who work in an enclave, work crew, bench work, or in an entrepreneurial model.

3. Criteria.

a. Only job development tasks that specifically [~~include~~ pertain to] the individual shall be allowable [~~job search~~] activities under the [~~MR/ID waiver~~ ID Waiver] supported employment service and DMAS shall cover this service only after determining that this service is not available from DRS for this [~~waiver~~] individual [enrolled in the waiver].

b. In order to qualify for these services, the individual shall have demonstrated that competitive employment at or above the minimum wage is unlikely without ongoing supports and, that because of his disability, he needs ongoing support to perform in a work setting.

c. Providers shall participate as requested in the completion of the DBHDS-approved assessment.

d. The Plan for Supports shall document the amount of supported employment required by the individual.

4. Service units and service limitations.

a. Service providers shall be reimbursed only for the amount and type of supported employment included in the individual's Plan for Supports, which must be based on the intensity and duration of the service delivered.

b. The unit of service for individual job placement supported employment shall be one hour. This service shall be limited to 40 hours per week per individual.

c. Group models of supported employment shall be billed according to the DMAS fee schedule.

d. Group supported employment shall be limited to 780 [~~unit~~] blocks per individual, or its equivalent under the DMAS fee schedule, per Individual Support Plan year. A block shall be defined as a period of time from one hour through three hours and 59 [~~seconds~~ minutes]. [Two blocks are defined as four hours to six hours and 59 minutes. Three blocks are defined as seven hours to nine hours and 59 minutes.] If this service is used in combination with prevocational and day support services, the combined total unit blocks for these three services shall not exceed 780 units, or its equivalent under the DMAS fee schedule, per Individual Support Plan year.

O. Therapeutic consultation. Service description. This service shall provide expertise, training, and technical assistance in any of the following specialty areas to assist family members, caregivers, and other service providers in supporting the [~~waiver~~] individual [enrolled in the waiver]. The specialty areas shall be (i) psychology, (ii) behavioral consultation, (iii) therapeutic recreation, (iv) speech and language pathology, (v) occupational therapy, (vi) physical therapy, and (vii) rehabilitation engineering. The need for any of these services shall be based on the [~~waiver~~] individuals' Individual Support Plans, and shall be provided to those individuals for whom specialized consultation is clinically necessary and who have additional challenges restricting their abilities to function in the community. Therapeutic consultation services may be provided in individuals' homes, and in appropriate community settings (such as licensed or approved homes or day support programs) [~~and shall be~~ as long as they are] intended to facilitate implementation of individuals' desired outcomes as identified in their Individual Support Plans.

1. In order to qualify for these services, the individual shall have a demonstrated need for consultation in any of these services. Documented need must indicate that the Individual Support Plan cannot be implemented effectively and efficiently without such consultation as provided by this covered service.

a. The individual's therapeutic consultation Plan for Supports shall clearly reflect the individual's needs, as documented in the assessment information, for specialized consultation provided to family/caregivers and providers in order to effectively implement the Plan for Supports.

b. Therapeutic consultation services shall not include direct therapy provided to [~~waiver~~] individuals [~~or monitoring activities~~ enrolled in the waiver] and shall not duplicate the activities of other services that are available to the individual through the State Plan for Medical Assistance.

2. The unit of service shall be one hour. The services must be explicitly detailed in the Plan for Supports. Travel time, written preparation, and telephone communication shall be considered as in-kind expenses within this service and shall not be reimbursed as separate items. Therapeutic consultation shall not be billed solely for purposes of monitoring the individual.

3. Only behavioral consultation in this therapeutic consultation service may be offered in the absence of any other waiver service when the consultation is determined to be necessary [~~to prevent institutionalization~~].

P. Transition services. Transition services, as defined at [and controlled by] 12VAC30-120-2000 and 12VAC30-120-2010, provide for set-up expenses for qualifying applicants. The [~~MR/ID~~ ID] case manager shall coordinate with the discharge planner to ensure that [~~MR/ID~~ ID] Waiver eligibility criteria shall be met. [~~1.~~] Transition services shall be prior authorized by DMAS or its designated agent in order for reimbursement to occur.

[~~2. For the purposes of transition funding, an institution means an ICF/MR, as defined at 42 CFR 435.1009, long stay hospital, or nursing facility.~~]

12VAC30-120-1030. [Reserved]

12VAC30-120-1040. General requirements for participating providers.

A. Requests for participation [as Medicaid providers of waiver services] shall be screened by DMAS or its designated contractor to determine whether the provider applicant meets the basic requirements for provider participation. [All providers must be currently enrolled with DMAS in order to be reimbursed for services rendered. Providers who are not enrolled shall not be reimbursed. Consumer-directed assistants shall not be considered Medicaid providers for the purpose of enrollment procedures.]

B. For DMAS to approve provider agreements with home and community-based waiver providers, the following standards shall be met:

1. For services that have licensure and certification requirements, [~~licensure and certification requirements~~ the standards of any state licensure or certification requirements, or both as applicable] pursuant to 42 CFR 441.302;

2. Disclosure of ownership pursuant to 42 CFR 455.104 and 42 CFR 455.105; and

3. The ability to document and maintain individual records in accordance with state and federal requirements.

C. Providers approved for participation shall, at a minimum, perform the following activities:

1. Screen all new and existing employees and contractors to determine whether any are excluded from eligibility for payment from federal healthcare programs, including Medicaid (i.e., via the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals or Entities (LEIE) website). Immediately report in writing to DMAS any exclusion information discovered to: DMAS, ATTN: Program Integrity/Exclusions, 600 E. Broad St., Suite 1300, Richmond, VA 23219 or emailed to providerexclusion@dmas.virginia.gov;

2. Immediately notify DMAS and DBHDS, in writing, of any change in the information that the provider previously submitted [, for the purpose of the provider agreement,] to DMAS and DBHDS;

3. Assure freedom of choice to individuals in seeking services from any institution, pharmacy, practitioner, or other provider qualified to perform the service or services required and participating in the Medicaid program at the time the service or services were performed;

4. Assure the individual's freedom to refuse medical care, treatment, and services;

5. Accept referrals for services only when staff is available to initiate services and perform, as may be required, such services on an ongoing basis;

6. Provide services and supplies to individuals in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000d et seq.), which prohibits discrimination on the grounds of race, color, or national origin; the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia); § 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), which prohibits discrimination on the basis of a disability; [the Fair Housing Amendments Act of 1988 (42 USC § 3601 et seq.);] and the Americans with Disabilities Act, as amended (42 USC § 12101 et seq.), which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications;

7. Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public;

8. Submit charges to DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public and accept as payment in full the amount established by [the] DMAS payment methodology from the individual's authorization date for the waiver services;

9. Use program-designated billing forms for submission of charges;

10. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided;

a. In general, such records shall be retained for at least six years from the last date of service or as provided by applicable state or federal laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved. Records of minors shall be kept for at least six years after such minor has reached the age of 18 years.

b. Policies regarding retention of records shall apply even if the provider discontinues operation. DMAS shall be notified in writing of storage location and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth of Virginia.

11. Agree to furnish information on request and in the form requested to DMAS, DBHDS, the Attorney General of Virginia or his authorized representatives, federal personnel, and the state Medicaid Fraud Control Unit. The Commonwealth's right of access to provider agencies and records shall survive any termination of the provider agreement. No business or professional records shall be created or modified by providers once an audit has been initiated;

12. Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to individuals receiving Medicaid;

13. Hold confidential and use for authorized DMAS or DBHDS purposes only, all medical assistance information regarding individuals served pursuant to Subpart F of 42 CFR Part 431, 12VAC30-20-90, and any other applicable state or federal law. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of [~~the~~] DMAS in conjunction with the cited laws;

14. Notify DMAS of change of ownership. When ownership of the provider changes, DMAS shall be notified at least 15 calendar days before the date of change;

15. Comply with applicable standards that meet the requirements for board and care facilities for all facilities covered by § 1616(e) of the Social Security Act in which home and community-based waiver services will be provided. Health and safety standards shall be monitored through the DBHDS' licensure standards or through VDSS-approved standards for adult foster care providers;

16. Immediately report, pursuant to §§ 63.2-1509 and 63.2-1606 of the Code of Virginia, such knowledge if a participating provider knows or suspects that [an individual enrolled in] a home and community-based waiver service [~~individual~~] is being abused, neglected, or exploited. The party having knowledge or suspicion of the abuse, neglect, or exploitation shall from first knowledge report [the same] to the local department of social services' adult or child protective services worker and to DBHDS Offices of Licensing and Human Rights as applicable;

17. Perform criminal history record checks for barrier crimes, as [~~herein~~] defined [in 12VAC30-120-1000], within 15 days from the date of employment. If the [~~waiver~~] individual [enrolled in the waiver] to be served is a minor child, perform a search of the VDSS Child Protective Services Central Registry. The [personal care/respite] assistant or companion [for either agency-directed or consumer-directed services] shall not be compensated for services provided to the [~~waiver~~] individual [enrolled in the waiver] if any of these records checks verifies that the assistant or companion has been convicted of crimes described in § 37.2-416 of the Code of Virginia or if the assistant or companion has a finding in the VDSS Child Protective Services Central Registry; or if the assistant or companion is determined by a local department of social services as having abused, neglected, or exploited an adult 60 years of age or older or an adult who is 18 years of age [~~regardless of capacity~~ if incapacitated]. The personal assistant or companion shall not be reimbursed by DMAS for services provided to the [~~waiver~~] individual [enrolled in the waiver] effective on the date and thereafter that the criminal record check verifies that the assistant or companion has been convicted of crimes described in § 37.2-416 of the Code of Virginia. The personal assistant (for either agency-directed or consumer-directed services) and companion shall notify either their employer or the services facilitator, the [~~waiver~~] individual [enrolled in the waiver] and [~~family/caregiver, and~~] EOR, as appropriate, of all convictions occurring subsequent to this record check. Failure to report any subsequent convictions may result in termination of employment. Assistants or companions who refuse to consent to child protective services registry checks shall not be eligible for Medicaid reimbursement of services that they may provide;

18. Refrain from performing any type of direct marketing activities [, as defined in 12VAC30-120-1000,] to Medicaid [~~recipients~~ individuals]; [~~and~~]

19. Adhere to the provider participation agreement and the [~~DMAS provider service manual~~ Virginia Medicaid Provider Manual]. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their individual provider participation agreements and in the [~~DMAS provider manual.~~ Virginia Medicaid Provider Manual; and

20. Participate, as may be requested, in the completion of the DBHDS-approved assessment instrument when the provider possesses specific, relevant information about the individual enrolled in the waiver.]

