PART XI.

INDIVIDUAL AND FAMILY DEVELOPMENTAL DISABILITIES SUPPORT WAIVER

Subpart 1.

12VAC 30-120-700 Definitions.

"60 day assessment" means the initial plan of care developed by providers prior to the initiation of services that establishes goals for the recipient in accordance with the recipient's Consumer Service Plan.

"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 plan of care but not available under the State Plan for Medical Assistance, which 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 which are necessary to their proper functioning.

"Attendant care" means long-term maintenance or support services necessary to enable the mentally alert and competent 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. Recipients 18 years of age and older must be able to

manage their own affairs without help, be mentally alert, have no cognitive impairments, and not have a legal guardian. If recipients receiving services are younger than 18 years of age, the legal guardians or parents will act on behalf of minor recipients.

"Community-based care waiver services or waiver services" means the range of community support services approved by the Health Care Financing Administration (HCFA) 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.

"Companion services" means non-medical care, supervision and socialization, provided to a functionally 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 individual service plan. This shall not be the sole service used to divert recipients from institutional care.

"Consumer-directed respite care" means services given to caretakers of eligible individuals who are unable to care for themselves that is 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. For recipients 18 years of age and older, they must be able to manage their own affairs without help, be mentally alert and have no cognitive impairments and not have a legal guardian. If recipients receiving services are under 18 years of age, the legal guardian or parent will act on behalf of the minor.

"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. Plans of care (POC) developed by service providers are 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. The DRS currently operates the Personal Assistance Services Program, which is a state-funded program that provides a limited amount of personal care services to Virginians.

"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, and prevocational services aimed at preparing a recipient for paid or unpaid employment.

"Environmental modifications" means physical adaptations to a house, place of residence, vehicle or work site, when the 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 and caregiver training” means training and counseling services provided to families 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 and respite services.

"Guardian" means a person who has been legally invested with the authority and charged with the duty of taking care of, managing the property of, and protecting the rights of the 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.

"Home and community-based care" means a variety of in-home and community-based services reimbursed by the DMAS 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 as that 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, assistance 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)" mean social tasks (i.e., 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.

"Mental retardation" means mental retardation as 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 70-75 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; and the person meets existing criteria for placement in an ICF/MR. 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.

"Nursing services" means skilled nursing services listed in the plan of care which are ordered by a physician and required to prevent institutionalization, not available under the State Plan for Medical Assistance, are within the scope of the State's Nurse Practice Act, and are provided by a registered professional nurse, or 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 and exemption from Worker's Compensation, a domestic servant. Recipients shall be restricted from employing more than two personal attendants simultaneously at any given time.

"Personal care agency" means a participating provider which 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 at or return home rather than enter an Intermediate Care Facility for the Mentally Retarded. Personal care services include assistance with personal hygiene, 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 who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

"Plan of Care” or “POC" means the specific service plan developed by the recipient service provider related solely to the specific tasks required of that service provider. POCs help to comprise the overall CSP for the recipient.

"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) 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 given to 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, which renders services, designed to prevent or reduce inappropriate institutional care by providing respite care services to eligible recipients.

“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 and require that level of care.

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

"Service coordination provider" means the provider contracted by DMAS that is responsible for ensuring development and monitoring of the plan of care, management training, and review activities as required by DMAS for attendant care and consumer-directed respite care services are accomplished.

"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.

"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, 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 plan of care.

12VAC 30-120-710. 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 the following recipients who have been determined to require the level of care provided in an Intermediate Care Facility for the Mentally Retarded.

Recipients six years of age and older with related conditions as defined in 42 CFR § 435.1009, including autism. The individual must not also have a diagnosis of mental retardation as defined by the American Association on Mental Retardation (AAMR).

1. The AAMR defines mental retardation as being substantially limited in present functioning that is 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.

2. A diagnosis of mental retardation is made if the person's intellectual functioning level is approximately 70-75 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; and the person meets existing criteria for placement in an ICF/MR.

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 from errors caused by motor, sensory, emotional, language, or cultural factors.

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 and 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 in the aggregate 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 subsection (a)(10)(B) of § 1902 of the *Social Security Act* related to comparability.

C. Appeals. Recipient appeals shall be considered pursuant to 12 VAC 30-110-10 through 110-380. Provider appeals shall be considered pursuant to 12 VAC 30-10-1000 and 12 VAC 30-20-500 through 20-599.

12VAC 30-120-720. 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 § § 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 non-financial 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. The DMAS will reduce its payment for home and community-based waiver services by the amount that remains after the deductions listed below:

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 8 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 percent 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 8 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 percent 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 and preauthorization 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.

4. 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).

5. 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 are 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 either an ICF/MR or nursing facility placement, the IFDDS screening team shall initiate a referral for service to a support coordinator of the recipient's choice.

6. 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, or an assisted living facility licensed by the DSS.

7. 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.

8. 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 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 which 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 is Medicaid eligible as determined by the local office of DSS.

9. 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. To begin implementation of the waiver, individuals or the individuals' families will initially have the opportunity to request to be screened for waiver services from July 1, 2000, through August 31, 2000. This 60-day period is to allow for all interested individuals who wish to apply to do so. During this time, individuals or their families will request that the individual be screened for eligibility into the IFDDS waiver by the screening entity contracted by DMAS. Individuals will be screened with the Level of Functioning (LOF) Survey, which is the assessment instrument used to determine eligibility for ICF/MR level of care. Once the initial pool of applicants has been screened, applicants will be placed on the IFDDS waiver and in accordance with available funding. If more individuals are eligible to receive services than available funding allows, DMAS will randomly assign recipients a number (from 1 to the number of individuals eligible), and will begin serving individuals in numerical order (1, 2, 3, etc.). After the initial 60-day screening period, individuals requesting to receive 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 12 VAC 30-120-790 shall be eligible for immediate access to waiver services pending available funding.

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

c. Not have a diagnosis of mental retardation as defined by the American Association on Mental Retardation (AAMR) as contained in 12 VAC 30-120-720.

D. Waiver Approval Process: Available funding.

1. In order to assure 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 would be available to both levels.

2. Level one will be for individuals whose comprehensive consumer service plan (CSP) is anticipated to cost less than $25,000 per fiscal year. Level two will be for individuals whose CSP is anticipated 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, 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 percent of available waiver funds will be allocated to level two, in order to assure that the waiver will be cost-effective. The remaining 5 percent of available waiver funds will be allocated for emergencies as defined in 12 VAC 30-120-790. 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 12 VAC 30-120-790 to receive additional funding for services.

E. Waiver approval process: Accessing services.

1. Once the screening entity has determined an individual to be eligible 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. The individual will choose a support coordinator within five calendar days and the screening entity will forward the screening materials within five calendar days to the selected support coordinator.

2. The support coordinator will contact the recipient within five 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 comprehensive 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, the recipient's support coordination will be managed by DMAS.

3. Once the CSP has been developed, the support coordinator will contact DMAS to receive prior authorization to enroll the recipient onto the IFDDS waiver. 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 additional funds are available to cover the entire cost of the CSP.

4. Once the recipient has been authorized for the waiver, the recipient or support coordinator will contact service providers and shall initiate services within 60 days. 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 the authority to approve or deny the request in 30-day extensions. The service providers will develop a Plan of Care (POC) for each service and will submit a copy of these plans to the support coordinator. The support coordinator will monitor the service providers' POCs to assure that all providers are working toward the identified goals of recipients. The support coordinator will review and sign off on the POCs 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.

12VAC30-120-730. General Requirements for Home and Community-based Care Participating Providers.

A. General Requirements. Providers approved for participation shall, at a minimum, perform the following activities:

1. Immediately notify DMAS, in writing, of any change in the information which the provider previously submitted to DMAS.

2. Assure freedom of choice to recipients in seeking medical care 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.

3. Assure the recipient's freedom to reject medical care and treatment.

4. Accept referrals for services only when staff is available to initiate services and perform such services on an ongoing basis.

5. Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. § § 2000d through 200d 4a), which prohibits

discrimination on the grounds of race, color, or national origin; the Virginians with Disabilities Act (§§ 51.5-1 through 51.5-59 of the Code of Virginia), as amended; § 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act, as amended (42 U.S.C. § §12101 through 12213), which provides comprehensive civil rights protections to recipients with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications.

6. Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public.

7. Submit charges to DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public. The provider must accept as payment in full the amount established by DMAS payment methodology from the first day of eligibility.

8. Use program-designated billing forms for submission of charges.

9. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the care provided.

a. In general, such records shall be retained for at least five years from the last date of service or as provided by applicable state 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 five 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.

c. An attendance log or similar document must be maintained which indicates the date, type of services rendered, and number of hours/units provided (including specific time frame).

10. The provider agrees to furnish information on request and in the form requested to DMAS, the Attorney General of Virginia or his authorized representatives, federal personnel, or 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.

