12VAC30-50-490

Case management ~~(support coordination)~~ for individuals with developmental disabilities, including autism.

A. Target Group: Medicaid eligible ~~recipients~~ individuals with related conditions who are six years of age and older and who are on the waiting list or are receiving ~~eligible to receive~~ services under the Individual and Family Developmental Disabilities Support Waiver (IFDDS) waiver.

1. An active client for case management shall mean an individual for whom there is a plan of care in effect that requires regular direct or client-related contacts or communication or activity with the client, family, service providers, significant others and others including at least one face-to-face contact every 90 days. Billing can be submitted for an active client only for months in which direct or client-related contacts, activity or communications occur.

2. The unit of service is one month. There shall be no maximum service limits for case management services except case management services for individuals residing in institutions or medical facilities. For these individuals, reimbursement for case management for institutionalized individuals may be billed for no more than two months in a twelve month cycle.

B. Services will be provided in the entire State.

C. Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Social Security Act (Act) is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services. ~~Support coordination~~ Case Management services will be

provided for ~~recipients~~ Medicaid eligible individuals with related conditions who are on the waiting list for or participants in the home and community-based care IFDDS waiver. ~~Support coordination~~ Case Management services to be provided include:

1. Assessment and planning services, to include developing a consumer service plan (does not include performing medical and psychiatric assessment but does include referral for such assessments);
2. Linking the ~~recipient~~ individual to services and supports specified in the consumer service plan;
3. Assisting the ~~recipient~~ individual directly for the purpose of locating, developing, or obtaining needed services and resources;
4. Coordinating services with other agencies and providers involved with the ~~recipient~~ individual;
5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic, and recreational services;
6. Making collateral contacts with the ~~recipient's~~ individual’s significant others to promote implementation of the service plan and community adjustment;
7. Following up and monitoring to assess ongoing progress and ensure services are delivered;
8. Education and counseling that guides the ~~recipient~~ individual and develops a supportive relationship that promotes the service plan; and
9. Benefits counseling.

E. Qualifications of Providers: 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 qualify as a provider of services through DMAS for IFDDS waiver ~~support coordination~~ case management, the service provider must meet these criteria:

   a. Have the administrative and financial management capacity to meet state and federal requirements;

   b. Have the ability to document and maintain recipient case records in accordance with state and federal requirements; and

   c. Be ~~certified~~ enrolled as an IFDDS ~~support coordination~~ case management agency by DMAS.

2. Providers may bill for Medicaid ~~support coordination~~ case management only when the services are provided by qualified ~~support coordinators~~ case managers. The ~~support coordinator~~ case manager must possess a combination of developmental disability work experience or relevant education, which indicates that the individual possesses the following knowledge, skills, and abilities, at the entry level. These must be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).

   a. Knowledge of:

      (1) The definition, causes, and program philosophy of developmental disabilities;

      (2) Treatment modalities and intervention techniques, such as behavior management, independent living skills, training, supportive counseling, family education, crisis intervention, discharge planning and service coordination;

      (3) Different types of assessments and their uses in program

planning;

(4) ~~Recipients~~ Individuals' rights;

(5) Local service delivery systems, including support services;

(6) Types of developmental disability programs and services;

(7) Effective oral, written, and interpersonal communication principles and techniques;

(8) General principles of record documentation; and

(9) The service planning process and the major components of a service plan.

b. Skills in:

(1) Interviewing;

(2) Negotiating with ~~recipients~~ individuals and service providers;

(3) Observing, recording, and reporting behaviors;

(4) Identifying and documenting ~~a~~ an ~~recipient's~~ individual's needs for resources, services, and other assistance;

(5) Identifying services within the established service system to meet the ~~recipient's~~ individual's needs;

(6) Coordinating the provision of services by diverse public and private providers;

(7) Analyzing and planning for the service needs of developmentally disabled persons;

(8) Formulating, writing, and implementing ~~recipient~~ individual-specific ~~individual~~ service plans to promote goal attainment for recipients with developmental disabilities; and

(9) Using assessment tools.

c. Abilities to:

(1) Demonstrate a positive regard for ~~recipients~~ individuals and their families (e.g., ~~treating recipients as individuals,~~ allowing risk taking, avoiding stereotypes of developmentally disabled people, respecting ~~recipients'~~ individuals' and families' privacy, believing ~~recipients~~ individuals can grow);

(2) Be persistent and remain objective;

(3) Work as a team member, maintaining effective inter- and intra-agency working relationships;

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

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

(6) Establish and maintain ongoing supportive relationships.

3. In addition, case managers who enroll with DMAS to provide case management services after the effective date of these regulations must possess a minimum of an undergraduate degree in a human services field. Providers who had a Medicaid participation agreement to provide case management prior to February 1, 2005 and who maintain that agreement without interruption may continue to provide case management using the KSA requirements effective prior to February 1, 2005.

