12VAC30-120-700. Definitions.

"Activities of daily living (ADL)" means personal care tasks, e.g., bathing, dressing, toileting, transferring, and eating/feeding. A recipient's degree of independence in performing these activities is a part of determining appropriate level of care and services.

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

"Attendant care" means long-term maintenance or support services necessary to enable the recipient to remain at or return home rather than enter or remain in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). The recipient will be responsible for hiring, training, supervising and firing the personal attendant. If the recipient is unable to independently manage his own attendant care, a family caregiver can serve as the employer on behalf of the recipient. Recipients with cognitive impairments will not be able to manage their own care.

<u>“Behavioral health authority” or “BHA” means the local agency, established by a city or county or combination of counties or cities or cities and counties under §37.1-194 et seq. of the Code of Virginia, that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the jurisdiction or jurisdictions it serves.</u>

"CARF" means Commission on Accreditation of Rehabilitation Facilities.

“Case manager” means the individual on behalf of the community services board or behavioral health authority staff possessing a combination of mental retardation work experience and relevant education which indicates that the individual possesses the knowledge, skills and abilities, at entry level, as established by the Department of Medical Assistance Services, 12VAC30-50-450. [~~This individual provides case management services as defined in 12 VAC 30-50-440.~~]

"Centers for Medicare and Medicaid Services” or “CMS” means the unit of the federal Department of Health and Human Services which administers the Medicare and Medicaid programs.

"Community-based care waiver services" or "waiver services" means the range of community support services approved by the ~~Health Care Financing Administration (HCFA)~~ Centers for Medicare and Medicaid Services (CMS) pursuant to §1915(c) of the Social Security Act to be offered to developmentally disabled recipients who would otherwise require the level of care provided in an ICF/MR.

“Community Services Board or CSB” means the local agency established by a city or county or combination of counties or cities, or cities and counties, under § 37.1-194 of the *Code of Virginia*, that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the jurisdiction or jurisdictions it serves.

"Companion aide" means, for the purpose of these regulations, a domestic servant who is also exempt from workers' compensation.

"Companion services" means nonmedical care, supervision and socialization, provided to a functionally or cognitively impaired adult. The provision of companion services does not entail hands-on nursing care and is provided in accordance with a therapeutic goal in the consumer service plan. This shall not be the sole service used to divert recipients from institutional care.

"Consumer-directed companion care" means nonmedical care, supervision and socialization provided to a functionally or cognitively impaired adult. The provision of companion services does not entail hands-on nursing care and is provided in accordance with a therapeutic goal in the consumer service plan. This shall not be the sole service used to divert recipients from institutional care. The recipient will be responsible for hiring, training, supervising, and firing the ~~personal attendant~~ companion. If the recipient is unable to independently manage his own consumer-directed ~~respite~~ care, a family caregiver can serve as the employer on behalf of the recipient. ~~Recipients with cognitive impairments will not be able to manage their own care.~~

"Consumer-directed respite care" means services given to caretakers of eligible individuals who are unable to care for themselves that are provided on an episodic or routine basis because of the absence or need for relief of those persons residing with the recipient who normally provide the care. The recipient will be responsible for hiring, training, supervising, and firing the personal attendant. If the recipient is unable to independently manage his own consumer-directed respite care, a family caregiver can serve as the employer on behalf of the recipient. ~~Recipients with cognitive impairments will not be able to manage their own care.~~

"Consumer-directed (CD) services facilitator" means the provider contracted by DMAS that is responsible for ensuring development and monitoring of the CSP, management training, and review activities as required by DMAS for attendant care, consumer-directed companion care, and consumer-directed respite care services.

"Consumer service plan" or "CSP" means that document addressing all needs of recipients of home and community-based care developmental disability services, in all life areas. Supporting documentation developed by service providers ~~are~~ is to be incorporated in the CSP by the support coordinator. Factors to be considered when these plans are developed may include, but are not limited to, recipients' ages and levels of functioning.

"Crisis stabilization" means direct intervention to persons with developmental disabilities who are experiencing serious psychiatric or behavioral problems, or both, that jeopardize their current community living situation. This service must provide 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 recipients and strengthen the current living situations so that recipients can be maintained in the community during and beyond the crisis period.

"Current functional status" means recipients' degree of dependency in performing activities of daily living.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means individuals who perform utilization review, recommendation of preauthorization for service type and intensity, and review of recipient level of care criteria.

"DMHMRSAS" means the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DRS" means the Department of Rehabilitative Services.

"DSS" means the Department of Social Services.

"Day support" means training in intellectual, sensory, motor, and affective social development including awareness skills, sensory stimulation, use of appropriate behaviors and social skills, learning and problem solving, communication and self care, physical development, services and support activities.