11. 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 recipients of Medicaid.

12. Hold confidential and use for DMAS authorized purposes only all medical assistance information regarding recipients served. 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. DMAS shall not disclose medical information to the public.

13. Change of Ownership. When ownership of the provider agency changes, DMAS shall be notified at least 15 calendar days before the date of change.

14. All facilities covered by § 1616(e) of the *Social Security Act* in which home and community-based care services will be provided shall be in compliance with applicable standards that meet the requirements for board and care facilities. Health and safety standards shall be monitored through the DMHMRSAS' licensure standards, 12 VAC 35-102-10 et seq.

15. Suspected Abuse or Neglect. Pursuant to §§ 63.1-55.3 and 63.1-248.3, Code of Virginia, if a participating provider knows or suspects that a home and community-based care recipient is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or exploitation shall report this immediately from first knowledge to the local DSS adult or child protective services worker and to DMAS.

16. Adherence to provider contract and the DMAS provider service 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 recipient provider contracts and in the DMAS provider service manual.

12 VAC 30-120-740. Participation Standards for Home and Community-Based Care Participating Providers.

A. Requests for participation. Requests will be screened to determine whether the provider applicant meets the basic requirements for participation.

B. Provider participation standards. For DMAS to approve contracts with home and community based care providers, the following standards shall be met:

1. Licensure and certification requirements pursuant to 42 CFR § 441.352.

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

C. Adherence to provider contract and special participation conditions. 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 provider contracts.

D. Recipient choice of provider agencies. The recipient will have the option of selecting the provider agency of his choice.

E. Review of provider participation standards and renewal of contracts. DMAS is responsible for assuring continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies and recertify each provider for contract renewal with DMAS to provide home and community-based services. A provider's non-compliance with DMAS policies and procedures, as required in the provider's contract, may result in a written request from DMAS for a corrective action plan which details the steps the provider must take and the length of time permitted to achieve full compliance with the plan to correct the deficiencies which have been cited.

F. Termination of provider participation. A participating provider may voluntarily terminate his participation in Medicaid by providing 30 days' written notification. DMAS shall be permitted to administratively terminate a provider from participation upon 30 days' written notification. DMAS may also cancel a contract immediately or may give notification in the event of a breach of the contract by the provider as specified in the DMAS contract. Such action precludes further payment by DMAS for services provided to recipients subsequent to the date specified in the termination notice.

G. Reconsideration of adverse actions. A provider shall have the right to appeal adverse action taken by DMAS. Adverse action includes, but shall not be limited to, termination of the provider agreement by DMAS, and retraction of payments from the provider by DMAS for noncompliance with applicable law, regulation, policy, or procedure. All disputes regarding provider reimbursement or termination of the agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative

proceedings shall be conducted pursuant to the Virginia Administrative Process Act (§§ 9-6.14:1 through 9.6-14.25 of the Code of Virginia) ,the State Plan for Medical Assistance provided for in § 32.1-325 of the *Code of Virginia*, and duly promulgated regulations. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

H. Termination of a provider contract upon conviction of a felony**.** Section 32.1-325(C), as amended, of the *Code of Virginia*, mandates that "any such [Medicaid] agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states or Washington D.C. must, within 30 days, notify the Medicaid Program of this conviction and relinquish its provider agreement. Reinstatement will be contingent upon provisions of state law. In addition, termination of a provider contract will occur as may be required for federal financial participation.

I. Support coordinator's responsibility for the Recipient Information Form (DMAS-122). It is the responsibility of the support coordinator to notify DMAS and DSS, in writing, when any of the following circumstances occur:

1. Home and community-based care services are implemented.

2. A recipient dies.

3. A recipient is discharged or terminated from services.

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

J. Changes or termination of care. It is the DMAS staff's responsibility to authorize any changes to a recipient's Plan of Care components of the Consumer Service Plan based on the recommendations of the support coordinator. Agencies providing direct service are responsible for modifying the POC if the recipient or parent/legal guardian agrees. The provider will submit the POC to the support coordinator any time there is a change in the recipient's condition or circumstances, which may warrant a change in the amount or type of service rendered. The support coordinator will review the need for a change and will sign the POC if he agrees to the changes. The support coordinator will submit the revised POC to the DMAS staff to receive approval for that change. The DMAS staff has the final authority to approve or deny the requested change to recipients' POCs.

1. Non-emergency termination of home and community-based care services by the participating provider. The participating provider shall give the recipient and family and support coordinator ten days written notification of the intent to terminate services. The letter shall provide the reasons for and effective date of the termination. The effective date of services termination shall be at least ten days from the date of the termination notification letter.

2. Emergency termination of home and community-based care services by the participating provider. In an emergency situation when the health and safety of the recipient or provider agency personnel is endangered, the support coordinator and DMAS must be notified prior to termination. The ten day written notification period shall not be

required. If appropriate, the local DSS adult protective services or child protective services must be notified immediately.

3. The DMAS termination of eligibility to receive home and community-based care services. DMAS shall have the ultimate responsibility for assuring appropriate placement of the recipient in home and community-based care services and the authority to terminate such services to the recipient for the following reasons:

a. The home and community-based care service is not the critical alternative to prevent or delay institutional (ICF/MR) placement;

b. The recipient no longer meets the institutional level of care criteria;

c. The recipient's environment does not provide for his health, safety, and welfare; or

d. An appropriate and cost-effective plan of care cannot be developed.

Subpart 2.

Covered services and limitations and related provider requirements.

12 VAC 30-120-750. In-home residential support services.

A. Service Description. In-home residential support services shall be based in the recipient's apartment or home. The service shall be designed to enable recipients qualifying for the IFDDS

waiver to be maintained in living arrangements in the community and shall include: (i) training in or reinforcement of functional skills and appropriate behavior related to a recipient's health and safety, personal care, activities of daily living and use of community resources; (ii) assistance with medication management and monitoring health, nutrition, and physical condition; (iii) life skills training; (iv) cognitive rehabilitation; and (v) assistance with personal care activities of daily living and use of community resources. Service providers shall be reimbursed only for the amount and type of in–home residential support services included in the recipient's approved plan of care. In–home residential support services shall not be authorized in the plan of care unless the recipient requires these services and these services exceed services provided by the family or other caregiver. Services will not be provided for a continuous 24-hour period.

1. This service must be provided on a recipient-specific basis according to the plan of care and service setting requirements.

2. This service may not be provided simultaneously to any recipient who receives personal care or attendant care services under the IFDDS waiver or other residential program that provides a comparable level of care.

3. Room and board and general supervision shall not be components of this service.

4. This service shall not be used solely to provide routine or emergency respite care for the parent or parents or other caregivers with whom the recipient lives.

B. Criteria.

1. All recipients must meet the following criteria in order for Medicaid to reimburse for in-home residential support services. The recipient must meet the eligibility requirements for this waiver service as herein defined. The recipient shall have a demonstrated need for supports to be provided by staff who are paid by the in-home residential support provider.

2. A functional assessment should be conducted to evaluate each recipient in his home environment and community settings.

3. Routine supervision/oversight of direct care staff. To provide additional assurance for the protection or preservation of a recipient's health and safety, there are specific requirements for the supervision and oversight of direct care staff providing residential support as outlined below.

   a. For all in-home residential support services provided under a DMHMRSAS license:

      (1) An employee of the agency, typically by position, must be formally designated as the supervisor of each direct care staff person who is providing in-home residential support services.

      (2) The supervisor must have and document at least one supervisory contact per month with each staff person regarding service delivery and staff performance.

(3) The supervisor must observe each staff person delivering services at least quarterly. Staff performance and service delivery according to the CSP should be documented, along with evaluation and evidence of recipient satisfaction with service delivery by staff.

(4) Providers of in-home residential supports must also have and document at least one monthly contact with the recipient regarding satisfaction with services delivered by each staff person. If the recipient has a caregiver, the caregiver should be contacted.

4. The in-home residential support POC must indicate the necessary amount and type of activities required by the recipient, the schedule of residential support services, the total number of hours per day and the total number of hours per week of residential support.

5. Medicaid reimbursement is available only for in-home residential support services provided when the recipient is present and when a qualified provider is providing the services.

C. Service units and service limitations. In-home residential supports shall be reimbursed on an hourly basis for time the in-home residential support staff is working directly with the recipient. Total monthly billing cannot exceed the total hours authorized in the POC. The provider must maintain documentation of the date, times, services that were provided, and specific circumstances which prevented provision of all of the scheduled services.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, in-home residential support service providers must be licensed by DMHMRSAS as a provider of residential services or supportive residential services. They must also have training in the characteristics of developmental disabilities and appropriate interventions, strategies, and support methods for persons with developmental disabilities and functional limitations.