4. Case managers who are employed by an organization must receive supervision within the same organization. Case managers who are self-employed must obtain one hour of documented supervision every three months when the case manager has active cases. The individual who provides the supervision to the case manager

must have a Masters' level degree in a human services field and/or have five years of satisfactory experience in the field working with individuals with related conditions as defined in 42CFR 435.1009. A case management provider cannot supervise another case management provider.

5. Case managers must complete 8 hours of training annually in one or a combination of the areas described in the Knowledge, Skills and Abilities (KSA). Case managers must have documentation to demonstrate training is completed. The documentation must be maintained by the case manager for the purposes of utilization review.

6. Parents, spouses, or any person living with the individual may not provide direct case management services for their child, spouse or the individual with whom they live or be employed by a company that provides case management for their child, spouse, or the individual with whom they live.

7. A case manager may provide services facilitation services. In these cases, the case manager must meet all the case management provider requirements as well as the service facilitation provider requirements. Individuals and family/caregivers have the right to choose whether the case manager may provide services facilitation or to have a separate services facilitator and this choice must be clearly documented in the individual's record. If case managers are not services facilitation providers, the case manager must assist the individual and family/caregiver to locate an available services facilitator.

8. If the case manager is not serving as the individual's services facilitator, the case manager may conduct the assessments and reassessment for CD Services if the individual or family/caregiver chooses. The individual's choice must be clearly

documented in the case management record along with which provider is responsible for conducting the assessments and reassessments required for CD Services.

F. The State assures that the provision of case management ~~(support coordination)~~ services will not restrict an individual's free choice of providers in violation of §1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of ~~support coordination~~ case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management ~~(support coordination)~~ services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

CERTIFIED:

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12VAC30-120-700. Definitions.

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

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

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

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

"Behavioral health authority" or "BHA" means the local agency, established by a city or county or a combination of counties or cities or cities and counties under ~~§37.1-194~~ §37.2-100 et seq.

of the Code of Virginia, that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the jurisdiction or jurisdictions it serves.

"CARF" means the Rehabilitation Accreditation Commission, formerly known as the Commission on Accreditation of Rehabilitation Facilities.

"Case management" means services as defined in 12VAC30-50-490.

"Case manager" means ~~individual on behalf of the community services board or behavioral health authority staff possessing a combination of mental retardation work experience and relevant education that indicates that the individual possesses the knowledge, skills and abilities, at the entry level, as established by the Department of Medical Assistance Services, 12VAC30-50-450.~~ the provider of case management services as defined in 12VAC30-50-490.

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

"Community-based ~~care~~ waiver services" or "waiver services" means ~~the range of community support services approved by the Centers for Medicare and Medicaid Services (CMS) pursuant to §1915(c) of the Social Security Act to be offered to developmentally disabled recipients who would otherwise require the level of care provided in an ICF/MR.~~ a variety of home and community-based services paid for by DMAS as authorized under a §1915(c) waiver designed to offer individuals an alternative to institutionalization. Individuals 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.

"Community Services Board" or "CSB" means the local agency established by a city or county or combination of counties or cities, or cities and counties, under §37.2-100 ~~§37.1-194~~ et seq. of the Code of Virginia, that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the jurisdiction or jurisdictions it serves.

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

"Companion services" means nonmedical care, supervision and socialization, provided to a functionally or cognitively impaired adult age 18 and older. The provision of companion services does not entail hands-on ~~nursing~~ care and is provided in accordance with a therapeutic goal in the ~~consumer service~~ plan of care. ~~This shall not be the sole service used to divert recipients from institutional care.~~

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

~~"Consumer-directed respite care" means services given to caretakers of eligible individuals who are unable to care for themselves that are provided on an episodic or routine basis because of the absence or need for relief of those persons residing with the recipient who normally provide the care. The recipient will be responsible for hiring, training, supervising, and firing~~

~~the personal attendant. If the recipient is unable to independently manage his own consumer-directed respite care, a family caregiver can serve as the employer on behalf of the recipient.~~

“Consumer-directed employee” means, for purposes of these regulations, a person who provides consumer directed services, personal care, companion services and/or respite care, who is also exempt from Workers’ Compensation.

“Consumer directed services” means personal care, companion services and/or respite care services where the individual or family/caregiver is responsible for hiring, training, supervising, and firing of the employee or employees.

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

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

"Crisis stabilization" means direct intervention ~~to~~ for persons with ~~developmental disabilities~~ related conditions who are experiencing serious psychiatric or behavioral ~~problems~~ challenges, 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~~ individuals and strengthen the current living situations so that ~~recipients~~ individuals ~~can~~ may be maintained in the community during and beyond the crisis period.

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

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means ~~individuals~~ DMAS employees who perform utilization review, ~~recommendation of preauthorization for~~ preauthorize service type and intensity, provide technical assistance, and review ~~of recipient~~ individual level of care criteria.