D. DMAS [or its contractor] shall be responsible for assuring continued adherence to provider participation standards. DMAS [or its contractor] shall conduct ongoing monitoring of compliance with provider participation standards and DMAS' policies and periodically [~~re-certify~~ recertify] each provider for participation agreement renewal to provide home and community-based waiver services. A provider's noncompliance with DMAS' policies and procedures, as required in the provider's participation agreement, may result in a written request from DMAS for a corrective action plan that details the

steps the provider must take and the length of time permitted to achieve full compliance with the plan to correct the deficiencies that have been cited. Failure to comply may result in termination of the provider enrollment agreement as well as other sanctions.

E. Felony convictions. DMAS shall immediately terminate the provider's Medicaid provider agreement pursuant to § 32.1-325 of the Code of Virginia [~~and~~] as may be required for federal financial participation. A provider who has been convicted of a felony, or who has otherwise pled guilty to a felony, in Virginia or in any other of the 50 states, the District of Columbia, or the U.S. Territories shall, within 30 days of such conviction, notify DMAS of this conviction and relinquish its provider agreement. Such provider agreement terminations shall be effective immediately and conform to 12VAC30-10-690 and 12VAC30-20-491.

1. Providers shall not be reimbursed for services that may be rendered between the conviction of a felony and the provider's notification to DMAS of the conviction.

2. Except as otherwise provided by applicable state or federal law, the Medicaid provider agreement may be terminated [by DMAS] at will on 30 days written notice. The agreement may be terminated if DMAS determines that the provider poses a threat to the health, safety, or welfare of any individual enrolled in a DMAS administered program.

3. A participating provider may voluntarily terminate his participation with DMAS by providing 30 days written notification.

F. Providers shall [be required to] use [~~the required forms~~ IDOLS] to document services, for purposes of reimbursement, to [~~waiver~~] individuals [enrolled in the waiver]. The DBHDS approved assessment shall be the Supports Intensity Scale (SIS), as published by the American Association on Intellectual and Developmental Disabilities and as may be amended from time to time [~~, or its required successor form. Such forms shall be further described and discussed in the agency's guidance documents for this waiver program~~].

[~~1. The Supports Intensity Scale form's use shall be phased-in across all CSBs/BHAs with completion effective by July 2012. During the phase-in process, CSBs/BHAs may use alternative assessment forms with the approval of DBHDS.~~

2. ~~This provision for the phase-in process of the use of the SIS shall sunset effective July 1, 2012, except if otherwise noted in agency guidance documents. During the phase-in process, CSBs/BHAs may use alternative assessment forms with the approval of DBHDS.~~]

G. Fiscal employer/agent requirements. Pursuant to a duly negotiated contract or interagency agreement, the contractor or entity shall be reimbursed by DMAS to perform certain employer functions including, but not limited to, payroll and bookkeeping functions on the part of the [~~waiver~~] individual/employer who is receiving consumer-directed services.

1. The fiscal employer/agent shall be responsible for administering payroll services on behalf of the [~~waiver~~] individual [enrolled in the waiver] including, but not limited to:

a. Collecting and maintaining citizenship and alien status employment eligibility information required by the Department of Homeland Security;

b. Securing all necessary authorizations and approvals in accordance with state and federal tax requirements;

c. Deducting and filing state and federal income and employment taxes and other withholdings;

d. Verifying that assistants' or companions' submitted timesheets do not exceed the maximum hours prior authorized for [~~waiver~~] individuals [enrolled in the waiver];

e. Processing timesheets for payment;

f. Making all deposits of income taxes, FICA, and other withholdings according to state and federal requirements; and

g. Distributing bi-weekly payroll checks to [~~waiver~~] individuals' assistants.

2. All timesheet discrepancies shall be reported promptly upon their identification to DMAS for investigation and resolution.

3. The fiscal employer/agent shall maintain records and information as required by DMAS and state and federal laws and regulations and make such records available upon DMAS' request in the needed format.

4. The fiscal employer/agent shall establish and operate a customer service center to respond to individuals' and assistants' payroll and related inquiries.

5. The fiscal employer/agent shall maintain confidentiality of all Medicaid information pursuant to HIPAA and DMAS requirements. Should any breaches of confidential information occur, the fiscal/employer agent shall assume all liabilities under both state and federal law.

H. Changes to or termination of services. DBHDS shall have the authority, subject to final approval by DMAS, to approve changes to [~~a waiver~~ an] individual's Individual Support Plan, based on the recommendations of the case management provider.

1. Providers of direct services shall be responsible for modifying their plans for supports, with the involvement of the [~~waiver~~] individual [enrolled in the waiver] and the individual's family/caregiver, as appropriate, and submitting such revised plans for supports to the case manager any time there is a change in the [~~waiver~~] individual's condition or circumstances that may warrant a change in the amount or type of service rendered.

(a) The case manager shall review the need for a change and may recommend a change to the plan for supports to the DBHDS staff.

(b) DBHDS shall review and approve, deny, or suspend for additional information, the requested change or changes to the individual's Plan for Supports. DBHDS shall communicate its determination to the case manager within 10 business days of receiving all supporting documentation regarding the request for change or in the case of an emergency within three [~~working~~ business] days of receipt of the request for change.

2. The [~~waiver~~] individual [enrolled in the waiver] and the individual's family/caregiver, as appropriate, shall be notified in writing by the case manager of his right to appeal pursuant to DMAS client appeals regulations, Part I of 12VAC30-110, about the decision or decisions to reduce, terminate, suspend, or deny services. The case manager shall submit this written notification to the [~~waiver~~] individual [enrolled in the waiver] within 10 business days of the decision.

3. In a nonemergency situation, when a participating provider determines that services to [~~a waiver~~ an] individual [enrolled in the waiver] must be terminated, the participating provider shall give the individual and the individual's family/caregiver, as appropriate, and case manager 10 business days

written notification of the provider's intent to discontinue services. The notification letter shall provide the reasons for the planned termination and the effective date the provider will be discontinuing services. The effective date shall be at least 10 business days from the date of the notification letter. The [~~waiver~~] individual [enrolled in the waiver] shall [~~not~~] be eligible for appeal rights in this situation and may pursue services from another provider.

4. In an emergency situation when the health, safety, [~~and~~ or] welfare of the [~~waiver~~] individual [enrolled in the waiver], other individuals in that setting, or provider personnel are endangered, the case manager and DBHDS shall be notified prior to discontinuing services. The 10-business-day [prior] written notification period shall not be required. The local department of social services adult protective services unit or child protective services unit, as appropriate, and DBHDS Offices of Licensing and Human Rights shall be notified immediately [by the case manager and the provider] when the individual's health, safety, [~~and~~ or] welfare may be in danger.

5. The case manager shall have the responsibility to identify those individuals who no longer meet the level of care criteria or for whom home and community-based waiver services are no longer an appropriate alternative. In such situations, such individuals shall be discharged from the waiver.

(a) The case manager shall notify the individual of this determination and afford the individual and family/caregiver, as appropriate, with his right to appeal such discharge.

(b) The individual shall be entitled to the continuation of his waiver services pending the final outcome of his appeal action. Should the appeal action confirm the case manager's determination that the individual shall be discharged from the waiver, the individual shall be responsible for the costs of his waiver services incurred by DMAS during his appeal action.

12VAC30-120-1060. Participation standards for provision of services; providers' requirements.

A. The required documentation for residential support services, day support services, supported employment services, and prevocational support shall be as follows:

1. A completed copy of the DBHDS-approved SIS assessment form [, or] its approved alternative form during the phase in period [~~, or its successor form as specified in DBHDS guidance documents~~].

2. A Plan for Supports containing, at a minimum, the following elements:

(a) The [~~waiver~~] individual's strengths, desired outcomes, required or desired supports or both, and skill-building needs;

(b) The [~~waiver~~] individual's support activities to meet the identified outcomes;

(c) The services to be rendered and the schedule of such services to accomplish the above desired outcomes and support activities;

(d) A timetable for the accomplishment of the [~~waiver~~] individual's desired outcomes and support activities;

(e) The estimated duration of the [~~waiver~~] individual's needs for services; and

(f) The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports.