1. For DMHMRSAS licensed programs, a POC and ongoing documentation must be consistent with licensing regulations.

2. During the period when a 60-day assessment is used, documentation must confirm attendance, the amount of time in services and provide specific information regarding the recipient's response to various settings and supports as agreed to in the POC objectives. Assessment results must be available in at least a daily note or a weekly summary. Data must be collected as described in the POC, analyzed, summarized, and then, clearly addressed in the regular POC.

3. The POC must be reviewed by the provider with the recipient, and this review submitted to the support coordinator, at least quarterly, with goals, objectives, and activities modified as appropriate.

4. Documentation must be maintained for routine supervision and oversight of all in-home residential support staff. All significant contacts as described in this section must be documented.

5. Documentation must be completed and signed by the staff person designated to perform the supervision and oversight and include:

a. Date of contact or observation.

b. Person or persons contacted or observed.

c. A note regarding staff performance and POC service delivery for monthly contact and quarterly home visits.

d. Quarterly observation documentation must also address recipient satisfaction with service provision.

e. Any action planned or taken to correct problems identified during supervision and oversight.

12 VAC 30-120-751. Reserved.

12 VAC 30-120-752. Day support services.

A. Service description. Day support services shall include a variety of training, support, and supervision offered in a setting (other than the home or recipient residence), which allows peer interactions and community integration. If prevocational services are offered, the plan of care must contain documentation regarding whether prevocational services are available in vocational

rehabilitation agencies through § 110 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 730), or in special education services through the Individuals with Disabilities Education Act (20 U.S.C. §§ 1400 through 1487). When services are provided through these sources, the plan of care shall not authorize them as a waiver funded expenditure. Compensation for prevocational services can only be made when the recipient's productivity is less than 50% of the minimum wage. Service providers are reimbursed only for the amount and type of day support services included in the recipient's approved plan of care based on the setting, intensity, and duration of the service to be delivered.

B. Criteria. For day support services, recipients shall have demonstrated the need for functional training, assistance, and specialized training offered in settings other than the recipient's own residence which allow an opportunity for being productive and contributing members of communities. In addition, day support services will be available for recipients who cannot benefit from supported employment services and who need the services for: accessing in-home supported living services; or increasing levels of independent skills within current daily living situations; or sustaining skills necessary for continuing the level of independence in current daily living situations.

1. A functional assessment should be conducted by the provider to evaluate each recipient in his home environment and community settings.

2. Levels of day support. The amount and type of day support included in the recipient's plan of care is determined according to the services required for that recipient. There are two types of day support: center-based, which is provided partly or entirely in a segregated setting, or non-center-based, which is provided entirely in community

settings. Both types of day support may be provided at either intensive or regular levels. To be authorized at the intensive level, the recipient must have extensive disability-related difficulties and require additional, ongoing support to fully participate in programming and to accomplish his service goals; or the recipient requires extensive constant supervision to reduce or eliminate behaviors that preclude full participation in the program. A formal, written behavioral program is required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.

C. Service units and service limitations. Day support cannot be regularly or temporarily (e.g., due to inclement weather or recipient illness) provided in a recipient's home or other residential setting without written prior approval from DMAS. Non-center-based day support services must be separate and distinguishable from either in-home residential support services or personal assistance services. There must be separate POCs and separate documentation for each service and each must be clearly differentiated in documentation and corresponding billing. The POC must provide an estimate of the amount of day support required by the recipient. The maximum is 780 units per calendar year. Transportation shall not be billable as a day support service.

1. One unit shall be 1 to 3.99 hours of service a day.

2. Two units are 4 to 6.99 hours of service a day.

3. Three units are 7 or more hours of service a day.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, day support providers need to meet additional requirements.

1. For DMHMRSAS licensed programs, a POC and ongoing documentation must be consistent with licensing regulations. For non-DMHMRSAS licensed programs, there must be a POC, which contains, at a minimum, the following elements:

a. The recipient's strengths, desired outcomes, required or desired supports and training needs;

b. The recipient's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

c. Services to be rendered and the frequency of services to accomplish the above goals and objectives;

d. All individuals or organizations that will provide the services specified in the statement of services;

e. A timetable for the accomplishment of the recipient's goals and objectives;

f. The estimated duration of the recipient's needs for services; and

g. The individual or individuals responsible for the overall coordination and integration of the services specified in the plan.

2. During a period when a 60-Day assessment is used, documentation must confirm the recipient's attendance and amount of time in services and provide specific information regarding the recipient's response to various settings and supports as agreed to in the POC objectives. Assessment results shall be available in at least a daily note or a weekly summary.

a. The POC must be reviewed by the provider with the recipient, and this review submitted to the support coordinator, at least quarterly, with goals, objectives, and activities modified as appropriate.

b. An attendance log or similar document must be maintained which indicates the date, type of services rendered, and the number of hours and units provided (including specific time frame).

c. Documentation must indicate whether the services were center-based or non-center-based.

d. If high intensity day support services are requested, in order to verify which of these criteria the recipient met, documentation must be present in the recipient's record to indicate the specific supports and the reasons they are needed. For reauthorization of high intensity day support services, there must be clear documentation of the ongoing needs and associated staff supports.

12 VAC 30-120-753. Reserved.

12 VAC 30-120-754. Supported employment services.

A. Service description.

1. Supported employment services shall include training in specific skills related to paid employment and provision of ongoing or intermittent assistance or specialized training to enable a recipient to maintain paid employment. Each POC must contain documentation regarding whether supported employment services are available in vocational rehabilitation agencies through the Rehabilitation Act of 1973 or in special education services through 20 U.S.C. § 1401 of the Individuals with Disabilities Education Act. Providers of these DRS and IDEA services cannot be reimbursed by Medicaid with the IFDDS waiver funds. Waiver service providers are reimbursed only for the amount and type of habilitation services included in the recipient's approved POC based on the intensity and duration of the service delivered. Reimbursement shall be limited to actual interventions by the provider of supported employment, not for the amount of time the recipient is in the supported employment environment.

2. Supported employment can be provided in one of two models. Recipient supported employment is defined as intermittent support, usually provided one on one by a job coach to a recipient in a supported employment position. Group supported employment is defined as continuous support provided by staff to eight or fewer recipients with disabilities in an enclave, work crew, or bench work/entrepreneurial model. The

recipient's assessment and POC must clearly reflect the recipient's need for training and supports.

B. Criteria for receipt of services.

1. Only job development tasks that specifically include the recipient are allowable job search activities under the IFDDS waiver supported employment and only after determining this service is not available from DRS.

2. In order to qualify for these services, the recipient shall have a demonstrated need for training, specialized supervision, or assistance in paid employment and for whom competitive employment at or above the minimum wage is unlikely without this support and who, because of the disability, needs ongoing support, including supervision, training and transportation to perform in a work setting.

3. A functional assessment should be conducted to evaluate each recipient in his home environment and community settings.

4. The plan of care must provide the amount of supported employment required by the recipient. Service providers are reimbursed only for the amount and type of supported employment included in the recipient's POC.

C. Service units and service limitations.

1. Supported employment for recipient job placement will be billed on an hourly basis. Transportation shall not be billable as a supported employment service.

2. Group models of supported employment (enclaves, work crews and entrepreneurial model of supported employment) will be billed at the unit rate.

a. One unit is 1 to 3.99 hours of service a day.

b. Two units are 4 to 6.99 or more hours of service a day.

c. Three units are 7 or more hours of service a day.

3. For the recipient job placement model, reimbursement of supported employment will be limited to actual documented interventions or collateral contacts by the provider, not for the amount of time the recipient is in the supported employment situation.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, specific provider qualifications are:

1. Supported employment services shall be provided by agencies that are either licensed by the DMHMRSAS as a day support service or are vendors of extended employment services, long-term employment support services or supportive employment services for the DRS.

2. Recipient ineligibility for DRS or Special Education services must be documented in the recipient's record, as applicable. If the recipient is older than 22 years, and therefore not

eligible for Special Education funding, documentation is required only for lack of DRS funding. Acceptable documentation would include a copy of a letter from DRS or the local school system or a record of a phone call (name, date, person contacted) documented in the support coordinator's case notes, Consumer Profile/Social assessment or on the annual supported employment POC. Unless the recipient's circumstances change, the original verification can be forwarded into the current record or repeated on the POC or revised Consumer Profile/Social Assessment on an annual basis.

3. A POC and ongoing documentation consistent with licensing regulations, if a DMHMRSAS licensed program.

4. For non-DMHMRSAS licensed support programs, there must be a POC that contains, at a minimum, the following elements:

a. The recipient's strengths, desired outcomes, required/desired supports and training needs;

b. The recipient's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

c. Services to be rendered and the frequency of services to accomplish the above goals and objectives;

d. All individuals or organizations that will provide the services specified in the statement of services;

e. A timetable for the accomplishment of the recipient's goals and objectives.

f. The estimated duration of the recipient's needs for services;

g. Individuals responsible for the overall coordination and integration of the services specified in the plan.