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

"DRS" means the Department of Rehabilitative Services.

"DSS" means the Department of Social Services.

"Day support" means training in intellectual, sensory, motor, and affective social development including awareness skills, sensory stimulation, use of appropriate behaviors and social skills, learning and problem solving, communication and self care, physical development, services and support activities. These services take place outside of the individual's home/residence.

"Direct Marketing" means either (i) conducting directly or indirectly door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; (ii) mailing directly; (iii) paying "finders' fees"; (iv) offering financial incentives, rewards, gifts, or special opportunities to eligible individuals or family/caregivers as inducements to use the providers' services; (v) continuous, periodic marketing activities to the same prospective individual or

family/caregiver, for example, monthly, quarterly, or annual giveaways as inducements to use the providers' services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of the providers' services or other benefits as a means of influencing the individual's or family/caregiver's use of the providers' services.

"Enroll" means that the individual has been determined by the IFDDS screening team to meet the eligibility requirements for the waiver, DMAS has approved the individual's plan of care and has assigned an available slot to the individual, and DSS has determined the individual's Medicaid eligibility for home and community based services.

"Entrepreneurial model" means a small business employing eight or fewer individuals with disabilities on a shift and may involve interactions with the public and coworkers with disabilities.

"Environmental modifications" means physical adaptations to a house, place of residence, primary vehicle or work site, when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act, necessary to ensure ~~recipients'~~ individuals' 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~~ individuals.

"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 as defined in 12VAC30-50-130.

"Face-to-face visit" means the case manager or service provider must meet with the individual in person and that the individual should be engaged in the visit to the maximum extent possible.

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

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

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

"Home and community-based ~~care~~ waiver services" means a variety of ~~in-~~home and community-based services reimbursed by DMAS as authorized under a §1915(c) waiver designed to offer ~~recipients~~ individuals an alternative to institutionalization. ~~Recipients~~ Individuals 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.

"ICF/MR" means a facility or distinct part of a facility certified as meeting the federal certification regulations for an Intermediate Care Facility for the Mentally Retarded and persons with related conditions. These facilities must address the residents' total needs including physical, intellectual, social, emotional, and habilitation. An ICF/MR must provide active treatment, as that term is defined in 42 CFR 483.440(a).

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

“IFDDS screening team” means the persons employed by the entity under contract with DMAS who are responsible for performing level of care screenings for the IFDDS Waiver.

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

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

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

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

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

“MR Waiver” means the Mental Retardation Waiver.

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

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

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

“Pend” means delaying the consideration of an individual’s request for authorization of services until all required information is received by DMAS.

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

"Personal care services" means long-term maintenance or support services necessary to enable ~~recipients~~ individuals to remain in or return to the community rather than enter an Intermediate Care Facility for the Mentally Retarded. Personal care services include assistance with activities of daily living, instrumental activities of daily living, access to the community, medication or other medical needs, and monitoring health status and physical condition. ~~nutritional support, and the environmental maintenance necessary for recipients to remain in their homes and in the community.~~ This does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated in accordance with 18 VAC 90-20-420 through 18 VAC 90-20-460.

Person-centered planning" means a process, directed by the family or the individual with long term care needs, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual.

"Personal emergency response system (PERS)" is an electronic device that enables certain ~~recipients~~ individuals at high risk of institutionalization to secure help in an emergency. PERS services are limited to those ~~recipients~~ individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

"Plan of care" means a document developed by the individual or family/caregiver and the individual's case manager addressing all needs of individuals of home and community-based

waiver services, in all life areas. Supporting documentation developed by waiver service providers is to be incorporated in the plan of care by the case manager. Factors to be considered when these plans are developed must include, but are not limited to, individuals' ages, levels of functioning, and preferences.

"Preauthorized" means the preauthorization agent has approved a service for initiation and reimbursement prior to the commencement of the service by the service provider.

"Qualified developmental disabilities professional (QDDP)" means a professional possessing (i) at least one year of documented experience working directly with individuals who have related conditions; (ii) is one of the following: a doctor of medicine or osteopathy, a registered nurse, a provider holding at least a bachelor's degree in a human service field including, but not limited to, sociology, social work, special education, rehabilitation engineering, counseling or psychology, or a provider who has documented equivalent qualifications; and (iii) the required Virginia or national license, registration, or certification in accordance with his profession, if applicable.

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

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

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

1. It is attributable to:

a. Cerebral palsy or epilepsy; or

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

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

3. It is likely to continue indefinitely.

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

a. Self-care.

b. Understanding and use of language.

c. Learning.

d. Mobility.

e. Self-direction.

f. Capacity for independent living.

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

"Respite care ~~agency~~ provider" means a participating provider that renders services designed to prevent or reduce inappropriate institutional care by providing respite care services ~~to~~ for unpaid caregivers living in the home of eligible ~~recipients~~ individuals ~~for their caregivers~~.