"Environmental modifications" means physical adaptations to a house, place of residence, vehicle or work site, when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act, necessary to ensure recipients' 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 and is of direct medical or remedial benefit to recipients.

"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by DMAS for children under the age of 21 according to federal guidelines which prescribe specific preventive and treatment services for Medicaid-eligible children.

"Family/caregiver training" means training and counseling services provided to families or caregivers of recipients receiving services in the IFDDS Waiver.

"Fiscal agent" means an agency or organization contracted by DMAS to handle employment, payroll, and tax responsibilities on behalf of recipients who are receiving consumer-directed attendant, respite, and companion services.

"Home" means, for purposes of the IFDDS Waiver, an apartment or single family dwelling in which no more than two individuals who require services live with the exception of siblings living in the same dwelling with family. This does not include an assisted living facility or group home.

"Home and community-based care" means a variety of in-home and community-based services reimbursed by DMAS as authorized under a §1915(c) waiver designed to offer recipients an alternative to institutionalization. Recipients may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid ICF/MR placement.

~~"HCFA" means the Health Care Financing Administration, which is the unit of the federal Department of Health and Human Services which administers the Medicare and Medicaid programs.~~

"IFDDS Waiver" means the Individual and Family Developmental Disabilities Support Waiver.

"In-home residential support services" means support provided in the developmentally disabled recipient's home, which includes training, assistance, and supervision in enabling the recipient to maintain or improve his health; assisting in performing recipient care tasks; training in activities of daily living; training and use of community resources; providing life skills training; and adapting behavior to community and home-like environments.

"Instrumental activities of daily living (IADL)" means social tasks (e.g., meal preparation, shopping, housekeeping, laundry, money management). A recipient's degree of independence in performing these activities is part of determining appropriate level of care and services.

"Legal guardian" means a person who has been legally invested with the authority and charged with the duty to take care of, manage the property of, and protect the rights of a recipient who has been declared by the circuit court to be incapacitated and incapable of administering his own affairs. The powers and duties of the guardian are defined by the court and are limited to matters within the areas where the recipient has been determined to be incapacitated.

"Mental retardation" means, as defined by the American Association on Mental Retardation (AAMR), being substantially limited in present functioning as characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests

itself before age 18. A diagnosis of mental retardation is made if the person's intellectual functioning level is approximately 70 to 75 or below, as diagnosed by a licensed clinical professional; and there are related limitations in two or more applicable adaptive skill areas; and the age of onset is 18 or below. If a valid IQ score is not possible, significantly subaverage intellectual capabilities means a level of performance that is less than that observed in the vast majority of persons of comparable background. In order to be valid, the assessment of the intellectual performance must be free of errors caused by motor, sensory, emotional, language, or cultural factors.

“MR waiver” means the Mental Retardation waiver.

"Nursing services" means skilled nursing services listed in the consumer service plan which are ordered by a physician and required to prevent institutionalization, not otherwise available under the State Plan for Medical Assistance, are within the scope of the state's Nurse Practice Act (Chapters 30 (§54.1-3000 et seq.) and 34 (§54.1-3400 et seq.) of the Code of Virginia, and are provided by a registered professional nurse or by a licensed practical nurse under the supervision of a registered nurse who is licensed to practice in the state.

"Participating provider" means an institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by DMAS, and has a current, signed contract with DMAS.

"Personal attendant" means, for purposes of this regulation, a domestic servant who is also exempt from Workers' Compensation.

"Personal care agency" means a participating provider that renders services designed to prevent or reduce inappropriate institutional care by providing eligible recipients with personal care aides who provide personal care services.

"Personal care services" means long-term maintenance or support services necessary to enable recipients to remain in or return to the community rather than enter an Intermediate Care Facility for the Mentally Retarded. Personal care services include assistance with activities of daily living, nutritional support, and the environmental maintenance necessary for recipients to remain in their homes and in the community.

"Personal emergency response system (PERS)" is an electronic device that enables certain recipients at high risk of institutionalization to secure help in an emergency. PERS services are limited to those recipients 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.

"Qualified mental health professional" means a professional having: (i) at least one year of documented experience working directly with recipients who have developmental disabilities; (ii) at least a bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology; and (iii) the required Virginia or national license, registration, or certification in accordance with his profession.

"Related conditions" means those persons who have autism or who have a severe chronic disability that meets all of the following conditions identified in 42 CFR 435.1009:

1. It is attributable to:

a. Cerebral palsy or epilepsy; or

b. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

2. It is manifested before the person reaches age 22.

3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three or more of the following areas of major life activity:

a. Self-care.

b. Understanding and use of language.

c. Learning.

d. Mobility.

e. Self-direction.

f. Capacity for independent living.