5. During the 60-day assessment period, documentation must confirm attendance and provide specific information regarding the recipient's response to various settings and supports as agreed to in the POC objectives. Assessment results should be available in at least a daily note or weekly summary.

6. The POC must be reviewed by the provider with the recipient, and this review submitted to the support coordinator, at least quarterly, with goals, objectives and activities modified as appropriate.

12 VAC 30-120-755. Reserved.

12 VAC 30-120-756. Therapeutic consultation.

A. Service description. Therapeutic consultation is available under the waiver for Virginia licensed or certified practitioners in psychology, social work, occupational therapy, physical therapy,

therapeutic recreation, rehabilitation engineering, and speech therapy. Behavior consultation performed by these individuals may also be a covered waiver service. These services may be provided, based on the recipient plan of care, for those recipients for whom specialized consultation is clinically necessary to enable their utilization of waiver services. Therapeutic consultation services, other than behavior consultation, may be provided in in-home residential or day support settings or in office settings in conjunction with another waiver service. Only behavior consultation may be offered in the absence of any other waiver service when the consultation provided to informal caregivers is determined to be necessary to prevent institutionalization. Therapeutic consultation service providers are reimbursed according to the amount and type of service authorized in the POC based on an hourly fee for service.

B. Criteria. In order to qualify for these services, the recipient shall have a demonstrated need for consultation in any of these services. Documented need indicates that the Plan of Care could not be implemented effectively and efficiently without such consultation from this service.

1. The recipient's POC must clearly reflect the recipient's needs, as documented in the social assessment, for specialized consultation provided to caregivers in order to implement the plan of care effectively.

2. Therapeutic consultation services may not include direct therapy provided to waiver recipients, nor duplicate the activities of other services that are available to the recipient through the State Plan of Medical Assistance.

C. Service units and service limitations. The unit of service shall equal one hour. The services must be explicitly detailed in the POC. Travel time, written preparation, and telephone

communication are in-kind expenses within this service and are not billable as separate items. Therapeutic consultation may not be billed solely for purposes of monitoring.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, professionals rendering therapeutic consultation services, including behavior consultation services, shall meet all applicable state licensure or certification requirements. Persons providing rehabilitation engineering shall be contracted with DRS.

1. POC for therapeutic consultation. The standard therapeutic consultation POC must be used for this purpose. The following information is required on the POC:

a. Identifying information; recipient's name and Medicaid number; provider name and provider number; responsible person and telephone number; effective dates for POC; and quarterly review dates, if applicable;

b. Targeted objectives/time frames/expected outcomes;

c. Specific consultation; and

d. The expected products.

2. Monthly and contact notes shall include:

a. Summary of consultative activities for the month;

b. Dates, locations, and times of service delivery;

c. POC objectives addressed;

d. Specific details of the activities conducted;

e. Services delivered as planned or modified; and

f. Effectiveness of the strategies and recipients' and caregivers' satisfaction with service.

3. Quarterly reviews are required by the service provider if consultation extends three months or longer and are to be forwarded to the support coordinator and include:

a. Activities related to the therapeutic consultation POC;

b. Recipient status and satisfaction with services; and

c. Consultation outcomes and effectiveness of support plan.

4. If consultation services extend less than 3 months, the provider must forward monthly/contact notes or a summary of them to the support coordinator for the quarterly review.

5. A written support plan, detailing the interventions and strategies for staff, family or caregivers to use to better support the recipient in the service.

6. A final disposition summary must be forwarded to the support coordinator within 30 days following end of this service and must include:

a. Strategies utilized;

b. Objectives met;

c. Unresolved issues; and

d. Consultant recommendations.

12 VAC 30-120-757. Reserved.

12 VAC 30-120-758. Environmental modifications.

A. Service description. Environmental modifications shall be available to recipients who are receiving at least one other waiver service. Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate

the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repairs, central air conditioning, etc. Adaptations which add to the total square footage of the home shall be excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes. Modifications can be made to a vehicle if it is the primary vehicle being used by the individual.

B. Criteria. In order to qualify for these services, the recipient shall have a demonstrated need for equipment or modifications of a remedial or medical benefit offered primarily in a recipient's home, vehicle, community activity setting, or day program to specifically improve the recipient's personal functioning. This service shall encompass those items not otherwise covered in the State Plan for Medical Assistance or through another program (e.g., DRS or the Consumer Service Fund).

C. Service units and service limitations. A maximum limit of $5,000 may be reimbursed per calendar year. Costs for environmental modifications shall not be carried over from year to year.

D. Provider requirements. In addition to meeting the general conditions and requirements for HCBC participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, environmental modifications shall be provided in accordance with all applicable state or local building codes by contractors of DMAS or DRS who shall be reimbursed for the amount charged by said contractors.

12 VAC 30-120-759. Reserved.

12 VAC 30-120-760. Skilled nursing services.

A. Service Description. Skilled nursing services shall be provided for recipients with serious medical conditions and complex health care needs who require specific skilled nursing services that cannot be provided by non-nursing personnel. Skilled nursing may be provided in the recipient's home or other community setting on a regularly scheduled or intermittent need basis.

B. Criteria. In order to qualify for these services, the recipient shall have demonstrated complex health care needs, which require specific skilled nursing services which are ordered by a physician and which cannot be otherwise accessed under the Title XIX State Plan for Medical Assistance. The recipient's plan of care must stipulate that this service is necessary in order to prevent institutionalization.

C. Service units and service limitations. Skilled nursing services to be rendered by either registered or licensed practical nurses are provided in hourly units. Recipients may receive up to 250 hours of skilled nursing services per calendar year without prior authorization.

D. Provider requirements. Skilled nursing services shall be provided by EITHER a DMAS certified private duty nursing or home health provider OR by a licensed registered nurse or licensed practical nurse contracted or employed by a Community Services Board. In addition to meeting the general conditions and requirements for home and community-based care participating

providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, specific provider qualifications to be approved for skilled nursing contracts include:

1. Being a home health agency certified by the VDH for Medicaid participation, with which DMAS has a contract for private duty nursing.

2. Demonstrating a prior successful health care delivery business or practice;

3. Operating from a business office;

4. Employing or subcontracting with and directly supervising a registered nurse (RN) or a licensed practical nurse (LPN) with a current and valid license issued by the Virginia State Board of Nursing. The RN or LPN shall have at least two years of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, or nursing home.

12 VAC 30-120-761. Reserved.

12 VAC 30-120-762. Assistive technology.

A. Service description. Assistive technology is available to recipients who are receiving at least one other waiver service and may be provided in a residential or nonresidential setting.

B. Criteria. In order to qualify for these services, the recipient shall have a demonstrated need for equipment or modification for remedial or medical benefit primarily in a recipient's home, vehicle, community activity setting, or day program to specifically serve to improve the recipient's personal functioning. This shall encompass those items not otherwise covered under the State Plan.

C. Service units and service limitations. A maximum limit of $5,000 may be reimbursed per calendar year. Costs for assistive technology shall not be carried over from year to year.

D. Provider requirements. In addition to meeting the general conditions and requirements for HCBC participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, assistive technology shall be provided by agencies under contract with the DMAS as durable medical equipment and supply providers.

12 VAC 30-120-763. Reserved.

12 VAC 30-120-764. Crisis stabilization services.

A. Service Description. Crisis stabilization services shall provide, as appropriate, neuropsychological, psychiatric, psychological and functional assessments and stabilization, medication management and behavior assessment and support, and intensive care coordination with other agencies and providers. These services shall be provided to:

1. Assist planning and delivery of services and supports to maintain community placement of the recipient;

2. Training of family members and other care givers and service providers in positive behavioral supports to maintain the recipient in the community;

3. Temporary crisis supervision to ensure the safety of the recipient and others; and

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

B. Criteria.

1. In order to receive crisis stabilization services, the recipient must meet at least one of the following criteria:

a. The recipient is experiencing marked reduction in psychiatric, adaptive, or behavioral functioning;

b. The recipient is experiencing extreme increase in emotional distress;

c. The recipient needs continuous intervention to maintain stability; or

d. The recipient is causing harm to self or others.

2. The recipient must be at risk of at least one of the following:

a. Psychiatric hospitalization;

b. Emergency ICF/MR placement;

c. Disruption of community status (living arrangement, day placement, or school); or

d. Causing harm to self or others.

C. Service units and service limitations. Crisis stabilization services must be authorized following a documented face-to-face assessment conducted by a qualified mental retardation professional.

1. The unit for each component of the service shall equal one hour. This service may be authorized for a maximum period of 15 days and no more than 60 days in a calendar year. The actual service units per episode shall be based on the documented clinical needs of the recipients being served. Extension of services, beyond the 15-day limit per authorization, must be authorized following a documented face-to-face reassessment conducted by a qualified professional.