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

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

"Skilled nursing services" means nursing services listed in the plan of care that do not meet home health criteria, required to prevent institutionalization, not otherwise available under the State Plan for Medical Assistance, are provided within the scope of the state's Nurse Practice Act and Drug Control Act (Chapters 30 (§54.1-3000 et seq.) and 34 (§54.1-3400 et seq.), respectively) of the Code of Virginia, and provided by a registered professional nurse or by a licensed practical nurse under the supervision of a registered nurse who is licensed to practice in the state. Skilled nursing services are to be used to provide training, consultation, nurse delegation as appropriate and oversight of direct care staff as appropriate.

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

"Specialized Supervision" means staff presence necessary for ongoing or intermittent intervention to ensure an individual's health and safety.

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

~~"Support coordination" means the assessment, planning, linking, and monitoring for recipients referred for the IFDDS community-based care waiver. Support coordination: (i) ensures the development, coordination, implementation, monitoring, and modification of consumer service plans; (ii) links recipients with appropriate community resources and supports; (iii) coordinates service providers; and (iv) monitors quality of care. Support coordination providers cannot be service providers to recipients in the IFDDS Waiver with the exception of consumer-directed service facilitators.~~

"Supporting documentation" means the specific ~~service~~ plan of care developed by the ~~recipient~~ individual and waiver service provider related solely to the specific tasks required of that service provider. Supporting documentation helps to comprise the overall ~~CSP~~ plan of care for the ~~recipient~~ individual, developed by the case manager and the individual.

"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~~ an individual to maintain paid employment.

"Therapeutic consultation" means consultation provided by members of psychology, social work, rehabilitation engineering, behavioral analysis, speech therapy, occupational therapy, psychiatry, psychiatric clinical nursing, therapeutic recreation, or physical therapy ~~disciplines~~ or behavior consultation to assist ~~recipients~~ individuals, parents, family members, in-home

residential support, day support and any other providers of support services in implementing a ~~CSP~~ plan of care.

"VDH" means the Virginia Department of Health.

CERTIFIED:

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

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

A. Waiver service populations. Home and community-based services shall be available through a §1915(c) waiver. Coverage shall be provided under the waiver for ~~recipients~~ individuals six years of age and older with related conditions as defined in ~~42 CFR 435.1009~~ 12VAC30-120-700, including autism, who have been determined to require the level of care provided in an ~~intermediate care facility for the mentally retarded~~ ICF/MR. The individual must not ~~also~~ have a diagnosis of mental retardation as defined by the American Association on Mental Retardation (AAMR). Mental Retardation (MR) Waiver recipients who are six years of age on or after October 1, 2002, who are determined to not have a diagnosis of mental retardation, and who meet all IFDDS Waiver eligibility criteria, shall be eligible for and shall transfer to the IFDDS Waiver effective with their sixth birthday. Psychological evaluations confirming diagnoses must be completed less than one year prior to the child's sixth birthday. These recipients transferring from the MR Waiver will automatically be assigned a slot in the IFDDS Waiver. Such slot shall be in addition to those slots available through the screening process described in 12VAC30-120-720 ~~C~~ B and ~~D~~ C.

B. ~~Coverage statement~~ Covered services.

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

2. These services shall be ~~medically~~ appropriate and medically necessary to maintain these ~~recipients~~ individuals in the community. Federal waiver requirements provide that the average per capita fiscal year expenditures under the waiver must not exceed the average per capita expenditures for the level of care provided in ~~Intermediate Care Facilities for the Mentally Retarded~~ ICFs/MR under the State Plan that would have been made had the waiver not been granted.

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

C. Eligibility criteria for emergency access to the waiver.

1. Subject to available funding and a finding of eligibility under 12 VAC30-120-720, individuals must meet at least one of the emergency criteria below 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. The criteria are as follows:

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

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

~~3.~~ c. The individual demonstrates behaviors which present risk to personal or public safety; or

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

~~5~~ e. The individual lives in an institutional setting and has a viable discharge plan in place.

2. When emergency slots become available:

a. All individuals who have been found eligible for the IFDDS Waiver but have not been enrolled shall be notified by either DMAS or the individual's case manager.

b. Individuals and family/caregivers shall be given 30 calendar days to request emergency consideration.

c. An interdisciplinary team of DMAS professionals shall evaluate the requests for emergency consideration within 10 business days from the 30 day deadline using the emergency criteria to determine who will be assigned an emergency slot. If DMAS receives more requests than the number of available emergency slots, then the interdisciplinary team will make a decision on slot allocation based on need as documented in the request for emergency consideration. A waiting list of emergency cases will not be kept.

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

CERTIFIED:

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

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

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

1. Under this waiver, the coverage groups authorized under § 1902(a)(10)(A)(ii)(VI) of the Social Security Act will be considered as if they were institutionalized for the purpose of applying institutional deeming rules. All ~~recipients~~ individuals 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~~ individuals as if the ~~recipient~~ individual were residing in an institution or would require that level of care.