3. Documentation indicating that the Plan for Supports' desired outcomes and support activities have been reviewed by the provider quarterly, annually, and more often as needed. The results of the review must be submitted to the case manager. For the annual review and in cases where the Plan for Supports is modified, the Plan for Supports shall be reviewed with [and agreed to by] the individual [enrolled in the waiver] and the individual's family/caregiver, as appropriate.

4. All correspondence to the individual and the individual's family/caregiver, as appropriate, the case manager, DMAS, and DBHDS.

5. Written documentation of contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.

B. The required documentation for personal assistance services, respite services, and companion services shall be as set out in this subsection. The agency provider holding the service [~~prior~~] authorization or the services facilitator [, or the EOR in the absence of a services facilitator,] shall maintain records regarding each individual who is receiving services. At a minimum, these records shall contain:

1. A copy of the completed DBHDS-approved SIS assessment (or its approved alternative during the phase in [~~period or its required successor form as specified in DBHDS guidance documents~~ period)] and, as needed, an initial assessment completed by the supervisor or services facilitator prior to or on the date services are initiated.

2. A Plan for Supports, that contains, at a minimum, the following elements:

(a) The individual's strengths, desired outcomes, required or desired supports;

(b) The individual's support activities to meet these identified outcomes;

(c) Services to be rendered and the frequency of such services to accomplish the above desired outcomes and support activities; and

(d) For the agency-directed model, the provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports. For the consumer-directed model, the identifying information for the assistant or assistants and the Employer of Record.

3. Documentation indicating that the Plan for Supports' desired outcomes and support activities have been reviewed by the provider quarterly, annually, and more often as needed. The results of the review must be submitted to the case manager. For the annual review and in cases where the Plan for Supports is modified, the Plan for Supports shall be reviewed with [and agreed to by] the individual [enrolled in the waiver] and the individual's family/caregiver, as appropriate.

4. The companion services supervisor or CD services facilitator, as required by [~~12VAC30-120-1060~~ 12VAC30-120-1020], shall document in the [~~waiver~~] individual's record in a summary note following significant contacts with the companion and home visits with the individual:

a. Whether companion services continue to be appropriate;

b. Whether the plan is adequate to meet the individual's needs or changes are indicated in the plan;

c. The individual's satisfaction with the service;

d. The presence or absence of the companion during the supervisor's visit;

e. Any suspected abuse, neglect, or exploitation and to whom it was reported; and

f. Any hospitalization or change in medical condition, and functioning or cognitive status;

5. All correspondence to the individual and the individual's family/caregiver, as appropriate, the case manager, DMAS, and DBHDS; [~~and~~]

6. Contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual [~~.~~; and

7. Documentation provided by the case manager as to why there are no providers other than family members available to render respite assistant care if this service is part of the individual's Plan for Supports.]

C. The required documentation for assistive technology, environmental modifications (EM), and Personal Emergency Response Systems (PERS) shall be as follows:

1. The appropriate [~~Individualized Service Authorization Request (ISAR) form~~ IDOLS documentation], to be completed by the case manager, may serve as the Plan for Supports for the provision of AT, EM, and PERS services. A rehabilitation engineer may be involved for AT or EM services if disability expertise is required that a general contractor may not have. The [~~Plan for Supports/ISAR~~ Plan for Supports/IDOL] shall include justification and explanation that a rehabilitation engineer is needed, if one is required. The [~~ISAR~~ IDOL] shall be submitted to the state-designated agency or its contractor in order for [~~prior~~ service] authorization to occur;

2. Written documentation for AT services regarding the process and results of ensuring that the item is not covered by the State Plan for Medical Assistance as DME and supplies, and that it is not available from a DME provider;

3. AT documentation of the recommendation for the item by a qualified professional;

4. Documentation of the date services are rendered and the amount of service that is needed;

5. Any other relevant information regarding the device or modification;

6. Documentation in the case management record of notification by the designated individual or individual's representative family/caregiver of satisfactory completion or receipt of the service or item; and

7. Instructions regarding any warranty, repairs, complaints, or servicing that may be needed.

D. Assistive technology (AT). In addition to meeting the [service coverage requirements in 12VAC30-120-1020 and the] general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-1040, AT shall be provided by DMAS-enrolled [~~DME~~

durable medical equipment (DME)] providers or DMAS-enrolled CSBs/BHAs with [~~a MR/ID~~ an ID] Waiver provider agreement to provide AT. DME shall be provided in accordance with 12VAC30-50-165.

E. Companion services (both agency-directed and consumer-directed). In addition to meeting the [service coverage requirements in 12VAC30-120-1020 and the] general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-1040, companion service providers shall meet the following qualifications:

1. For the agency-directed model, the provider shall be licensed by DBHDS as either a residential service provider, supportive in-home residential service provider, day support service provider, or respite service provider or [shall] meet the DMAS criteria to be a personal care/respite care provider.

2. For the consumer-directed model, there may be a services facilitator (or person serving in this capacity) meeting the requirements found in 12VAC30-120-1020.

3. Companion qualifications. Persons functioning as companions shall meet the following requirements:

a. Be at least 18 years of age;

b. Be able to read and write English to the degree required to function in this capacity and possess basic math skills;

c. Be capable of following a Plan for Supports with minimal supervision and be physically able to perform the required work;

d. Possess a valid social security number that has been issued by the Social Security Administration to the person who is to function as the companion;

e. Be capable of aiding in IADLs; and

f. Receive an annual tuberculosis screening.

4. Persons rendering companion services for reimbursement by DMAS shall not be the [~~waiver~~] individual's spouse. Other family members living under the same roof as the individual being served may not provide companion services unless there is objective written documentation [~~, as defined in the DMAS MR/ID Provider Manual,~~ completed by the services facilitator, or the EOR when the individual does not select services facilitation,] as to why there are no other providers available to provide companion services.

[~~a. For CD companion services, the case manager shall determine and document why no other providers are available.~~]

[~~b.~~ a.] Family members who are approved to be reimbursed by DMAS to provide companion services shall meet all of the companion qualifications.

[~~c.~~ b.] Companion services shall not be provided by adult foster care providers or any other paid caregivers for an individual residing in that foster care home.

5. For the agency-directed model, companions shall be employees of enrolled providers that have participation agreements with DMAS to provide companion services. Providers shall be required to have a companion services supervisor to monitor companion services. The companion services

supervisor shall have a bachelor's degree in a human services field and have at least one year of experience working in the [~~MR/ID~~ ID] field, or be a licensed practical nurse (LPN) or a registered nurse (RN) with at least one year of experience working in the [~~MR/ID~~ ID] field. Such LPNs and RNs shall have the appropriate current licenses to either practice nursing in the Commonwealth or have multi-state licensure privilege as defined herein.

6. The companion services supervisor or services facilitator, as appropriate, shall conduct an initial home visit prior to initiating companion services to document the efficacy and appropriateness of such services and to establish a Plan for Supports for the [~~waiver~~] individual [enrolled in the waiver]. The companion services supervisor or services facilitator must provide quarterly follow-up home visits to monitor the provision of services under the agency-directed model and semi-annually (every six months) under the consumer-directed model or more often as needed.

7. In addition to the requirements in subdivisions 1 through 6 of this subsection the companion record for agency-directed service providers must also contain:

(a) The specific services delivered to the [~~waiver~~] individual [enrolled in the waiver] by the companion, dated the day of service delivery, and the individual's responses;

(b) The companion's arrival and departure times;

(c) The companion's weekly comments or observations about the [~~waiver~~] individual [enrolled in the waiver] to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and

(d) The companion's and individual's and the individual's family/caregiver's, as appropriate, weekly signatures recorded on the last day of service delivery for any given week to verify that companion services during that week have been rendered.

8. Consumer-directed model companion record. In addition to the requirements outlined in this subsection, the companion record for services facilitators must contain:

[~~(1)~~ a.] The services facilitator's dated notes documenting any contacts with the [~~waiver~~] individual [enrolled in the waiver] and the individual's family/caregiver, as appropriate, and visits to the individual's home;

[~~(2)~~ b.] Documentation of training provided to the companion by the individual or EOR, as appropriate;

[~~(3)~~ c.] Documentation of all [~~employee~~ employer] management training provided to the [~~waiver~~] individual [~~and the individual's family/caregiver, as appropriate~~ enrolled in the waiver or the EOR], including the individual's and the [~~individual's family/caregiver's~~ EOR's], as appropriate, receipt of training on their [legal] responsibility for the accuracy [and timeliness] of the companion's timesheets; and

[~~(4)~~ d.] All documents signed by the [~~waiver~~] individual [enrolled in the waiver] and the EOR [~~, as appropriate.~~] that acknowledge their responsibilities and legal liabilities as the companion's or companions' employer, as appropriate.

F. Crisis stabilization services. In addition to the [service coverage requirements in 12VAC30-120-1020 and the] general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-1040, the following crisis stabilization provider qualifications shall apply:

1. A crisis stabilization services provider shall be licensed by DBHDS as a provider of either outpatient services, crisis stabilization services, residential services with a crisis stabilization track, supportive residential services with a crisis stabilization track, or day support services with a crisis stabilization track.