"Respite care" means services provided to unpaid caretakers of eligible recipients who are unable to care for themselves that is provided on an episodic or routine basis because of the absence of or need for relief of those persons residing with the recipient who normally provide the care.

"Respite care agency" means a participating provider that renders services designed to prevent or reduce inappropriate institutional care by providing respite care services to eligible recipients for their caregivers.

"Screening" means the process to evaluate the medical, nursing, and social needs of recipients referred for screening; determine Medicaid eligibility for an ICF/MR level of care; and authorize Medicaid-funded ICF/MR care or community-based care for those recipients who meet ICF/MR level of care eligibility and require that level of care.

"Screening team" means the entity contracted with DMAS which is responsible for performing screening for the IFDDS Waiver.

"State Plan for Medical Assistance" or "the Plan" means the document containing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Support coordination" means the assessment, planning, linking, and monitoring for recipients referred for the IFDDS community-based care waiver. Support coordination: (i) ensures the development, coordination, implementation, monitoring, and modification of consumer service plans; (ii) links recipients with appropriate community resources and supports; (iii) coordinates service providers; and (iv) monitors quality of care. Support

coordination providers cannot be service providers to recipients in the IFDDS waiver with the exception of consumer-directed service facilitators.

"Supporting documentation" means the specific service plan developed by the recipient service provider related solely to the specific tasks required of that service provider. Supporting documentation helps to comprise the overall CSP for the recipient.

"Supported employment" means training in specific skills related to paid employment and provision of ongoing or intermittent assistance and specialized supervision to enable a recipient to maintain paid employment.

"Therapeutic consultation" means consultation provided by members of psychology, social work, behavioral analysis, speech therapy, occupational therapy, therapeutic recreation, or physical therapy disciplines or behavior consultation to assist recipients, parents, family members, in-home residential support, day support and any other providers of support services in implementing a CSP.

12VAC30-120-710. General coverage and requirements for all home and community-based care waiver services.

A. Waiver service populations. Home and community-based services shall be available through a §1915(c) waiver. Coverage shall be provided under the waiver for recipients six years of age and older with related conditions as defined in 42 CFR 435.1009, including autism, who have been determined to require the level of care provided in an

intermediate care facility for the mentally retarded. The individual must not also have a diagnosis of mental retardation as defined by the American Association on Mental Retardation (AAMR). Mental Retardation (MR) Waiver recipients who are six years of age on or after October 1, 2002, who are determined to not have a diagnosis of mental retardation, and meet all IFDDS waiver eligibility criteria, shall be eligible for and transfer to the IFDDS waiver effective with their sixth birthday. Psychological evaluations confirming diagnoses must be completed less than one year prior to the child's sixth birthday. These recipients transferring from the MR waiver will automatically be assigned a slot in the IFDDS waiver, subject to approval of the slot by CMS. Such slot shall be in addition to those slots available through the screening process described in subsections 12 VAC 30-120-720 C and D.

B. Coverage statement.

1. Covered services shall include in-home residential supports, day support, supported employment, personal care (agency directed), attendant care (consumer directed), respite care (both agency and consumer directed), assistive technology, environmental modifications, nursing services, therapeutic consultation, crisis stabilization, personal emergency response systems (PERS), family/caregiver training, and companion care.

2. These services shall be medically appropriate and necessary to maintain these recipients in the community. Federal waiver requirements provide that the average per capita fiscal year expenditures under the waiver must not exceed the average per capita expenditures for the level of care provided in Intermediate Care Facilities for the

Mentally Retarded under the State Plan that would have been made had the waiver not been granted.

3. Under this §1915(c) waiver, DMAS waives subdivision (a)(10)(B) of §1902 of the Social Security Act related to comparability.

C. Appeals. Recipient appeals shall be considered pursuant to 12VAC30-110-10 through 12VAC30-110-380. Provider appeals shall be considered pursuant to 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-599.

12VAC30-120-720. Recipient qualification and eligibility requirements; intake process.

A. Recipients receiving services under this waiver must meet the following requirements. Virginia will apply the financial eligibility criteria contained in the State Plan for the categorically needy. Virginia has elected to cover the optional categorically needy groups under 42 CFR 435.121 and 435.217. The income level used for 42 CFR 435.121 and 435.217 is 300% of the current Supplemental Security Income payment standard for one person.