2. Virginia shall reduce its payment for home and community-based waiver services provided to an individual who is eligible for Medicaid services under 42 CFR 435.217 by that amount of the individual's total income (including amounts disregarded in determining eligibility) that remains after allowable deductions for personal maintenance needs, deductions for other dependents, and medical needs have been made, according to the guidelines in 42 CFR 435.735 and §1915(c)(3) of the Social Security Act as amended by the Consolidated Omnibus Budget Reconciliation Act of 1986. DMAS will reduce its payment for home and community-based waiver services by the amount that remains after the following deductions:

a. For ~~recipients~~ individuals 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 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

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

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

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

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

(1) The basic maintenance needs for an individual, which is equal to the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of 300% SSI; for an individual employed at least 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 Title XIX medically needy income standard based on the number of dependent children.

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

B. Screening ~~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~~ individuals who would otherwise be placed in an ICF/MR, home and community-based ~~care~~ waiver services shall be considered only for individuals who are eligible for admission to an ICF/MR, absent a diagnosis of mental retardation and are age 6 or older. Home and community-based ~~care~~ waiver services shall be the critical service that enables the individual to remain at home rather than being placed in an ICF/MR.

2. Individuals requesting IFDDS waiver services will be screened and will receive services on a first-come, first-served basis in accordance with available funding based on the date the individuals' applications are received. Individuals who meet at least one of the emergency criteria pursuant to 12VAC30-120-710 shall be eligible for immediate access to waiver services if funding is available.

3. To be eligible for IFDDS waiver services, the individual must:

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

b. Be six years of age or older,

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

d. Not have a diagnosis of mental retardation as defined by the American Association on Mental Retardation (AAMR).

4~~2~~. The ~~recipient's~~ individual's status as an individual in need of IFDDS home and community-based ~~care~~ waiver services shall be determined by the IFDDS screening team after completion of a thorough assessment of the ~~recipient's~~ individual's needs and available ~~support~~ supports. Screening ~~of~~ for home and community-based ~~care~~ waiver services by the IFDDS screening team or DMAS staff is mandatory before Medicaid will assume payment responsibility of home and community-based ~~care~~ waiver services.

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

6. The IFDDS screening team determines the level of care by applying existing DMAS ICF/MR criteria (12VAC30-130-430 et seq.).

3~~7~~. The IFDDS screening team shall gather relevant medical~~,~~ and social~~, and psychological~~ data and identify all services received by and supports available to the ~~recipient~~ individual. The IFDDS screening team shall also gather psychological evaluations or refer the individual to a private or publicly funded psychologist for evaluation of the cognitive abilities of each screening applicant. ~~For children to transfer to the IFDDS waiver at age six, case managers shall submit to DMAS the child's~~

~~most recent Level of Functioning form, the CSP, and a psychological examination completed no more than one year prior to the child's sixth birthday if they are receiving MR waiver services. Such documentation must demonstrate that no diagnosis of mental retardation exists in order for this transfer to the IFDDS Waiver to be approved.~~

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

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

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

8~~7~~. The IFDDS screening team shall explore alternative settings and services to provide the care needed by the individual with the individual and family/caregiver. If placement in an ICF/MR or a combination of other services is determined to be appropriate, the IFDDS screening team shall initiate a referral for service to DMAS. If Medicaid-funded home and community-based ~~care~~ waiver services are determined to be the critical service to delay or avoid placement in an ICF/MR or promote exiting from an institutional setting, the IFDDS screening team shall initiate a referral for service to a ~~support coordinator~~ case manager of the ~~recipient's~~ individual's choice. Referrals are based on the individual choosing either ICF/MR placement or home and community-based waiver services.

9~~8~~. Home and community-based ~~care~~ waiver services shall not be provided to any individual who ~~also~~ resides in a nursing facility, an ICF/MR, a hospital, an adult family home approved ~~licensed~~ by the DSS, a group home licensed by DMHMRSAS, or an assisted living facility licensed by the DSS.

~~9. Medicaid will not pay for any home and community-based care ervices 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.~~

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

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

~~b. The Consumer Service Plan and services 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 must be eligible for Medicaid as determined by the local office of DSS.~~

10~~11~~. The IFDDS screening ~~teams~~ team 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 home and community-based ~~care~~ waiver services.

11. For children receiving MR Waiver services prior to age six to transfer to the IFDDS waiver during their sixth year, the individual's MR Waiver case manager shall submit to DMAS the child's most recent Level of Functioning form, the plan of care, and a psychological examination completed no

more than one year prior to transferring. Such documentation must demonstrate that no diagnosis of mental retardation exists in order for this transfer to the IFDDS Waiver to be approved. The case manager shall be responsible for notifying DMAS, DMHMRSAS, and DSS, via the DMAS-122, when a child transfers from the MR Waiver to the IFDDS Waiver. Transfers must be completed prior to the child's seventh birthday.