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

a. The home of a recipient who lives with family or other primary caregiver or caregivers;

b. The home of a recipient who lives independently or semi-independently to augment any current services and support;

c. A community-based residential program to augment current services and supports;

d. A day program or setting to augment current services and supports; or

e. A respite care setting to augment current services and supports.

3. Crisis stabilization may be provided as a component of this service only if clinical or behavioral interventions allowed under this service are also provided during the authorized period. Crisis supervision must be provided face-to-face with the recipient.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, specific provider qualifications are:

1. Crisis stabilization services shall be provided by agencies licensed by DMHMRSAS as a provider of outpatient, residential, supportive residential services, or day support services. The provider agency must employ or utilize qualified licensed mental health professionals or other qualified personnel competent to provide crisis stabilization and

related activities to recipients with developmental disabilities who are experiencing serious behavioral problems.

2. A crisis stabilization POC must be developed (or revised, if requesting an extension) and submitted to the support coordinator for authorization within 72 hours of assessment or reassessment.

3. Documentation indicating the dates and times of crisis stabilization services and amount and type of service provided must be recorded in the recipient's record.

4. Documentation of qualifications of providers must be maintained for review by DMAS staff. This service shall be designed to stabilize the recipient and strengthen the current semi-independent living situation, or situation with family or other primary care givers so the recipient can be maintained during and beyond the crisis period.

12 VAC 30-120-765. Reserved.

12 VAC 30-120-766. Personal care services.

A. Service description. Personal care services may be offered to recipients in their homes and communities as an alternative to more costly institutional care. This service shall provide care to recipients with activities of daily living, medication or other medical needs or the monitoring of health status or physical condition.

B. Criteria. In order to qualify for these services, the individual shall have demonstrated a need for such personal care.

C. Service units and service limitations. Recipients can have personal care and in-home residential support services in their service plan but cannot receive in-home residential supports and personal care services at the same time. The recipient must have an emergency back-up plan in case the personal care aide does not show up for work as expected.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, personal care providers must meet additional provider requirements.

1. Personal care services shall be provided by a DMAS certified personal care provider or by a DMHMRSAS licensed residential support provider.

2 The personal care provider shall:

a. Demonstrate a prior successful health care delivery business.

b. Operate from a business office.

c. Employ or subcontract with and directly supervise an RN or an LPN who will provide ongoing supervision of all personal care aides.

(1) The supervising RN and LPN shall be currently licensed to practice in the Commonwealth and have at least 2 years of related clinical nursing experience which may include work in an acute care hospital, public health clinic, home health agency, or nursing facility.

(2) The RN supervisor shall make an initial assessment home visit prior to the start of care for all new recipients admitted to personal care.

(3) The RN or LPN shall make supervisory visits as often as needed to ensure both quality and appropriateness of services. A minimum frequency of these visits is every 30 - 90 days depending on recipient needs.

(4) The supervising RN or LPN summary shall note:

(a) Whether personal care services continue to be appropriate;

(b) Whether the plan is adequate to meet the need or changes are indicated in the plan;

(c) Any special tasks performed by the aide and the aide's qualifications to perform these tasks;

(d) Recipient's satisfaction with the service;

(e) Hospitalization or change in medical condition or functioning status;

(f) Other services received and their amount; and

(g) The presence or absence of the aide in the home during the RN's or LPN's visit.

(5) Employ and directly supervise personal care aides who will provide direct care to personal care recipients. Each aide hired by the provider agency shall be evaluated by the provider agency to ensure compliance with minimum qualifications as required by the DMAS. Each aide:

(a) Shall be able to read and write;

(b) Shall complete 40 hours of training consistent with the DMAS standards. Prior to assigning an aide to a recipient, the provider agency shall ensure that the aide has satisfactorily completed a training program consistent with DMAS standards;

(c) Shall be physically able to do the work;

(d) Shall have a satisfactory work record, as evidenced by two references from prior job experiences, including no evidence of

possible abuse, neglect or exploitation of aged or incapacitated adults and children; and

(e) Shall not be a member of the recipient's family (e.g., family is defined as parents, spouses, children, siblings, grandparents, legal guardian, and grandchildren).

3. Provider inability to render services and substitution of aides.

a. When a personal care aide is absent and the agency has no other aide available to provide services, the provider agency is responsible for ensuring that services continue to recipients. The agency may either obtain a substitute aide from another agency, if the lapse in coverage is to be less than two weeks in duration, or may transfer the recipient to another agency.

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

(1) The personal care agency having recipient responsibility shall provide the RN or LPN supervision for the substitute aide.

(2) The agency providing the substitute aide shall send a copy of the aide's signed daily records signed by the recipient to the personal care agency having recipient care responsibility.

(3) The provider agency having recipient responsibility shall bill DMAS for services rendered by the substitute aide.

c. If a provider agency secures a substitute aide, the provider agency shall be responsible for ensuring that all DMAS requirements continue to be met including documentation of services rendered by the substitute aide and documentation that the substitute aide's qualifications meet DMAS' requirements.

4. Required documentation in recipients' records. The provider agency shall maintain all records of each personal care recipient. At a minimum these records shall contain:

a. The most recently updated Level of Functioning Survey (LOF) and addendum, the Screening Authorization, the recipient choice form, all provider agency plans of care, and all DMAS-122 forms;

b. All the DMAS utilization review forms and plans of care;

c. Initial assessment by the RN supervisory nurse completed prior to or on the date services are initiated;

d. Nurses notes recorded and dated during any contacts with the personal care aide and during supervisory visits to the recipient's home;

e. All correspondence to the recipient and to DMAS;

f. Reassessments made during the provision of services; and

g. Contacts made with family, physicians, DMAS, formal and informal service providers and all professionals concerning the recipient.

h. All personal care aide records. The personal care aide record shall contain:

(1) The specific services delivered to the recipient by the aide and the recipient's responses;

(2) The aide's arrival and departure times;

(3) The aide's weekly comments or observations about the recipient to include observations of the recipient's physical and emotional condition, daily activities, and responses to services rendered;

(4) The aide's and recipient's weekly signatures to verify that personal care services during that week have been rendered, and

i. Signatures, times, and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered.

12 VAC 30-120-767. Reserved.

12 VAC 30-120-768. Respite care services.

A. Service description. Respite care means services specifically designed to provide a temporary but periodic or routine relief to the primary caregiver of a recipient who is incapacitated or dependent due to physical disability. Respite care services includes assistance with personal hygiene, nutritional support and environmental maintenance authorized as either episodic, temporary relief, or as a routine periodic relief of the caregiver. Persons can have respite care and in-home residential support services in their service plan but cannot receive in-home residential supports and respite care services simultaneously.

B. Criteria. Respite care may only be offered to recipients who have a primary caregiver living in the home who requires temporary relief to avoid institutionalization of the recipient. Respite care is designed to focus on the need of the caregiver for temporary relief and to help prevent the breakdown of the caregiver due to the physical burden and emotional stress of providing continuous support and care to the dependent recipient.

C. Service units and service limitations. Respite care services are limited to a maximum of 30 days or 720 hours per year.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, specific provider qualifications include, but are not limited to:

1. Respite care services shall be provided by a DMAS certified personal care provider; a DMHMRSAS licensed supportive in-home residential support provider, respite care services provider (ICF/MR) or in-home respite care provider.

2. The respite care provider shall employ or subcontract with and directly supervise an RN and an LPN who will provide ongoing supervision of all respite care aides.

a. The RN and LPN shall be currently licensed to practice in the Commonwealth and have at least two years of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, or nursing facility.

b. Based on continuing evaluations of the aides' performance and recipients' needs, the RN and LPN supervisor shall identify any gaps in the aides' ability to function competently and shall provide training as indicated.

c. The RN supervisor shall make an initial assessment visit prior to the start of care for any recipient admitted to respite care.

d. The RN or LPN shall make supervisory visits as often as needed to ensure both quality and appropriateness of services.

(1) When respite care services are received on a routine basis, the minimum acceptable frequency of these supervisory visits shall be every 30 days.

(2) When respite care services are not received on a routine basis, but are episodic in nature, the RN or LPN shall not be required to conduct a supervisory visit every 30 days. Instead, the nurse supervisor shall conduct the initial home visit with the respite care aide immediately preceding the start of care and make a second home visit within the respite care period.

(3) When respite care services are routine in nature and offered in conjunction with personal care, the 30-day supervisory visit conducted for personal care may serve as the RN or LPN visit for respite care. However, the RN or LPN supervisor shall document supervision of respite care separately. For this purpose, the same recipient record can be used with a separate section for respite care documentation.

e. The RN or LPN shall document in a summary note:

(1) Whether respite care services continue to be appropriate.