2. The provider shall employ or use QMRPs, licensed mental health professionals, or other qualified personnel who have demonstrated competence to provide crisis stabilization and related activities to individuals with [~~MR/ID~~ ID] who are experiencing serious psychiatric or behavioral problems. [~~The QMRP shall have: (i) at least one year of documented experience working directly with individuals who have MR/ID or developmental disabilities; (ii) at least either a bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology, or a bachelor's degree in another field in addition to an advanced degree in a human services field; and (iii) the required Virginia or national license, registration, or certification in accordance with his profession.~~]

3. To provide the crisis supervision component, providers must be licensed by DBHDS as providers of residential services, supportive in-home residential services, or day support services. Documentation of providers' qualifications shall be maintained for review by DBHDS and DMAS staff or DMAS' designated agent.

4. A Plan for Supports must be developed or revised and submitted to the case manager for submission to DBHDS within 72 hours of the requested start date for authorization.

5. Required documentation in the [~~waiver~~] individual's record. The provider shall maintain a record regarding each [~~waiver~~] individual [enrolled in the waiver] who is receiving crisis stabilization services. At a minimum, the record shall contain the following:

a. Documentation of the face-to-face assessment and any reassessments completed by a QMRP;

b. A Plan for Supports that contains, at a minimum, the following elements:

(1) The individual's strengths, desired outcomes, required or desired supports;

(2) Services to be rendered and the frequency of services to accomplish these desired outcomes and support activities;

(3) A timetable for the accomplishment of the individual's desired outcomes and support activities;

(4) The estimated duration of the individual's needs for services; and

(5) The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports; and

c. Documentation indicating the dates and times of crisis stabilization services, the amount and type of service or services provided, and specific information regarding the individual's response to the services and supports as agreed to in the Plan for Supports.

G. Day support services. In addition to meeting the [service coverage requirements in 12VAC30-120-1020 and the] general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-1040, day support providers, for both intensive and regular service levels, shall meet the following additional requirements:

1. The provider of day support services must be specifically licensed by DBHDS as a provider of day support services. [(12VAC 35-105-20)]

2. In addition to licensing requirements, day support staff shall also have training in the characteristics of [~~MR/ID~~ intellectual disabilities] and the appropriate interventions, skill building strategies, and support methods for individuals with [~~MR/ID~~ intellectual disabilities] and such functional limitations. All providers of day support services shall pass an objective, standardized test of skills, knowledge, and abilities approved by DBHDS and administered according to DBHDS' defined procedures. (See www.dbhds.virginia.gov for further information.)

3. Documentation confirming the individual's attendance and amount of time in services and specific information regarding the individual's response to various settings and supports as agreed to in the Plan for Supports. An attendance log or similar document must be maintained that indicates the individual's name, date, type of services rendered, staff signature and date, and the number of service units delivered, in accordance with the DMAS fee schedule.

4. Documentation indicating whether the services were center-based or noncenter-based shall be included on the Plan for Supports.

5. In instances where day support staff may be required to ride with the [~~waiver~~] individual [enrolled in the waiver] to and from day support services, the day support staff transportation time may be billed as day support services and documentation maintained, provided that billing for this time does not exceed 25% of the total time spent in day support services for that day.

6. If intensive day support services are requested, documentation indicating the specific supports and the reasons they are needed shall be included in the Plan for Supports. For ongoing intensive day support services, there shall be specific documentation of the ongoing needs and associated staff supports.

H. Environmental modifications. In addition to meeting the [service coverage requirements in 12VAC30-120-1020 and the] general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-1040, environmental modifications shall be provided in accordance with all applicable federal, state, or local building codes and laws by CSBs/BHAs contractors or DMAS-enrolled providers.

I. Personal assistance services (both consumer-directed and agency directed models). In addition to meeting the [service coverage requirements in 12VAC30-120-1020 and the] general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-1040, personal assistance providers shall meet additional provider requirements:

1. For the agency-directed model, services shall be provided by an enrolled DMAS personal care provider or by a residential services provider licensed by the DBHDS that is also enrolled with DMAS. All [agency-directed] personal assistants shall pass an objective standardized test of skills, knowledge, and abilities approved by DBHDS that must be administered according to DBHDS' defined procedures.

2. For the CD model, services shall meet the requirements found in 12VAC30-120-1020.

3. For DBHDS-licensed residential services providers, a residential supervisor shall provide ongoing supervision of all personal assistants.

4. For DMAS-enrolled personal care providers, the provider shall employ or subcontract with and directly supervise an RN or an LPN who shall provide ongoing supervision of all assistants. The supervising RN or LPN [shall] have at least one year of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, [~~ICF/MR~~ ICF/ID], or nursing facility.

5. For agency-directed services, the supervisor, or for CD services the services facilitator, shall make a home visit to conduct an initial assessment prior to the start of services for all [~~waiver~~] individuals [enrolled in the waiver] requesting, and who have been approved to receive, personal assistance services. The supervisor or services facilitator, as appropriate, shall also perform any subsequent reassessments or changes to the Plan for Supports. [All changes that are indicated for an individual's Plan for Supports shall be reviewed with and agreed to by the individual and, if appropriate, the family/caregiver.]

6. The supervisor or services facilitator, as appropriate, shall make supervisory home visits as often as needed to ensure both quality and appropriateness of services. The minimum frequency of these visits shall be every 30 to 90 days under the agency-directed model and semi-annually (every six months) under the CD model of services, depending on the [~~waiver~~] individual's needs.

7. Based on continuing evaluations of the assistant's performance and individual's needs, the supervisor (for agency-directed services) or the individual or the employer of record (EOR) (for the CD model) shall identify any gaps in the assistant's ability to function competently and shall provide training as indicated.

8. Qualifications for consumer directed personal assistants. The assistant shall:

a. Be 18 years of age or older and possess a valid social security number that has been issued by the Social Security Administration to the person who is to function as the attendant;

b. Be able to read and write English to the degree necessary to perform the tasks expected and possess basic math skills;

c. Have the required skills and physical abilities to perform the services as specified in the individual's Plan for Supports;

d. Be willing to attend training at the [~~waiver~~] individual's [~~and the family/caregiver's,~~] and EOR's, as appropriate, request;

e. Understand and agree to comply with the DMAS' [~~MR/ID~~ ID] Waiver requirements [as contained in this part (12VAC30-120-1000 et seq.)]; and

f. Receive an annual tuberculosis screening.

9. Additional requirements for DMAS-enrolled (agency-directed) personal care providers.

a. Personal assistants shall have completed an educational curriculum of at least 40 hours of study related to the needs of individuals who have disabilities, including intellectual/developmental disabilities, as ensured by the provider prior to being assigned to support an individual, and have the required skills and training to perform the services as specified in the individual's Plan for Supports and related supporting documentation. Personal assistants' required training, as further detailed in the applicable provider manual, shall be met in one of the following ways:

(1) Registration with the Board of Nursing as a certified nurse aide;

(2) Graduation from an approved educational curriculum as listed by the Board of Nursing; or

(3) Completion of the provider's educational curriculum, as conducted by a licensed RN who shall have at least one year of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, [~~ICF/MR~~ ICF/ID], or nursing facility.

b. Assistants shall have a satisfactory work record, as evidenced by two references from prior job experiences, if applicable, including no evidence of possible abuse, neglect, or exploitation of elderly persons, children, or adults with disabilities.

10. Personal assistants to be paid by DMAS shall not be the parents of [~~waiver~~] individuals [enrolled in the waiver] who are [~~minors~~ minor children] or the individuals' spouses.

a. Payment shall not be made for services furnished by other family members living under the same roof as the [~~waiver~~] individual [enrolled in the waiver] receiving services unless there is objective written documentation [completed by the services facilitator, or the case manager when the individual does not select services facilitation,] as to why there are no other providers available to render the services [~~required by the waiver individual. The case manager shall make and document this determination~~].

b. Family members who are approved to be reimbursed for providing this service shall meet the same qualifications as all other personal assistants.

11. Provider inability to render services and substitution of assistants (agency-directed model).

a. When assistants are absent or otherwise unable to render scheduled supports to [~~waiver~~] individuals [enrolled in the waiver], the provider shall be responsible for ensuring that services continue to be provided to [the affected] individuals. The provider may either provide another assistant, obtain a substitute assistant from another provider if the lapse in coverage is to be less than two weeks in duration, or transfer the individual's services to another personal care or respite provider. The provider that has the [~~prior~~ service] authorization to provide services to the [~~waiver~~] individual [enrolled in the waiver] must contact the case manager to determine if additional, or modified, [~~prior~~ service] authorization is necessary.

b. If no other provider is available who can supply a substitute assistant, the provider shall notify the individual and the individual's family/caregiver, as appropriate, and the case manager so that the case manager may find another available provider of the individual's choice.

c. During temporary, short-term lapses in coverage that are not expected to exceed approximately two weeks in duration, the following procedures [~~must~~ shall] apply:

(1) The [~~prior~~ service] authorized provider shall provide the supervision for the substitute assistant;

(2) The provider of the substitute assistant shall send a copy of the assistant's daily documentation signed by the assistant, the individual, and the individual's family/caregiver, as appropriate, to the provider having the [service] authorization; and

(3) The [~~prior~~ service] authorized provider shall bill DMAS for services rendered by the substitute assistant.

d. If a provider secures a substitute assistant, the provider agency shall be responsible for ensuring that all DMAS requirements continue to be met including documentation of services rendered by the substitute assistant and documentation that the substitute assistant's qualifications meet DMAS' requirements. The two providers involved shall be responsible for negotiating the financial arrangements of paying the substitute assistant.