~~C. Screening for the IFDDS waiver.~~

~~1. Individuals requesting IFDDS waiver services will be screened and will receive services on a first-come, first-served basis in accordance with available funding based on the date the recipients' applications are received. Individuals who meet at least one of the emergency criteria pursuant to 12 VAC 30-120-790 12VAC30-120-710 shall be eligible for immediate access to waiver services if funding is available.~~

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

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

~~b. Be six years of age or older,~~

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

~~d. Not have a diagnosis of mental retardation as defined by the American Association on Mental Retardation (AAMR) as contained in 12 VAC 30-120-710.~~

C~~D~~. Waiver approval process: available funding.

1. In order to ensure cost effectiveness of the IFDDS Waiver, the funding available for the waiver ~~will be~~ is allocated between two "budget" levels. The "budget" ~~will be~~ is the cost of waiver services only and ~~will~~ does not include the costs of other Medicaid covered services. Other Medicaid services,

however, must be counted toward cost-effectiveness of the IFDDS Waiver. All services available under the waiver are available to both levels.

2. Level one ~~will be~~ is for individuals whose comprehensive ~~consumer service plan (CSP)~~ plans of care ~~is expected to~~ cost less than $25,000 per fiscal year. Level two ~~will be~~ is for individuals whose ~~CSP~~ plans of care ~~is expected to cost~~ costs are equal to or more than $25,000. There ~~will not be~~ is no ~~a~~ threshold for budget level two; however, if the actual cost of waiver services exceeds the average annual cost of ICF/MR care for an individual, the ~~recipient's~~ individual's care ~~will be~~ is case managed ~~coordinated~~ by DMAS staff.

3. Fifty-~~five~~ percent of available waiver funds ~~will be~~ are allocated to budget level one, and 40 percent of available waiver funds ~~will be~~ are allocated to level two, in order to ensure that the waiver ~~will be~~ is cost-effective. The remaining ~~5~~ 10 percent of available waiver funds ~~will be~~ is allocated for emergencies as defined in ~~12 VAC 30-120-790~~ 12VAC30-120-710. In order to transition an appropriate number of level one slots to emergency slots, every third level one slot that becomes available will convert to an emergency slot until the percentage of emergency slots reaches 10 percent. ~~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~~. Half of emergency slots will be allocated for individuals in institutional settings who are discharge ready and have a viable discharge plan to transition into the community within sixty days. If there are no such individuals who choose to discharge into the community when emergency slots are available for institutionalized individuals, the emergency slot will be allocated to an individual residing in the community who meets emergency criteria.

D~~E~~. Assessment and Enrollment~~Waiver approval process: accessing services~~.

1. The IFDDS Screening Team shall determine if an individual meets the functional criteria within 45 days of receiving the request for screening from DMAS. Once the IFDDS screening ~~entity~~ team ~~has determined~~ determines that an individual meets the eligibility criteria for IFDDS Waiver services and the individual has chosen this service, the IFDDS screening team ~~entity will~~ shall provide the individual with a list of available ~~support coordinators~~ case managers. ~~For MR Waiver recipients transferring to the IFDDS Waiver, the case manager must provide the recipient or family/caregiver with a list of support coordinators.~~ The individual or family/caregiver ~~will~~ shall choose a ~~support coordinator~~ case manager within 10 calendar days of receiving the list of ~~support coordinators~~ case managers and the IFDDS screening ~~entity~~ team~~/case manager~~ ~~will~~ shall forward the screening materials~~, CSP, and all MR Waiver related documentation~~ within 10 calendar days of the ~~coordinator's~~ case manager's selection to the selected ~~support coordinator~~ case manager.

2. The ~~support coordinator~~ case manager ~~will~~ shall contact the ~~recipient~~ individual within ten calendar days of receipt of screening materials. The ~~support coordinator~~ case manager ~~and~~ must meet face-to-face with the ~~recipient~~ individual ~~or recipient's~~ and the individual's family/caregiver as appropriate, ~~will meet~~ within 30 calendar days to discuss the ~~recipient's~~ individual's needs, existing supports and to develop a preliminary ~~consumer service plan (CSP)~~ plan of care ~~which will identify~~ identifying needed services ~~needed~~ and ~~will estimate~~ estimating the annual waiver cost of the ~~recipient's~~ individual's ~~CSP~~ plan of care. If the ~~recipient's~~ individual's annual waiver services cost is expected to exceed the average annual cost of ICF/MR care for an individual, the ~~recipient's~~ individual's ~~support coordination~~ case management ~~will be managed~~ shall be provided by DMAS.

3. Once the ~~CSP~~ plan of care has been initially developed, the ~~support coordinator~~ case manager ~~will~~ shall contact DMAS to request ~~receive prior authorization~~ approval of the plan of care and to enroll the ~~recipient~~ individual in the IFDDS waiver. DMAS shall, within 14 days of receiving all supporting

documentation, either approve for Medicaid coverage or deny for Medicaid coverage the ~~CSP~~ plan of care.