(2) Whether the plan of care is adequate to meet the recipient's needs or if changes need to be made.

(3) The recipient's satisfaction with the service.

(4) Any hospitalization or change in medical condition or functioning status.

(5) Other services received and their amount.

(6) The presence or absence of the aide in the home during the visit.

3. Employ and directly supervise respite care aides who provide direct care to respite care recipients. Each aide hired by the provider agency shall be evaluated by the provider agency to ensure compliance with minimum qualifications. Each aide:

a. Shall be able to read and write;

b. Shall have completed 40 hours of training consistent with the DMAS standards. Prior to assigning an aide to a recipient, the provider agency shall ensure that the aide has satisfactorily completed a training program consistent with the DMAS standards;

c. Shall be evaluated in his job performance by the RN or LPN supervisor;

d. Shall have the physical ability to do the work;

e. Shall have a satisfactory work record, as evidenced by two references from prior job experiences, including no evidence of possible abuse, neglect or exploitation of aged or incapacitated adults or children; and

f. Shall not be a member of a recipient's family (family is defined as parents, spouses, siblings, legal guardian, grandparents, and grandchildren).

4. Inability to provide services and substitution of aides. When a respite care aide is absent and the respite care provider agency has no other aide available to provide services, the provider agency is responsible for ensuring that services continue to recipients.

a. If a provider agency cannot supply a respite care aide to render authorized services, the agency may either obtain a substitute aide from another agency, if the lapse in coverage is to be less than two weeks in duration, or may transfer the recipient's care to another agency.

b. If no other provider agency is available who can supply an aide, the provider agency shall notify the recipient or family so that they may contact the support coordinator to request a screening if ICF/MR placement is desired.

c. During temporary, short-term lapses in coverage, not to exceed two weeks in duration, a substitute aide may be secured from another respite care provider agency or other home care agency. Under these circumstances, the following requirements shall apply:

(1) The respite care agency having recipient responsibility shall be responsible for providing the RN or LPN supervision for the substitute aide.

(2) The respite care agency having recipient care responsibility shall obtain a copy of the aide's daily records signed by the recipient and the substitute aide from the respite care agency providing the substitute aide. All documentation of services rendered by the substitute aide shall be in the recipient's record. The documentation of the substitute aide's qualifications shall also be obtained and recorded in the personnel files of the agency having recipient care responsibility. The two agencies involved shall negotiate the financial arrangements of paying the substitute aide.

(3) The provider agency having recipient responsibility shall bill the DMAS for services rendered by the substitute aide.

d. Substitute aides obtained from other agencies may be used only in cases where no other arrangements can be made for recipient respite care services coverage and may be used only on a temporary basis. If a substitute aide is needed for more than two weeks, the case shall be transferred to another respite care provider agency that has the aide capability to serve the recipient or recipients.

5. Required documentation for recipients' records. The provider agency shall maintain all records of each respite care recipient. These records shall be separated from those of other non-home and community-based care services, such as companion services or home health. These records shall be reviewed periodically by the DMAS staff. At a minimum these records shall contain:

(a) DMAS service authorization form, all respite care assessment and Plans of Care, and all DMAS-122s;

(b) All DMAS utilization review forms and Plans of Care;

(c) Initial assessment by the RN or LPN supervisory nurse completed prior to or on the date services are initiated;

(d) Nurse's notes recorded and dated during significant contacts with the respite care aide and during supervisory visits to the recipient's home;

(e) All correspondence to the recipient and to the DMAS;

(f) Reassessments made during the provision of services;

(g) Significant contacts made with family, physicians, the DMAS, and all professionals concerning the recipient;

6. Respite care aide record of services rendered and recipient's responses. The aide record shall contain:

(a) The specific services delivered to the recipient by the respite care aide and the recipient's response.

(b) The arrival and departure time of the aide for respite care services only.

(c) Comments or observations recorded weekly about the recipient. Aide comments shall include but not be limited to observation of the recipient's physical and emotional condition, daily activities, and the recipient's response to services rendered.

(d) The signature of the aide and the recipient once each week to verify that respite care services have been rendered.

(e) Signature, times, and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered.

7. Copies of all aide records shall be subject to review by State and federal Medicaid representatives.

12 VAC 30-120-769. Reserved.

12 VAC 30-120-770. Consumer-directed services: Attendant care and consumer-directed respite care.

A. Service definition.

1. Attendant services include hands-on care specific to the needs of a medically stable, physically disabled recipient. Attendant care includes assistance with ADLs, bowel/bladder programs, range of motion exercises, routine wound care which does not

include sterile technique, and external catheter care. Supportive services are those, which substitute for the absence, loss, diminution, or impairment of a physical function. When specified, supportive services may include assistance with instrumental activities of daily living (IADLs) which are incidental to the care furnished, or which are essential to the health and welfare of the recipient. Attendant care shall not include either practical or professional nursing services or those practices as regulated in Chapters 30 and 34 of Subtitle III of Title 54.1 of the Code of Virginia, as appropriate. Recipients can have attendant care and in-home residential support services in their service plan but cannot simultaneously receive these two services.

2. Consumer-directed respite care means services specifically designed to provide a temporary but periodic or routine relief to the primary caregiver of a recipient who is incapacitated or dependent due to frailty or physical disability. Respite care services includes assistance with personal hygiene, nutritional support, and environmental maintenance authorized as either episodic, temporary relief, or as a routine periodic relief of the caregiver.

3. DMAS shall contract for the services of a fiscal agent for attendant care and consumer-directed respite care services. The fiscal agent will be reimbursed by DMAS to perform certain tasks as an agent for the recipient/employer who is receiving attendant care or consumer-directed respite care. The fiscal agent will handle responsibilities for the recipient for employment taxes. The fiscal agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services in order to fulfill all of these duties.

B. Criteria.

1. In order to qualify for these services, the recipient shall have demonstrated a need for personal care in activities of daily living, medication, or other medical needs, or monitoring health status or physical condition.

2. Respite care may only be offered to recipients who have a primary caregiver living in the home who requires temporary relief to avoid institutionalization of the recipient and is designed to focus on the need of the caregiver for temporary relief.

3. Attendant care and consumer-directed respite services shall be available to recipients who must be mentally alert and have no cognitive impairments who would otherwise require the level of care provided in an ICF/MR. If 18 years of age or older, recipients must be able to manage their own affairs without help and not have a legal guardian. If recipients receiving services are under 18 years of age, the legal guardian or parent will act on behalf of the minor. Recipients (and their parent or legal guardian, if minors) who are eligible for attendant care and consumer-directed respite care must have the capability to hire and train their own personal attendants and supervise the attendant's performance.

4. Responsibilities as employer. The recipient is the employer in this service, and is responsible for hiring, training, supervising, and firing personal attendants. If the recipient is a minor, the recipient's parent or legal guardian will serve on behalf of the recipient and monitor the recipient's care. Specific duties include checking references of personal attendants, determining that personal attendants meet basic qualifications,

training personal attendants, supervising the personal attendant's performance, and submitting timesheets to the service coordinator and fiscal agent on a consistent and timely basis. The recipient must have an emergency back-up plan in case the personal attendant does not show up for work as expected or terminates employment without prior notice.

C. Service units and service limitations.

1. Respite care services are limited to a maximum of 30 days or 720 hours per calendar year.

2. Recipients can have consumer-directed personal care and attendant care and in-home residential support services in their service plans but cannot simultaneously receive these services.

3. For attendant care and consumer-directed respite care services, recipients will hire their own personal attendants and manage and supervise the attendants' performance.

a. The attendant must the following requirements:

(1) Be 18 years of age or older;

(2) Have the required skills to perform attendant care services as specified in the recipient's POC;

(3) Possess basic math, reading, and writing skills;

(4) Possess a valid Social Security number;

(5) Submit to a criminal records check and, if the recipient is a minor, the child protective services registry. The personal attendant will not be compensated for services provided to the recipient if the records check verifies the personal attendant has been convicted of crimes described in the Code of Virginia § 32.1-162.9:1 or if the personal attendant has a complaint confirmed by the DSS child protective services registry.

(6) Be willing to attend training at the recipient's or family's request;

(7) Understand and agree to comply with the DMAS IFDDS waiver requirements; and

(8) Be willing to register in a personal attendant registry which will be maintained by the service coordinator chosen by the recipient or recipient's parent/guardian.

4. Restrictions. Attendants shall not be members of the recipients' family. Family is defined as a parent or stepparent, spouse, children or stepchildren, legal guardian, siblings or stepsiblings, grandparents or stepgrandparents, grandchildren, or stepgrandchildren.