12. For the agency-directed model, the personal assistant record shall contain:

a. The specific services delivered to the [~~waiver~~] individual [enrolled in the waiver] by the assistant, dated the day of service delivery, and the individual's responses;

b. The assistant's arrival and departure times;

c. The assistant's weekly comments or observations about the [~~waiver~~] individual [enrolled in the waiver] to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and

d. The assistant's and [~~waiver~~] individual's and the individual's family/caregiver's, as appropriate, weekly signatures recorded on the last day of service delivery for any given week to verify that services during that week have been rendered.

13. The records of [~~waiver~~] individuals [enrolled in the waiver] who are receiving personal assistance services in a congregate residential setting (because skill building services are no longer appropriate or desired for the individual), must contain:

a. The specific services delivered to the [~~waiver~~] individual [enrolled in the waiver], dated the day that such services were provided, the number of hours as outlined in the Plan for Supports, the individual's responses, and observations of the individual's physical and emotional condition; and

b. At a minimum, monthly verification by the residential supervisor of the services and hours rendered and billed to DMAS.

14. For the consumer-directed model, the services facilitator's record shall contain, at a minimum:

a. Documentation of all [~~employee~~ employer] management training provided to the [~~waiver~~] individual [enrolled in the waiver] and the EOR [~~, as appropriate.~~] including the [~~waiver~~] individual [~~and~~ or] the individual's family/caregiver, [as appropriate,] and EOR, as appropriate, receipt of training on their legal responsibilities for the accuracy and timeliness of the assistant's timesheets;

b. All documents signed by the [~~waiver~~] individual [enrolled in the waiver] and the EOR, as appropriate, which acknowledge the responsibilities as the employer.

J. Personal Emergency Response Systems. In addition to meeting the [service coverage requirements in 12VAC30-120-1020 and the] general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-1040, PERS providers shall also meet the following qualifications:

1. A PERS provider shall be either: (i) an enrolled personal care agency; (ii) an enrolled durable medical equipment provider; (iii) a licensed home health provider; or (iv) a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and service calls), and PERS monitoring services.

2. The PERS provider must provide an emergency response center with fully trained operators who are capable of receiving signals for help from an individual's PERS equipment 24-hours a day, 365, or 366, days per year as appropriate, of determining whether an emergency exists, and of notifying an emergency response organization or an emergency responder that the PERS service [~~waiver~~] individual needs emergency help.

3. A PERS provider must comply with all applicable Virginia statutes, applicable regulations of DMAS, and all other governmental agencies having jurisdiction over the services to be performed.

4. The PERS provider shall have the primary responsibility to furnish, install, maintain, test, and service the PERS equipment, as required, to keep it fully operational. The provider shall replace or repair the PERS device within 24 hours of the individual's notification of a malfunction of the console unit, activating devices, or medication-monitoring unit.

5. The PERS provider must properly install all PERS equipment into a PERS individual's functioning telephone line or cellular system and must furnish all supplies necessary to ensure that the PERS system is installed and working properly.

6. The PERS installation shall include local seize line circuitry, which guarantees that the unit shall have priority over the telephone connected to the console unit should the phone be off the hook or in use when the unit is activated.

7. A PERS provider shall install, test, and demonstrate to the individual and family/caregiver, as appropriate, the PERS system before submitting his claim for services to DMAS.

8. A PERS provider shall maintain a data record for each PERS individual at no additional cost to DMAS or DBHDS. The record must document the following:

a. Delivery date and installation date of the PERS;

b. Individual or family/caregiver, as appropriate, signature verifying receipt of PERS device;

c. Verification by a [monthly, or more frequently as needed,] test that the PERS device is operational [~~, monthly or more frequently as needed~~];

d. Updated and current individual responder and contact information, as provided by the individual, the individual's family/caregiver, or case manager; and

e. A case log documenting the individual's utilization of the system and contacts and communications with the individual, family/caregiver, case manager, and responders.

9. The PERS provider shall have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.

10. All PERS equipment shall be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard for home health care signaling equipment [in Underwriter's Laboratories Safety Standard 1637, Standard for Home Health Care Signaling Equipment, Fourth Edition, December 29, 2006]. The UL listing mark on the equipment shall be accepted as evidence of the equipment's compliance

with such standard. The PERS device shall be automatically reset by the response center after each activation, ensuring that subsequent signals can be transmitted without requiring manual reset by the [~~waiver~~] individual [enrolled in the waiver or family/caregiver, as appropriate].

11. A PERS provider shall instruct the individual, family/caregiver, and responders in the use of the PERS service.

12. The emergency response activator shall be able to be activated either by breath, by touch, or by some other means, and must be usable by individuals who are visually or hearing impaired or physically disabled. The emergency response communicator must be capable of operating without external power during a power failure at the individual's home for a minimum period of 24-hours and automatically transmit a low battery alert signal to the response center if the back-up battery is low. The emergency response console unit must also be able to self-disconnect and redial the back-up monitoring site without the individual [or family/caregiver] resetting the system in the event it cannot get its signal accepted at the response center.

13. The PERS provider shall be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It shall be the PERS provider's responsibility to ensure that the monitoring function and the agency's equipment meets the following requirements. The PERS provider must be capable of simultaneously responding to signals for help from multiple individuals' PERS equipment. The PERS provider's equipment shall include the following:

a. A primary receiver and a back-up receiver, which must be independent and interchangeable;

b. A back-up information retrieval system;

c. A clock printer, which must print out the time and date of the emergency signal, the PERS individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;

d. A back-up power supply;

e. A separate telephone service;

f. A toll-free number to be used by the PERS equipment in order to contact the primary or back-up response center; and

g. A telephone line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

14. The PERS provider shall maintain detailed technical and operations manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment, emergency response protocols, and recordkeeping and reporting procedures.

15. The PERS provider shall document and furnish within 30 days of the action taken a written report to the case manager for each emergency signal that results in action being taken on behalf of the individual [~~. This excludes~~, excluding] test signals or activations made in error.

K. Prevocational services. In addition to meeting the [service coverage requirements in 12VAC30-120-1020 and the] general conditions and requirements for home and community-based services participating providers as specified in 12VAC30-120-1040, prevocational providers shall also meet the following qualifications:

1. The provider of prevocational services shall be a vendor of either extended employment services, long-term employment services, or supported employment services for DRS, or be licensed by DBHDS as a provider of day support services. Both licensee groups must also be enrolled with DMAS.

2. In addition to licensing requirements, prevocational staff shall also have training in the characteristics of [~~MR/ID~~ ID] and the appropriate interventions, skill building strategies, and support methods for individuals with [~~MR/ID~~ ID] and such functional limitations. All providers of prevocational services shall pass an objective, standardized test of skills, knowledge, and abilities approved by DBHDS and administered according to DBHDS' defined procedures. (See www.dbhds.virginia.gov for further information.)

3. [~~Documentation~~ Preparation and maintenance of documentation] confirming the individual's attendance and amount of time in services and specific information regarding the individual's response to various settings and supports as agreed to in the Plan for Supports. An attendance log or similar document must be maintained that indicates the individual's name, date, type of services rendered, staff signature and date, and the number of service units delivered, in accordance with the DMAS fee schedule.

4. [~~Documentation~~ Preparation and maintenance of documentation] indicating whether the services were center-based or noncenter-based shall be included on the Plan for Supports.

5. In instances where prevocational staff may be required to ride with the [~~waiver~~] individual [enrolled in the waiver] to and from prevocational services, the prevocational staff transportation time (actual time spent in transit) may be billed as prevocational services and documentation maintained, provided that billing for this time does not exceed 25% of the total time spent in prevocational services for that day.

6. If intensive prevocational services are requested, documentation indicating the specific supports and the reasons they are needed shall be included in the Plan for Supports. For ongoing intensive prevocational services, there shall be specific documentation of the ongoing needs and associated staff supports.

7. [~~Documentation~~ Preparation and maintenance of documentation] indicating that prevocational services are not available in vocational rehabilitation agencies through § 110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA).

L. Residential support services.

1. In addition to meeting the [service coverage requirements in 12VAC30-120-1020 and the] general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-1040 and in order to be reimbursed by DMAS for rendering these services, the provider of residential services shall have the appropriate DBHDS residential license [(12VAC35-105)].

2. Residential support services may also be provided in adult foster care homes approved by local department of social services' offices pursuant to 22VAC40-771-20.

3. In addition to licensing requirements, provider personnel rendering residential support services shall participate in training in the characteristics of [~~MR/ID~~ ID] and appropriate interventions, skill building strategies, and support methods for individuals who have diagnoses of [~~MR/ID~~ ID] and functional limitations. See www.dbhds.virginia.gov for information about such training. All providers of residential support services must pass an objective, standardized test of skills, knowledge, and abilities approved by DBHDS and administered according to DBHDS' defined procedures.

4. Provider professional documentation shall confirm the [~~waiver~~] individual's participation in the services and provide specific information regarding the individual's responses to various settings and supports as set out in the Plan for Supports.