1. Under this waiver, the coverage groups authorized under §1902(a)(10)(A)(ii)(VI) of the Social Security Act will be considered as if they were institutionalized for the purpose of applying institutional deeming rules. All recipients under the waiver must meet the financial and nonfinancial Medicaid eligibility criteria and meet the institutional level of

care criteria. The deeming rules are applied to waiver eligible recipients as if the recipient were residing in an institution or would require that level of care.

2. Virginia shall reduce its payment for home and community-based 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, deductions for 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 will reduce its payment for home and community-based waiver services by the amount that remains after the following deductions:

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

(1) The basic maintenance needs for an individual, which is equal to the SSI payment for one person. 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 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 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 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 Virginia waives the requirement for comparability pursuant to §1902(a)(10)(B), deduct the following in the respective order:

(1) The basic maintenance needs for an individual, which is equal to the SSI payment for one person. 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 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 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 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 medical assistance plan.

B. Assessment and authorization of home and community-based care services.

1. To ensure that Virginia's home and community-based care waiver programs serve only recipients who would otherwise be placed in an ICF/MR, home and community-based care services shall be considered only for individuals who are eligible for admission to an ICF/MR, absent a diagnosis of mental retardation. Home and community-based care services shall be the critical service that enables the individual to remain at home rather than being placed in an ICF/MR.

2. The recipient's status as an individual in need of IFDDS home and community-based care services shall be determined by the IFDDS screening team after completion of a thorough assessment of the recipient's needs and available support. Screening of home

and community-based care services by the IFDDS screening team or DMAS staff is mandatory before Medicaid will assume payment responsibility of home and community-based care services.

3. The IFDDS screening team shall gather relevant medical, social, and psychological data and identify all services received by the recipient. For children to transfer to the IFDDS waiver at age six, case managers shall submit to DMAS the child's most recent Level of Functioning form, the CSP, and a psychological examination completed no more than one year prior to the child's sixth birthday if they are receiving MR waiver services. Such documentation must demonstrate that no diagnosis of mental retardation exists in order for this transfer to the IFDDS waiver to be approved.

4. The case manager shall be responsible for notifying DMAS, DMHMRSAS, and DSS, via the DMAS-122, when a child transfers from the MR waiver to the IFDDS waiver.

~~4.~~ 5. Children under six years of age shall not be screened until three months prior to the month of their sixth birthday. Children under six years of age shall not be added to the waiver/wait list until the month in which their sixth birthday occurs.

~~5.~~ 6. An essential part of the IFDDS screening team's assessment process is determining the level of care required by applying existing DMAS ICF/MR criteria (12VAC30-130-430 et seq.).

~~6.~~ 7. The team shall explore alternative settings and services to provide the care needed by the individual. If placement in an ICF/MR or a combination of other services is determined to be appropriate, the IFDDS screening team shall initiate a referral for

service. If Medicaid-funded home and community-based care services are determined to be the critical service to delay or avoid placement in an ICF/MR or promote exiting from an institutional setting, the IFDDS screening team shall initiate a referral for service to a support coordinator of the recipient's choice.

~~7.~~ 8. Home and community-based care services shall not be provided to any individual who also resides in a nursing facility, an ICF/MR, a hospital, an adult family home licensed by the DSS, or an assisted living facility licensed by the DSS.

~~8.~~ 9. Medicaid will not pay for any home and community-based care services delivered prior to the authorization date approved by DMAS. Any Consumer Service Plan for home- and community-based care services must be pre-approved by DMAS prior to Medicaid reimbursement for waiver services.

~~9.~~ 10. The following five criteria shall apply to all IFDDS Waiver services:

a. Individuals qualifying for IFDDS Waiver services must have a demonstrated clinical need for the service resulting in significant functional limitations in major life activities. In order to be eligible, a person must be six years of age or older, have a related condition as defined in these regulations and cannot have a diagnosis of mental retardation, and who would, in the absence of waiver services, require the level of care provided in an ICF/MR facility, the cost of which would be reimbursed under the Plan;

b. The Consumer Service Plan and services that are delivered must be consistent with the Medicaid definition of each service;

c. Services must be approved by the support coordinator based on a current functional assessment tool approved by DMAS or other DMAS approved assessment and demonstrated need for each specific service;

d. Individuals qualifying for IFDDS Waiver services must meet the ICF/MR level of care criteria; and

e. The individual must be eligible for Medicaid as determined by the local office of DSS.

~~10.~~ 11. The IFDDS screening teams must submit the results of the comprehensive assessment and a recommendation to DMAS staff for final determination of ICF/MR level of care and authorization for community-based care services.

C. Screening for the IFDDS Waiver.

1. Individuals requesting IFDDS Waiver services will be screened and will receive services on a first-come, first-served basis in accordance with available funding based on the date the recipients' applications are received. Individuals who meet at least one of the emergency criteria pursuant to 12VAC30-120-790 shall be eligible for immediate access to waiver services if funding is available.