5. Retention, hiring, and substitution of attendants. Upon the recipient's request, the service coordination provider shall provide the recipient with a list of persons on the personal attendant registry who can provide temporary assistance until the attendant returns or the recipient or recipient's parent/legal guardian is able to select and hire a new personal attendant. If a recipient or recipient's parent/legal guardian is consistently unable to hire and retain the employment of an attendant to provide attendant or consumer-directed respite services, the service coordination provider must contact the support coordinator and DMAS to transfer the recipient, at the recipient's choice, to a provider which provides Medicaid-funded agency-directed personal care or respite care services. The service coordination provider will make arrangements with the support coordinator to have the recipient transferred.

D. Provider qualifications. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, specific provider qualifications are:

1. To be enrolled as a Medicaid service coordination provider and maintain provider status, the service coordination provider shall operate from a business office and have sufficient qualified staff who will function as service coordinators to perform the needed plans of care development and monitoring, reassessments, service coordination, and support activities as required. It is preferred that the employee of the service coordination provider possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth. In addition, it is preferable that the recipient have two years of satisfactory experience in the human services field working with persons with severe

physical disabilities or the elderly. The recipient shall possess a combination of work experience and relevant education, which indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills and abilities must be documented on the application form, found in supporting documentation. or be observed during the job interview. Observations during the interview must be documented. The knowledge, skills, and abilities shall include:

a. Knowledge of:

(1) Types of functional limitations and health problems that are common to different disability types and the aging process as well as strategies to reduce limitations and health problems;

(2) Physical assistance typically required by people with severe physical disabilities or elderly persons, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

(3) Equipment and environmental modifications commonly used and required by people with physical disabilities or elderly persons which reduces the need for human help and improves safety;

(4) Various long-term care program requirements, including nursing home and adult care residence placement criteria, Medicaid waiver services,

and other federal, state, and local resources that provide personal assistance services;

(5) IFDDS waiver requirements, as well as the administrative duties for which the recipient will be responsible;

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

(7) Interviewing techniques;

(8) The recipient's right to make decisions about, direct the provisions of, and control his attendant care and consumer-directed respite care services, including hiring, training, managing, approving time sheets, and firing an attendant;

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

(10) General principles of record documentation.

b. Skills in:

(1) Negotiating with recipients and service providers;

(2) Observing, recording, and reporting behaviors;

(3) Identifying, developing, or providing services to persons with developmental disabilities; and

(4) Identifying services within the established services system to meet the recipient's needs.

c. Abilities to:

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

(2) Demonstrate a positive regard for recipients and their families;

(3) Be persistent and remain objective;

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

(5) Communicate effectively, verbally and in writing; and

(6) Develop a rapport and communicate with different types of persons from diverse cultural backgrounds.

2. If the service coordination staff employed by the service coordination provider is not an RN, the service coordination provider must have RN consulting services available, either by a staffing arrangement or through a contracted consulting arrangement. The RN consultant is to be available as needed to consult with recipients/service coordination providers on issues related to the health needs of the recipient.

3. Initiation of services and service monitoring.

a. Attendant care services. The service coordination provider must make an initial, comprehensive home visit to develop the POC with the recipient and provide management training. After the initial visit, two routine onsite visits must occur in the recipient's home within 60 days of the initiation of care or the initial visit to monitor the POC. The service coordination provider will continue to monitor the POC on an as needed basis, not to exceed a maximum of one routine onsite visit every 30 days but no less than the minimum of one routine onsite visit every 90 days per recipient. The initial comprehensive visit is done only once upon the recipient's entry into the service. If a waiver recipient changes service coordination agencies, the new service coordination provider shall bill for a reassessment in lieu of a comprehensive visit.

b. Consumer-directed respite services. The service coordination provider must make an initial, comprehensive home visit to develop the POC with the recipient or parent/legal guardian and will provide management training. After the initial visit, the service coordinator will periodically review the utilization of services at a minimum of every six months or upon the use of 300 respite care hours. The

initial comprehensive visit is done only once upon the recipient's entry into the service. If a waiver recipient changes service coordination agencies, the new service coordination provider shall bill for a reassessment in lieu of a comprehensive visit.

4. Service coordinator reassessments for consumer-directed respite and attendant care. A reassessment of the recipient's level of care will occur six months after initial entry into the program, and subsequent reevaluations will occur at a minimum of every six months. During visits to the recipient's home, the service coordination provider shall observe, evaluate, and document the adequacy and appropriateness of personal attendant services with regard to the recipient's current functioning and cognitive status, medical, and social needs. The service coordination provider's summary shall include, but not necessarily be limited to:

a. Whether attendant care or consumer-directed respite care services continue to be appropriate and medically necessary to prevent institutionalization;

b. Whether the plan of care is adequate to meet the recipient's needs;

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

d. Recipient's satisfaction with the service;

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

f. Other services received and their amount; and

g. The presence or absence of the attendant in the home during the service coordinator's visit.

5. The service coordination provider shall be available to the recipient by telephone.

6. The service coordination provider will submit a criminal record check pertaining to the personal attendant on behalf of the recipient and report findings of the criminal record check to the recipient or the recipient's legal guardian/parent and the program's fiscal agent. Personal attendants will not be reimbursed for services provided to the recipient effective with the date the criminal record check confirms a personal attendant has been found to have been convicted of a crime as described in the § 32.1-162.9:1 of the Code of Virginia. If the recipient is a minor, the personal attendant must also be screened through the DSS child protective services registry.

7. The service coordination provider shall verify bi-weekly timesheets signed by the recipient or the legal guardian/parent and the personal attendant to ensure that the number of POC approved hours are not exceeded. If discrepancies are identified, the service coordination provider will contact the recipient to resolve discrepancies and will notify the fiscal agent. If a recipient is consistently being identified as having discrepancies in his timesheets, the service coordination provider will contact the support coordinator to resolve the situation. The service coordination provider shall not verify

timesheets for personal attendants who have been convicted of crimes described in the § 32.1-162.9:1 of the Code of Virginia and will notify the fiscal agent.

8. Personal attendant registry. The service coordination provider shall maintain a personal attendant registry.

9. Required documentation in recipients' records. The service coordination provider shall maintain all records of each recipient. At a minimum these records shall contain:

a. All copies of the Level of Functioning (LOF) Survey and its addendum, the screening authorization form (DMAS-96), the recipient choice form, all plans of care, and all DMAS-122 forms.

b. All DMAS utilization review forms.

c. Service coordination provider’s notes contemporaneously recorded and dated during any contacts with the recipient and during visits to the recipient’s home.

d. All correspondence to the recipient and to DMAS.

e. Reassessments made during the provision of services.

f. Records of contacts made with family, physicians, DMAS, formal and informal service providers, and all professionals concerning the recipient.

g. All training provided to the personal attendant or attendants on behalf of the recipient.

h. All management training provided to the recipients, including the recipient's responsibility for the accuracy of the timesheets.

i. All documents signed by the recipient or the recipient's parent or legal guardian which acknowledge the responsibilities of the services.

12 VAC 30-120-771. Reserved.

12 VAC 30-120-772. Family and caregiver training.

A. Service Description. Family and caregiver training shall be the provision of identified training and education related to disabilities, community integration, family dynamics, stress management, behavior interventions and mental health to a parent, other family members or primary caregiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a waiver recipient, and may include a parent, spouse, children, relatives, a legal guardian, foster family, or in-laws. "Family" does not include individuals who are employed to care for the recipient. All family training must be included in the recipient's written POC.

B. Criteria. The need for the training and the content of the training in order to assist family or caregivers with maintaining the recipient at home must be documented in the recipient's POC. The training must be necessary in order to improve the family or caregiver's ability to give care.

C Service units and service limitations. Services will be billed hourly and must be prior authorized for services billed beyond 40 hours per calendar year.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, specific provider qualifications include:

1. Family and caregiver training shall be provided on an individual basis, in small groups or through seminars and conferences provided by Medicaid certified family and caregiver training providers. Such training may only be billed as it is rendered, for example, billed as individual training when rendered to an individual, or billed as a group when rendered to a group of individuals.

2. Family and caregiver training must also be provided by practitioners or individuals with expertise who work for an agency with experience in or demonstrated knowledge of the training topic and who work for an agency or organization that has a provider agreement with DMAS to provide these services.

12 VAC 30-120-773. Reserved.

12 VAC 30-120-774. Personal Emergency Response System (PERS).

A. Service Description. PERS is a service which electronically monitors recipient safety in the home and provides access to emergency crisis intervention 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 recipient's home telephone line.

B. Criteria. PERS can be authorized when no one else is in the home that is competent and continuously available to call for help in an emergency. If the recipient's caregiver has a business in the home, such as a day care center, PERS will only be approved if the recipient is evaluated as being dependent in orientation and behavior pattern.

C. Service units and service limitations.

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

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

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, specific provider qualifications include, but are not limited to:

1. A PERS provider shall be a certified home health or personal care agency, a durable medical equipment provider, a hospital or a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e. installation, equipment maintenance and service calls), and PERS monitoring.