M. Respite services (both consumer-directed and agency-directed models). In addition to meeting the [service coverage requirements in 12VAC30-120-1020 and the] general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-1040, respite services providers shall meet additional provider requirements:

1. For the agency-directed model, services shall be provided by an enrolled DMAS respite care provider or by a residential services provider licensed by the DBHDS that is also enrolled by DMAS. In addition, respite services may be provided by a DBHDS-licensed respite services provider or a local department of social services-approved foster care home for children or by an adult foster care provider that [~~are~~ is] also enrolled by DMAS.

2 For the CD model, services shall meet the requirements found in Services Facilitation, 12VAC30-120-1020.

3. For DBHDS-licensed residential or respite services providers, a residential or respite supervisor shall provide ongoing supervision of all respite assistants.

4. For DMAS-enrolled respite care providers, the provider shall employ or subcontract with and directly supervise an RN or an LPN who will provide ongoing supervision of all assistants. The supervising RN or LPN must have at least one year of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, [~~ICF/MR~~ ICF/ID], or nursing facility.

5. For agency-directed services, the supervisor, or for CD services the services facilitator, shall make a home visit to conduct an initial assessment prior to the start of services for all [~~waiver~~] individuals [enrolled in the waiver] requesting respite services. The supervisor or services facilitator, as appropriate, shall also perform any subsequent reassessments or changes to the Plan for Supports.

6. The supervisor or services facilitator, as appropriate, shall make supervisory home visits as often as needed to ensure both quality and appropriateness of services. The minimum frequency of these visits shall be every 30 to 90 days under the agency-directed model and semi-annually (every six months) under the CD model of services, depending on the [~~waiver~~] individual's needs.

a. When respite services are not received on a routine basis, but are episodic in nature, the supervisor or services facilitator shall conduct the initial home visit with the respite assistant immediately preceding the start of services and make a second home visit within the respite [service authorization] period. The supervisor or services facilitator, as appropriate, shall review the use of respite services either every six months or upon the use of [~~100~~ 240] respite service hours, whichever comes first.

b. When respite services are routine in nature, that is occurring with a scheduled regularity for specific periods of time, and offered in conjunction with personal assistance, the supervisory visit conducted for personal assistance may serve as the supervisory visit for respite services. However, the supervisor or services facilitator, as appropriate, shall document supervision of respite services separately. For this purpose, the same individual record shall be used with a separate section for respite services documentation.

7. Based on continuing evaluations of the assistant's performance and individual's needs, the supervisor (for agency-directed services) or the individual or the EOR (for the CD model) shall identify any gaps in the assistant's ability to function competently and shall provide training as indicated.

8. Qualifications for respite assistants. The assistant shall:

[~~(a)~~ a.] Be 18 years of age or older and possess a valid social security number that has been issued by the Social Security Administration to the person who is to function as the [~~attendant~~ respite assistant];

[~~(b)~~ b.] Be able to read and write English to the degree necessary to perform the tasks expected and possess basic math skills; and

[~~(c)~~ c.] Have the required skills to perform services as specified in the individual's Plan for Supports and shall be physically able to perform the tasks required by the [~~waiver~~] individual [enrolled in the waiver].

9. Additional requirements for DMAS-enrolled (agency-directed) respite care providers.

a. Respite assistants shall have completed an educational curriculum of at least 40 hours of study related to the needs of individuals who have disabilities, including intellectual/developmental disabilities, as ensured by the provider prior to being assigned to support an individual, and have the required skills and training to perform the services as specified in the individual's Plan for Supports and related supporting documentation. Respite assistants' required training, as further detailed in the applicable provider manual, shall be met in one of the following ways:

(1) Registration with the Board of Nursing as a certified nurse aide;

(2) Graduation from an approved educational curriculum as listed by the Board of Nursing; or

(3) Completion of the provider's educational curriculum, as taught by an RN who shall have at least one year of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, [~~ICF/MR~~ ICF/ID], or nursing facility.

b. Assistants shall have a satisfactory work record, as evidenced by [~~one reference~~ two references] from prior job experiences including no evidence of possible abuse, neglect, or exploitation of [~~aged or incapacitated adults or children~~ any person regardless of age or disability].

10. Additional requirements for respite assistants for the CD option. The assistant shall:

a. Be willing to attend training at the [~~waiver~~] individual's and the individual family/caregiver's, as appropriate, request;

b. Understand and agree to comply with the DMAS' [~~MR/ID~~ ID] Waiver requirements [as contained in 12VAC30-120-1000 et seq.]; and

c. Receive an annual tuberculosis screening.

11. Assistants to be paid by DMAS shall not be the parents of [~~waiver~~] individuals [enrolled in the waiver] who are [~~minors~~ minor children] or the individuals' spouses. Payment shall not be made for services furnished by other family members living under the same roof as the [~~waiver~~] individual who is receiving services unless there is objective written documentation [completed by the services facilitator, or the case manager when the individual does not select services facilitation,] as to why there are no other providers available to render the services required by the [~~waiver~~] individual. [~~The case manager shall make and document this determination.~~] Family members who are approved to be reimbursed for providing this service shall meet the same qualifications as all other respite assistants.

12. Provider inability to render services and substitution of assistants (agency-directed model).

a. When assistants are absent or otherwise unable to render scheduled supports to [~~waiver~~] individuals [enrolled in the waiver], the provider shall be responsible for ensuring that services continue to be provided to individuals. The provider may either provide another assistant, obtain a substitute assistant from another provider if the lapse in coverage is expected to be less than two weeks in duration, or transfer the individual's services to another respite care provider. The provider that has the [~~prior~~ service] authorization to provide services to the [~~waiver~~] individual [enrolled in the waiver] must contact the case manager to determine if additional, or modified, [~~prior~~ service] authorization is necessary.

b. If no other provider is available who can supply a substitute assistant, the provider shall notify the individual and the individual's family/caregiver, as appropriate, and the case manager so that the case manager may find another available provider of the individual's choice.

c. During temporary, short-term lapses in coverage not to exceed two weeks in duration, the following procedures shall apply:

(1) The [~~prior~~ service] authorized provider shall provide the supervision for the substitute assistant;

(2) The provider of the substitute assistant shall send a copy of the assistant's daily documentation signed by the assistant, the individual and the individual's family/caregiver, as appropriate, to the provider having the [service] authorization; and

(3) The [~~prior~~ service] authorized provider shall bill DMAS for services rendered by the substitute assistant.

d. If a provider secures a substitute assistant, the provider agency shall be responsible for ensuring that all DMAS requirements continue to be met including documentation of services rendered by the substitute assistant and documentation that the substitute assistant's qualifications meet DMAS' requirements. The two providers involved shall be responsible for negotiating the financial arrangements of paying the substitute assistant.

13. For the agency-directed model, the assistant record shall contain:

a. The specific services delivered to the [~~waiver~~] individual [enrolled in the waiver] by the assistant, dated the day of service delivery, and the individual's responses;

b. The assistant's arrival and departure times;

c. The assistant's weekly comments or observations about the [~~waiver~~] individual [enrolled in the waiver] to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and

d. The assistant's and [~~waiver~~] individual's and the individual's family/caregiver's, as appropriate, weekly signatures recorded on the last day of service delivery for any given week to verify that services during that week have been rendered.

N. Services facilitation and consumer directed model of service delivery.

1. If the services facilitator is not an RN, the services facilitator shall inform the primary health care provider that services are being provided and request skilled nursing or other consultation as needed [by the individual].

2. To be enrolled as a Medicaid CD services facilitator and maintain provider status, the services facilitator shall have sufficient resources to perform the required activities, including the ability to maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided. To be enrolled, the services facilitator shall also meet the combination of work experience and relevant education [set out in this subsection] that indicate the possession of the specific knowledge, skills, and abilities [~~as set out in DMAS' guidance documents~~ to perform this function]. The services facilitator shall maintain a record of each individual containing elements as [~~described in the agency guidance documents~~ set out in this section.

a. It is preferred that the CD services facilitator possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth or hold multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia. In addition, it is preferable that the CD services facilitator have two years of satisfactory experience in a human service field working with individuals with intellectual disability or individuals with other developmental disabilities. Such knowledge, skills, and abilities must be documented on the provider's application form, found in supporting documentation, or be observed during a job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

(1) Knowledge of:

(a) Types of functional limitations and health problems that may occur in individuals with intellectual disability or individuals with other developmental disabilities, as well as strategies to reduce limitations and health problems;

(b) Physical assistance that may be required by individuals with intellectual disabilities, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

(c) Equipment and environmental modifications that may be required by individuals with intellectual disabilities that reduce the need for human help and improve safety;

(d) Various long-term care program requirements, including nursing home and ICF/ID placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal assistance, respite, and companion services;

(e) ID Waiver requirements, as well as the administrative duties for which the services facilitator will be responsible;

(f) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in service planning;

(g) Interviewing techniques;

(h) The individual's right to make decisions about, direct the provisions of, and control his consumer-directed personal assistance, companion and respite services, including hiring, training, managing, approving timesheets, and firing an assistant/companion;

(i) The principles of human behavior and interpersonal relationships; and

(j) General principles of record documentation.