2. To be eligible for IFDDS Waiver services, the individual must:

a. Be determined to be eligible for the ICF/MR level of care;

b. Be six years of age or older,

c. Meet the related conditions definition as defined in 42 CFR 435.1009 or be diagnosed with autism; and

d. Not have a diagnosis of mental retardation as defined by the American Association on Mental Retardation (AAMR) as contained in 12VAC30-120-710.

D. Waiver approval process: available funding.

1. In order to ensure cost effectiveness of the IFDDS Waiver, the funding available for the waiver will be allocated between two budget levels. The budget will be the cost of waiver services only and will not include the costs of other Medicaid covered services. Other Medicaid services, however, must be counted toward cost effectiveness of the IFDDS Waiver. All services available under the waiver are available to both levels.

2. Level one will be for individuals whose comprehensive consumer service plan (CSP) is expected to cost less than $25,000 per fiscal year. Level two will be for individuals whose CSP is expected to cost equal to or more than $25,000. There will not be a threshold for budget level two; however, if the actual cost of waiver services exceeds the average annual cost of ICF/MR care for an individual, the recipient's care will be coordinated by DMAS staff.

3. Fifty-five percent of available waiver funds will be allocated to budget level one, and 40% of available waiver funds will be allocated to level two in order to ensure that the waiver will be cost effective. The remaining 5.0% of available waiver funds will be allocated for emergencies as defined in 12VAC30-120-790. Recipients who have been placed in budget level one and who subsequently require additional services that would

exceed $25,000 per fiscal year must meet the emergency criteria as defined in 12VAC30-120-790 to receive additional funding for services.

E. Waiver approval process: accessing services.

1. Once the screening entity has determined that an individual meets the eligibility criteria for IFDDS Waiver services and the individual has chosen this service, the screening entity will provide the individual with a list of available support coordinators. For MR waiver recipients transferring to the IFDDS waiver, the case manager must provide the recipient or family/caregiver with a list of support coordinators. The individual or family/caregiver will choose a support coordinator within ten calendar days of receiving the list of support coordinators and the screening entity/case manager will forward the screening materials, CSP, and all MR waiver related documentation within ten calendar days of the coordinator's selection to the selected support coordinator.

2. The support coordinator will contact the recipient within 10 calendar days of receipt of screening materials. The support coordinator and the recipient or recipient's family will meet within 30 calendar days to discuss the recipient's needs, existing supports and to develop a preliminary consumer service plan (CSP) which will identify services needed and will estimate the annual waiver cost of the recipient's CSP. If the recipient's annual waiver cost is expected to exceed the average annual cost of ICF/MR care for an individual, the recipient's support coordination will be managed by DMAS.

3. Once the CSP has been initially developed, the support coordinator will contact DMAS to receive prior authorization to enroll the recipient in the IFDDS Waiver. DMAS shall,

within 14 days of receiving all supporting documentation, either approve for Medicaid coverage or deny for Medicaid coverage the CSP. DMAS shall only authorize waiver services for the recipient if funding is available for the entire CSP. Once this authorization has been received, the support coordinator shall inform the recipient so that the recipient can begin choosing service providers for services listed in the CSP. If DMAS does not have the available funding for this recipient, the recipient will be held on the waiting list until such time as funds are available to cover the cost of the CSP.

4. Once the recipient has been authorized for the waiver, the recipient or support coordinator shall contact service providers and initiate services within 60 days. During this time, the consumer, support coordinator, and service providers will meet to complete the CSP. If services are not initiated within 60 days, the support coordinator must submit information to DMAS demonstrating why more time is needed to initiate services. DMAS has authority to approve or deny the request in 30-day extensions. The service providers will develop supporting documentation for each service and will submit a copy of these plans to the support coordinator. The support coordinator will monitor the service providers' supporting documentation to ensure that all providers are working toward the identified goals of recipients. The support coordinator will review and sign off on the supporting documentation and will contact DMAS for prior authorization of services and will notify the service providers when services are approved.

5. The support coordinator will contact the recipient at a minimum on a monthly basis and as needed to coordinate services and maintain the recipient's CSP. DMAS will conduct annual level of care reviews in which the recipient is assessed to ensure he

continues to meet waiver criteria. DMAS will review recipients' CSPs and will review the services provided by support coordinators as well as service providers.

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

__July 11, 2003_____ _/s/ Patrick W. Finnerty/cbj_____

Date Patrick W. Finnerty, Director

Dept. of Medical Assistance Services