4. Medicaid will not pay for any home and community-based waiver services delivered prior to the authorization date approved by DMAS. Any plan of care for home and community-based waiver services must be pre-approved by DMAS prior to Medicaid reimbursement for waiver services.

5. 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, an individual must be six years of age or older, have a related condition as defined in these regulations, ~~and~~ cannot have a diagnosis of mental retardation, and 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 State Plan;

b. The plan of care and services which are delivered must be consistent with the Medicaid definition of each service;

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

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

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

6. DMAS shall only authorize a waiver slot ~~services~~ for the ~~recipient~~ individual if ~~funding is available for the entire CSP~~ a slot is available. If DMAS does not have a waiver slot for this individual, the individual shall be placed on the waiting list until such time as a waiver slot becomes available for the individual.

7. DMAS will notify the case manager when a slot is available for the individual and the initial plan of care has been approved.

8. Once the case manager receives authorization from DMAS ~~this authorization has been received~~, the ~~support coordinator~~ case manager shall inform the ~~recipient~~ individual so ~~that~~ the ~~recipient~~ individual ~~can~~ may apply for Medicaid if necessary and begin choosing waiver service providers for services listed in the ~~CSP.~~ plan of care. The case manager shall also notify the local DSS by submitting a DMAS 122 and IFDDS Level of Care Eligibility form.

9. The case manager forwards a copy of the completed DMAS-122 to DMAS. Upon receipt of the completed DMAS-122, DMAS shall enroll the individual into the IFDDS Waiver.

~~If DMAS does not have the available funding for this recipient, the recipient will be held on the waiting list until such time as funds are available to cover the cost of the CSP.~~

10~~4~~. Once the ~~recipient~~ individual has been determined to be Medicaid eligible and ~~authorized for~~ enrolled in the waiver, the ~~recipient~~ individual or ~~support coordinator~~ case manager shall contact the waiver service providers that the individual or family/caregiver chooses ~~and~~ who shall initiate waiver services within 60 days. During this time, the ~~consumer~~ individual, ~~support coordinator~~ case manager, and waiver service providers ~~will~~ shall meet to complete the ~~CSP~~ provider's supporting documentation for the plan of care, implementing a person-centered planning process. If services are not initiated within 60 days, the ~~support coordinator~~ case manager must submit information to DMAS demonstrating why more time is needed to initiate services and request in writing a 30-day extension, up to a maximum of 4 consecutive extensions, for the initiation of waiver services. DMAS must receive the request for extension letter within the thirty day extension period being requested. DMAS will review the request for extension and make a determination within ten business days of receiving the request. DMAS has authority to approve or deny the 30-day extension request ~~in 30-day extensions~~. The waiver service providers ~~will~~ shall

develop supporting documentation for each waiver service and ~~will~~ shall submit a copy of ~~these plans~~ this documentation to the ~~support coordinator~~ case manager.

11. The ~~support coordinator~~ case manager ~~will~~ shall monitor the waiver service providers' supporting documentation to ensure that all providers are working toward the identified goals of the ~~recipients~~ individual. The ~~support coordinator~~ case manager ~~will~~ shall review and sign off on the supporting documentation. ~~and~~ The case manager ~~will~~ shall contact ~~DMAS~~ the preauthorization agent for prior authorization of services and ~~will~~ shall notify the waiver service providers when waiver services are approved.

12~~5~~. The case manager ~~support coordinator will~~ shall contact the individual ~~recipient~~ at a minimum on a monthly basis and as needed to ~~coordinate services and maintain the recipient's CSP~~ conduct case management activities as defined in 12VAC30-50-490. DMAS ~~will~~ shall conduct annual level of care reviews in which the ~~recipient~~ individual is assessed to ensure ~~he continues~~ continued ~~to meet~~ waiver ~~criteria~~ eligibility. DMAS ~~will~~ shall review ~~recipients'~~ individuals' ~~CSPs~~ plans of care and ~~will~~ shall review the services provided by ~~support coordinators~~ case managers ~~as well as~~ and waiver service providers.

F. Reevaluation of service need and utilization review.

1. The plan of care.

a. The case manager shall develop the plan of care, implementing a person-centered planning process with the individual, the individual's family/caregiver, other service providers, and other interested parties identified by the individual and/or family/caregiver, based on relevant, current assessment data. The plan of care development process determines the services to be provided for individuals, the frequency of services, the type of service provided, and a description of the services to be offered. All plans of care written by the case managers must be approved by DMAS prior to seeking authorization

for services. DMAS is the single state authority responsible for the supervision of the administration of the home and community-based waiver.

b. The case manager is responsible for continuous monitoring of the appropriateness of the individual's services by reviewing supporting documentation and revisions to the plan of care as indicated by the changing needs of the individual. At a minimum, every three months the case manager must:

(i) review the plan of care face-to-face with the individual and family/caregiver, as appropriate, using a person-centered planning approach.