(2) Skills in:

(a) Negotiating with individuals and the individual's family/caregivers, as appropriate, and service providers;

(b) Assessing, supporting, observing, recording, and reporting behaviors;

(c) Identifying, developing, or providing services to individuals with intellectual disabilities; and

(d) Identifying services within the established services system to meet the individual's needs.

(3) Abilities to:

(a) Report findings of the assessment or onsite visit, either in writing or an alternative format, for individuals who have visual impairments;

(b) Demonstrate a positive regard for individuals and their families;

(c) Be persistent and remain objective;

(d) Work independently, performing position duties under general supervision;

(e) Communicate effectively, orally and in writing; and

(f) Develop a rapport and communicate with individuals of diverse cultural backgrounds.]

3. [~~For the consumer-directed model, the~~ The] services facilitator's record shall contain:

a. Documentation of all [~~employee~~ employer] management training provided to the [~~waiver~~] individual [enrolled in the waiver] and the EOR, as appropriate, including the [~~waiver~~] individual's or the EOR's, as appropriate, receipt of training on their responsibility for the accuracy and timeliness of the assistant's timesheets; and

b. All documents signed by the [~~waiver~~] individual [enrolled in the waiver] or the EOR, as appropriate, which acknowledge their legal responsibilities as the employer.

O. Skilled nursing services. In addition to meeting the [service coverage requirements in 12VAC30-120-1020 and the] general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-1040, participating skilled nursing providers shall meet the following qualifications:

1. Skilled nursing services shall be provided by either a DMAS-enrolled home health provider, or by a licensed registered nurse (RN), or licensed practical nurse (LPN) under the supervision of a licensed RN who shall be contracted with or employed by DBHDS-licensed day support, respite, or residential providers.

2. Skilled nursing services providers shall not be the parents (natural, adoptive, or foster) of [~~waiver~~] individuals [enrolled in the waiver] who are [~~minors~~ minor children] or the [~~waiver~~] individual's spouse [~~nor shall such persons be the employees of companies that render skilled nursing care to the waiver individual~~]. Payment shall not be made for services furnished by other family members who are living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers available to provide the care. Other family members who are approved to provide skilled nursing services must meet the same skilled nursing provider requirements as all other licensed providers.

3. Foster care providers shall not be the skilled nursing services providers for the same individuals for whom they provide foster care.

4. Skilled nursing hours shall not be reimbursed while the [~~waiver~~] individual [enrolled in the waiver] is receiving emergency care or is an inpatient in an acute care hospital or during emergency transport of the individual to such facilities. The attending RN or LPN shall not transport the [~~waiver~~] individual [enrolled in the waiver] to such facilities.

5. Skilled nursing services may be ordered but shall not be provided simultaneously with respite [~~care~~] or personal [~~care~~ assistance] services.

6. Reimbursement for skilled nursing services shall not be made for services that may be delivered prior to the attending physician's dated signature on the [~~waiver~~] individual's support plan in the form of the physician's order.

7. DMAS shall not reimburse for skilled nursing services that may be rendered simultaneously through the Medicaid EPSDT benefit and the Medicare home health skilled nursing service benefit.

8. Required documentation. The provider shall maintain a record, for each [~~waiver~~] individual [enrolled in the waiver] whom he serves, that contains:

a. A Plan for Supports that contains, at a minimum, the following elements:

(1) The individual's strengths, desired outcomes, required or desired supports;

(2) Services to be rendered and the frequency of services to accomplish the above desired outcomes and support activities;

(3) The estimated duration of the individual's needs for services; and

(4) The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports;

b. Documentation of all training, including the dates and times, provided to family/caregivers or staff, or both, including the person or persons being trained and the content of the training. Training of professional staff shall be consistent with the Nurse Practice Act;

c. Documentation of the physician's determination of medical necessity prior to services being rendered;

d. Documentation of nursing license/qualifications of providers;

e. Documentation indicating the dates and times of nursing services that are provided and the amount and type of service;

f. Documentation that the Plan for Supports was reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and results of these reviews submitted to the CSB/BHA case manager. For the annual review and in cases where the Plan for Supports is modified, the Plan for Supports shall be reviewed with [and agreed to by] the individual and the family/caregiver, as appropriate; and

g. Documentation that the Plan for Supports has been reviewed by a physician within 30 days of initiation of services, when any changes are made to the Plan for Supports, and also reviewed and approved annually by a physician.

P. Supported employment services. In addition to meeting the [service coverage requirements in 12VAC30-120-1020 and the] general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-1040, supported employment provider qualifications shall include:

1. Group and individual supported employment shall be provided only by agencies that are DRS-vendors of supported employment services;

2. Documentation indicating that supported employment services are not available in vocational rehabilitation agencies through § 110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA); and

3. In instances where supported employment staff are required to ride with the [~~waiver~~] individual [enrolled in the waiver] to and from supported employment activities, the supported employment staff's transportation time (actual transport time) may be billed as supported employment, provided that the billing for this time does not exceed 25% of the total time spent in supported employment for that day.

Q. Therapeutic consultation. In addition to meeting the [service coverage requirements in 12VAC30-120-1020 and the] general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-1040, professionals rendering therapeutic consultation services shall meet all applicable state or national licensure, endorsement or certification requirements. The following documentation shall be required for therapeutic consultation:

1. A Plan for Supports, that contains at a minimum, the following elements:

a. Identifying information;

b. Desired outcomes, support activities, and time frames; and

c. Specific consultation activities.

2. A written support plan detailing the recommended interventions or support strategies for providers and family/caregivers to better support the [~~waiver~~] individual [enrolled in the waiver] in the service.

3. Ongoing documentation of rendered consultative services which may be in the form of contact-by-contact or monthly notes, which must be signed and dated, that identify each contact, what was accomplished, the professional who made the contact and rendered the service.

4. If the consultation services extend three months or longer, written quarterly reviews are required to be completed by the service provider and shall be forwarded to the case manager. If the consultation service extends beyond one year [or when there are changes to the Plan for Supports], the Plan [~~for~~

~~Supports~~] shall be reviewed by the provider with the individual [~~,~~] and family/caregiver [~~,~~] as appropriate [~~,~~. The Plan for Supports shall be agreed to by the individual and family/caregiver, as appropriate,] and the case manager [~~,~~] and [~~this written annual review~~] shall be submitted to the case manager [~~, at least annually, or more often as needed~~]. All changes to the Plan for Supports shall be reviewed with [and agreed to by] the individual and the individual's family/caregiver, as appropriate.

5. A final disposition summary must be forwarded to the case manager within 30 days following the end of this service.

R. Transition services. Providers shall be enrolled as a Medicaid provider for case management. DMAS or the DMAS designated agent shall reimburse for the purchase of appropriate transition goods or services on behalf of the individual as set out in [12VAC30-120-1020 and] 12VAC30-120-2010.

S. Case manager's responsibilities for the Medicaid Long-Term Care Communication Form (DMAS-225).

1. When any of the following circumstances occur, it shall be the responsibility of the case management provider to notify DBHDS and the local department of social services, in writing using the DMAS-225 form, and the responsibility of DBHDS to update DMAS, as requested:

a. Home and community-based waiver services are implemented.

b. [~~A waiver~~ An] individual [enrolled in the waiver] dies.

c. [~~A waiver~~ An] individual [enrolled in the waiver] is discharged from all [~~MR/ID waiver~~ ID Waiver] services.

d. Any other circumstances (including hospitalization) that cause home and community-based waiver services to cease or be interrupted for more than 30 days.

e. A selection by the [~~waiver~~] individual [enrolled in the waiver] and the individual's family/caregiver, as appropriate, of [~~a different~~ an alternative] community services board/behavioral health authority that provides case management services.

2. Documentation requirements. [~~a.~~] The case manager shall maintain the following documentation for review by DMAS for a period of not less than six years from each individual's last date of service:

[~~(1)~~ a.] The initial comprehensive assessment, subsequent updated assessments, and all Individual Support Plans completed for the individual;

[~~(2)~~ b.] All Plans for Support from every provider rendering waiver services to the individual;

[~~(3)~~ c.] All supporting documentation related to any change in the Individual Support Plans;

[~~(4)~~ d.] All related communication with the individual and the individual's family/caregiver, as appropriate, consultants, providers, DBHDS, DMAS, DRS, local departments of social services, or other related parties;

[~~(5)~~ e.] An ongoing log that documents all contacts made by the case manager related to the individual [enrolled in the waiver] and the individual's family/caregiver, as appropriate; and

[~~(6)~~ f.] When a service provider [or consumer-directed personal or respite assistant or companion] is designated by the case manager to collect the patient pay amount, a copy of the case manager's written designation, as specified in 12VAC30-120-1010 D 5, and documentation of monthly monitoring of DMAS-designated system.

[~~b.~~ T.] The service providers shall maintain, for a period of not less than six years from the individual's last date of service, documentation necessary to support services billed. Review of individual-specific documentation shall be conducted by DMAS staff. This documentation shall contain, up to and including the last date of service, all of the following:

[~~(1)~~ 1.] All assessments and reassessments.

[~~(2)~~ 2.] All Plans for Support developed for that individual and the written reviews.

[~~(3)~~ 3.] Documentation of the date services were rendered and the amount and type of services rendered.

[~~(4)~~ 4.] Appropriate data, contact notes, or progress notes reflecting an individual's status and, as appropriate, progress or lack of progress toward the outcomes on the Plans for Support.