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

3. A PERS provider must comply with all applicable Virginia statutes and all 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 recipient's notification of a malfunction of the console unit, activating devices or medication-monitoring unit while the original equipment is being repaired.

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

6. The PERS installation shall include local seize line circuitry, which guarantees the unit to 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 must maintain all installed PERS equipment in proper working order.

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

a. Delivery date and installation date of the PERS;

b. Enrollee/caregiver signature verifying receipt of PERS device;

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

d. Updated and current recipient responder and contact information, as provided by the recipient or the recipient's care provider; and

e. A case log documenting recipient system utilization and recipient or responder contacts/communications.

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

10. Standards for PERS Equipment. All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard Number 1635 for Digital Alarm Communicator System Units and Number 1637, which is the UL safety standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The PERS device must be automatically reset by the response center after each activation, ensuring that subsequent signals can be transmitted without requiring manual reset by the recipient.

11. A PERS provider shall furnish education, data, and ongoing assistance to DMAS to familiarize staff with the service, allow for ongoing evaluation and refinement of the program and shall instruct the recipient, caregiver, and responders in the use of the PERS service.

12. The emergency response activator must be activated either by breath, by touch, or by some other means, and must be usable by persons 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 recipient'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

recipient resetting the system in the event it cannot get its signal accepted at the response center.

13. Monitoring agencies must 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 assure that the monitoring agency and the agency's equipment meets the following requirements. The monitoring agency must be capable of simultaneously responding to multiple signals for help from recipients' PERS equipment. The monitoring agency's equipment must 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 recipient'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 monitoring agency must maintain detailed technical and operations manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and record keeping and reporting procedures.

15. The PERS provider shall document and furnish a written report to the support coordinator each emergency signal which results in action being taken on behalf of the recipient. This shall exclude test signals or activations made in error.

12 VAC 30-120-775. Reserved.

12 VAC 30-120-776. Companion Care.

A. Service Description. Companion care is a covered service when its purpose is to supervise or monitor those individuals who require the physical presence of an aide to insure their safety during times when no other supportive individuals are available. Companion services will include, as appropriate, psychiatric, neuropsychiatric, and psychological assessment and other functional assessments and stabilization techniques; medication management and monitoring; behavior assessment and positive behavioral support; intensive care coordination with other agencies and providers to assist planning and delivery of services and supports to maintain community placement of the recipient; training of family members, other caregivers, and service

providers in positive behavioral supports to maintain the recipient in the community; and temporary crisis supervision to ensure the safety of the recipient and others.

B. Criteria.

1. The inclusion of companion care in the plan of care is appropriate only when the recipient cannot be left alone at any time due to mental or severe physical incapacitation. This includes recipients who cannot use a phone to call for help due to a physical or neurological disability. Recipients can only receive companion care due to their inability to call for help if PERS is not appropriate for them.

2. Recipients who have a current, uncontrolled medical condition which would make them unable to call for help during a rapid deterioration can be approved for companion care if there is documentation that the recipient has had recurring attacks during the two-month period prior to the authorization of companion care. Companion care shall not be covered if required only because the recipient does not have a telephone in the home or because the recipient does not speak English.

3. There must be a clear and present danger to the recipient as a result of being left unsupervised. Companion care cannot be authorized for persons whose only need for companion care is for assistance exiting the home in the event of an emergency.

C. Service units and service limitations.

1. The amount of companion care time included in the plan of care must be no more than is necessary to prevent the physical deterioration or injury to the recipient. In no event may the amount of time relegated solely to companion care on the plan of care exceed eight hours per day.

2. A personal/respite care aide cannot provide supervision to recipients who are on ventilators, continuous tube feedings, or those who require suctioning of their airways.

3. Companion care will be authorized for family members to sleep either during the day or during the night when the recipient cannot be left alone at any time, due to the recipient's severe agitation and physically wandering behavior. Companion aide services must be required to insure the recipient's safety secondary to a clear and present danger to the recipient as a result of being left unsupervised.

4. Companion care can be authorized when no one else is in the home who is competent to call for help in an emergency. If the recipient's caregiver has his business in the home, such as a day care center, companion care will only be considered if the recipient is dependent in orientation and behavior pattern.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, specific provider qualifications include:

1. Companion aide qualifications. Agencies must employ individuals to provide companion care who meet the following requirements:

a. Be at least 18 years of age;

b. Possess basic reading, writing, and math skills;

c. Be capable of following a plan of care with minimal supervision;

d. Submit to a criminal history record check. The companion will not be compensated for services provided to the recipient if the records check verifies the companion has been convicted of crimes described in § 32.1-162.9:1 of the *Code of Virginia*;

e. Possess a valid Social Security number; and

f. Be capable of aiding in the activities of daily living or instrumental activities of daily living.

2. Companions will be employees of agencies that will contract with DMAS to provide companion services. Agencies will be required to have a companion care supervisor to monitor companion care services. The supervisor must be a certified Home Health Aide, an LPN, or an RN and must have a current license or certification to practice in the Commonwealth.

3. The provider agency will conduct an initial home visit within the first three days of initiating companion care services to document the efficacy and appropriateness of

services and to establish an individual service plan for the recipient. The agency will provide follow-up home visits to monitor the provision of services every four months or as often as needed. The recipient will be reassessed for services every six months.

12 VAC 30-120-777 through 12 VAC 30-120-779. Reserved.

12VAC 30-120-780. Reevaluation of service need and utilization review.

A. The Consumer Service Plan (CSP).

1. The CSP shall be developed by the support coordinator mutually with other service providers, the recipient, the recipient's parents or legal guardians for minors, consultants, and other interested parties based on relevant, current assessment data. The plan of care process determines the services to be rendered to recipients, the frequency of services, the type of service provider, and a description of the services to be offered. All CSPs developed by the support coordinators are subject to approval by DMAS. DMAS is the single state authority responsible for the supervision of the administration of the community-based care waiver.

2. The support coordinator is responsible for continuous monitoring of the appropriateness of the recipient's plan of care and revisions to the CSP as indicated by the changing needs of the recipient. At a minimum, the case support coordinator shall review the plan of care every three months to determine whether service goals and objectives are being met and whether any modifications to the CSP are necessary.

3. The DMAS staff shall review the Consumer Service Plan every 12 months or more frequently as required to assure proper utilization of services. Any modification to the amount or type of services in the CSP must be authorized by DMAS.

B. Review of level of care.

1. The DMAS shall complete an annual comprehensive reassessment, in coordination with the recipient, family, and service providers. If warranted, the DMAS shall coordinate a medical examination and a psychological evaluation for every waiver recipient. The reassessment shall include an update of the assessment instrument and any other appropriate assessment data.

2. A medical examination shall be completed for adults based on need identified by the provider, recipient, support coordinator, or DMAS staff. Medical examinations for children shall be completed according to the recommended frequency and periodicity of the EPSDT program.

3. A psychological evaluation or standardized developmental assessment for children over six years of age must reflect the current psychological status (diagnosis), adaptive level of functioning, and cognitive abilities. A new psychological evaluation shall be required whenever the recipient's functioning has undergone significant change and is no longer reflective of the past psychological evaluation.

C. Documentation required.

1. The support coordination agency must maintain the following documentation for review by the DMAS staff for each waiver recipient:

   a. All assessment summaries and all CSPs completed for the recipient and maintained for a period of not less than five years from recipients' start of care.

   b. All individual providers' POCs from any provider rendering waiver services to the recipient.

   c. All supporting documentation related to any change in the plan of care.

   d. All related communication with the providers, recipient, consultants, DMHMRSAS, DMAS, DSS, DRS or other related parties.

   e. An ongoing log which documents all contacts made by the support coordinator related to the waiver recipient.

2. The recipient service providers must maintain the following documentation for review by the DMAS staff for each waiver recipient:

   a. All POC's developed for that recipient and maintained for a period of not less than five years from the date of the recipient's entry to waiver services.

   b. An attendance log which documents the date services were rendered and the amount and type of services rendered.

c. Appropriate progress notes reflecting recipient's status and, as appropriate, progress toward the goals on the POC.

12 VAC 30-120-790 Eligibility criteria for emergency access to the waiver.

A. Subject to available funding, individuals must meet at least one of the emergency criteria to be eligible for immediate access to waiver services without consideration to the length of time an individual has been waiting to access services. In the absence of waiver services, the individual would not be able to remain in his home.

B. The criteria are:

1. The primary caregiver has a serious illness, has been hospitalized, or has died;

2. The individual has been determined by the DSS to have been abused or neglected and is in need of immediate Waiver services;

3. The individual has behaviors which present risk to personal or public safety; OR

4. The individual presents extreme physical, emotional, or financial burden at home and the family or caregiver is unable to continue to provide care.

12 VAC 30-120-800 Reserved.