[~~(5)~~ 5.] Any documentation to support that services provided are appropriate and necessary to maintain the individual in the home and in the community.

[~~c. An individual's case manager shall not be the direct staff person or the immediate supervisor of a staff person who provides MR/ID Waiver services for the individual.~~

~~d.~~ 6.] Documentation shall be filed in the individual's record upon the documentation's completion but not later than two weeks from the date of the document's preparation. Documentation for an individual's record shall not be created or modified once a review or audit of that individual [enrolled in the waiver] has been initiated by either DBHDS or DMAS.

12VAC30-120-1070. Payment for services.

A. All residential support, day support, [~~supported employment,~~] personal assistance (both agency directed and consumer directed), respite (both agency directed and consumer directed), skilled nursing, therapeutic consultation, crisis stabilization, prevocational, PERS, companion (both agency directed and consumer directed), consumer-directed services facilitation, and transition services provided in this waiver shall be reimbursed consistent with the agency's service limits and payment amounts as set out in the fee schedule.

B. [Reimbursement rates for individual supported employment shall be the same as set by the Department for Aging and Rehabilitative Services for the same procedures. Reimbursement rates for group supported employment shall be as set by DMAS.

C.] All AT and EM covered procedure codes provided in the [~~MR/ID waiver~~ ID Waiver] shall be reimbursed as a service limit of one. [~~Effective July 1, 2011, the~~ The] maximum Medicaid funded expenditure per individual for all AT/EM covered procedure codes (combined total of AT/EM items and labor related to these items) shall be [~~$3,000~~ $5,000 each for AT and EM] per calendar year. No additional mark-ups, such as in the durable medical

equipment rules, shall be permitted. [~~Requests made for reimbursement between January 1, 2011, and June 30, 2011, shall be subject to a $5,000 annual maximum; requests made for reimbursement between July 1, 2011, and December 31, 2011, shall be subject to the $3,000 annual maximum, and shall consider, against the $3,000 limit, any relevant expenditure from the first six months of the calendar year. For subsequent calendar years, the limit shall be $3,000 throughout the period.~~]

[~~C.~~ D.] Duplication of services.

1. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the ADA (42 USC [§§] 12131 through [~~42 USC~~] 12165), the Rehabilitation Act of 1973, [~~or~~] the Virginians with Disabilities Act [, or any other applicable statute].

2. Payment for services under the Plan for Supports shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

3. Payment for services under the Plan for Supports shall not be made for services that are duplicative of each other.

4. Payments for services shall only be provided as set out in the individuals' Plans for Supports.

12VAC30-120-1080. Utilization review; level of care reviews.

A. Reevaluation of service need and case manager review. Case managers shall complete reviews and updates of the Individual Support Plan and level of care as specified in 12VAC30-120-1020. Providers shall meet the documentation requirements as specified in 12VAC30-120-1040 [~~and DMAS' guidance documents~~].

B. Quality management reviews (QMR) shall be performed [~~at least annually~~] by DMAS Division of Long Term Care Services [or its designated contractor]. Utilization review of rendered services shall be conducted by DMAS Division of Program Integrity (PI) or its designated contractor.

C. Providers who are determined during QMRs to not be in compliance with the requirements of these regulations may be requested to provide a corrective action plan. DMAS shall follow up with such providers on subsequent QMRs to evaluate compliance with their corrective action plans. Providers failing to comply with their corrective action plans shall be referred to Program Integrity for further review and possible sanctions.

D. Providers who are determined during PI utilization reviews to not be in compliance with these regulations may have their reimbursement retracted or other action pursuant to 12VAC30-120-1040 and 12VAC30-120-1060.

E. [~~Waiver individuals~~ Individuals enrolled in the waiver] who no longer meet the [~~MR/ID waiver~~ ID Waiver] services and level of care criteria shall be informed of the termination of services and shall be afforded their right to appeal pursuant to 12VAC30-120-1090.

12VAC30-120-1088. Waiver waiting list.

A. This waiver shall have both urgent and nonurgent waiting lists.

B. Urgent waiting list criteria. When a slot becomes available, the CSB/BHA shall determine, from among the [~~waiver~~] applicants [for enrollment in the waiver] included in the urgent category list, who shall be served first based on the needs of those applicants and consistent with these criteria. This determination [of the assignment of the slot] shall be based on statewide criteria as specified in DBHDS guidance [~~documents~~ document entitled MR/ID Waiver Slot Assignment Process (rev 08/20/2010)].

1. The urgent category shall be assigned when the applicant is in need of services because he is determined to meet one or more of the criteria established in subdivision 2 of this subsection and services will be required within 30 days of the date of established need. Only after all applicants in the Commonwealth who meet the urgent criteria have been served shall applicants in the nonurgent category waiting list be permitted to be served.

2. Assignment to the urgent category may be requested by the applicant, his legally responsible relative, or primary caregiver. The urgent category shall be assigned only when the applicant (who shall have [first] met all of the waiver's level of care criteria), the applicant's spouse or parent (either natural, adoptive, or foster), or the person who has legal decision-making authority for an individual who is a minor child would accept the requested service if it were offered. The urgent category list criteria shall be as follows:

a. Both primary caregivers are 55 years of age or older, or if there is one primary caregiver, that primary caregiver is 55 years of age or older;

b. The applicant is living with a primary caregiver, who is providing the service voluntarily and without pay, and the primary caregiver indicates that he can no longer care for the applicant with [~~MR/ID~~ ID];

c. There is a clear risk for the applicant with the [~~MR/ID~~ ID] of abuse, neglect, or exploitation;

d. A primary caregiver has a chronic or long-term physical or psychiatric condition or conditions that significantly limits the abilities of the primary caregiver or caregivers to care for the applicant with [~~MR/ID~~ ID];

e. The applicant with [~~MR/ID~~ ID] is aging out of publicly funded residential placement or otherwise becoming homeless (exclusive of children who are graduating from high school); or

f. The applicant with [~~MR/ID~~ ID] lives with the primary caregiver, and there is a risk to the health or safety of the applicant, primary caregiver, or other person living in the home due to either of the following conditions:

(1) The applicant's behavior or behaviors present a risk to himself or others that cannot be effectively managed by the primary caregiver even with generic or specialized support arranged or provided by the CSB/BHA; or

(2) There are physical care needs (such as lifting or bathing) or medical needs that cannot be managed by the primary caregiver even with generic or specialized supports arranged or provided by the CSB/BHA.

[3. The case manager shall notify the individual in writing within 10 business days of receiving DBHDS' notification that he has been placed on the Statewide ID Waiting List-Urgent and of his appeal rights.]

C. Nonurgent waiting list criteria. Applicants in the nonurgent category shall be those who meet the diagnostic and functional criteria for the waiver, including the need for services within 30 days, but who do not meet the urgent criteria. [The case manager shall notify the individual in writing within 10 business days of receiving DBHDS' notification that he has been placed on the Statewide ID Waiting List-Nonurgent and of his appeal rights.]

12VAC30-120-1090. Appeals.

A. Providers shall have the right to appeal actions taken by DMAS. Provider appeals shall be considered pursuant to § 32.1-325.1 of the Code of Virginia and the Virginia Administrative Process Act (Chapter 40 (§ 2.2-4000 et seq.) of Title 2.2 of the Code of Virginia), and DMAS regulations at 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.

B. Individuals shall have the right to appeal an action, as that term is defined in 42 CFR 431.201, taken by DMAS. Individuals' appeals shall be considered pursuant to 12VAC30-110-10 through 12VAC30-110-370. DMAS shall provide the opportunity for a fair hearing, consistent with 42 CFR Part 431, Subpart E.

C. The individual shall be advised in writing of such denial and of his right to appeal consistent with DMAS client appeals regulations 12VAC30-110-70 and 12VAC30-110-80.

DOCUMENTS INCORPORATED BY REFERENCE (12VAC30-120)

[~~User's Guide: Mental Retardation: Definition, Classification and Systems of Supports, 10th Edition, 2002, American Association on Intellectual and Developmental Disabilities.~~

Intellectual Disability: Definition, Classification, and Systems of Supports, 11th edition, 2010, American Association on Intellectual and Developmental Disabilities, 501 3rd Street, NW, Suite 200, Washington, DC 20001-2760; http://www.aaidd.org/intellectualdisabilitybook/.]

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DMS-IV-TR), 2000, American Psychiatric Association.

Underwriter's Laboratories Safety Standard 1635, Standard for Digital Alarm Communicator System Units, Third Edition, January 31, 1996, with revisions through August 15, 2005.

Underwriter's Laboratories Safety Standard 1637, Standard for Home Health Care Signaling Equipment, Fourth Edition, December 29, 2006.

[MR/ID Waiver Slot Assignment Process, August 20, 2010, Department of Behavioral Health and Developmental Services.

Virginia Medicaid Provider Manual

Chapter I: General Information (rev. 12/1/2011).

Chapter II: Provider Participation Requirements (rev. 2/8/2012).

Chapter III: Recipient Eligibility (rev. 12/1/2011).

Chapter IV: Covered Services and Limitations (rev. 7/14/2010).

Chapter V: Billing Instructions (rev. 1/26/2011).

Chapter VI: Quality Management Review (rev. 7/14/2010).

Chapter VII: Day Support Waiver (rev. 7/14/2010).]