(ii) review individual provider quarterly reports to ensure goals and objectives are being met, and

(iii) determine whether any modifications to the plan of care are necessary.

c. At least once per plan of care year this review must be performed with the individual present, and family/caregivers as appropriate, in the individual's home environment.

d. DMAS staff shall review the plan of care 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 plan of care must be approved by DMAS.

2. Annual reassessment.

a. The case manager or DMAS, if DMAS is acting as the individual's case manager, shall complete an annual comprehensive reassessment, in coordination with the individual, family, and service providers. If warranted, the case manager will coordinate a medical examination and a psychological evaluation for every waiver individual. The reassessment, completed in a person-centered planning manner, must include an update of the assessment instrument and any other appropriate assessment data.

b. A medical examination must be completed for adults 18 years of age and older based on need identified by the individual, the family/caregiver, providers, the case manager, or DMAS staff. Medical examinations for children must be completed according to the recommended frequency and periodicity of the EPSDT program.

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

3. Documentation required.

a. The case management provider must maintain the following documentation for review by the DMAS staff for each waiver individual:

(1) All assessment summaries and all plans of care completed for the individual are maintained for a period of not less than six years;

(2) All supporting documentation from any provider rendering waiver services for the individual;

(3) All supporting documentation related to any change in the plan of care;

(4) All related communication with the individual, family/caregiver, providers, consultants, DMHMRSAS, DMAS, DSS, DRS, or other related parties;

(5) An ongoing log documenting all contacts related to the individual made by the case manager that relate to the individual;

(6) The individual's most recent, completed level of functioning;

(7) Psychologicals;

(8) Communications with DMAS;

(9) Documentation of rejection or refusal of services and potential outcomes resulting from the refusal of services communicated to the individual; and

(10) Annual DMAS 122s.

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

(1) All supporting documentation developed for that individual and maintained for a period of not less than six years;

(2) An attendance log documenting the date and times services were rendered and the amount and the type of services rendered;

(3) Appropriate progress notes reflecting individual's status and, as appropriate, progress toward the identified goals on the supporting documentation;

(4) All communication relating to the individual. Any documentation or communication must be dated and signed by the provider;

(5) Prior authorization decisions;

(6) Plans of care specific to the service being provided; and

(7) Assessments/reassessments as required for the service being provided.

CERTIFIED:

_____ _____

Date Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12VAC30-120-730. General requirements for home and community-based care participating providers.

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

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

2. Assure freedom of choice ~~to recipients in~~ for individuals seeking ~~medical care~~ services from any institution, pharmacy, practitioner, or other provider qualified to perform the service or services required and participating in the Medicaid Program at the time the service or services were performed.

3. Assure the ~~recipient's~~ individual's freedom to reject medical care, ~~and~~ treatment, and services, and document that potential adverse outcomes that may result from refusal of services were discussed with the individual.

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

5. Provide services and supplies ~~to~~ for ~~recipients~~ individuals in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d ~~through 2000d-4a~~ et seq.), which prohibits discrimination on the grounds of race, color, or national origin; the Virginians with Disabilities Act (Title 51.5, § 51.5-1 et seq. of the Code of Virginia), § 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~~ et seq.), which provides comprehensive civil rights protections to ~~recipients~~ individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications.

6. Provide services and supplies to ~~recipients~~ individuals 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~~ for ~~recipients~~ individuals in amounts not to exceed the provider's usual and customary charges to the general public~~. The provider must~~ and accept as payment in full the amount

established by DMAS ~~payment methodology~~ from the ~~first day of eligibility for the waiver services~~ individual's authorization date for waiver services.

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

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

   c. An attendance log or similar document must be maintained which indicates the date services were rendered, 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, and the State Medicaid Fraud Control Unit. The Commonwealth's right

of access to provider ~~agencies~~ premises and records shall survive any termination of the provider participation 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~~ individuals ~~of~~ enrolled in Medicaid.

12. Pursuant to 42CFR Part 431, Subpart F, 12VAC30-20-90, and any other applicable federal or state law, all providers shall hold ~~Hold~~ confidential and use for DMAS authorized purposes only all medical assistance information regarding ~~recipients~~ individuals 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~~ are necessary for the functioning of the DMAS in conjunction with the cited laws. DMAS shall not disclose medical information to the public.

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

14. For (ICF-MR) facilities covered by § 1616(e) of the Social Security Act in which respite care as a home and community-based ~~care~~ waiver service will be provided, the facilities 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~~,~~ or through DSS approved standards for adult foster care providers. ~~12 VAC 35-102-10 et seq.~~

15. Suspected Abuse or Neglect. Pursuant to §§ ~~63.1-55.3~~ 63.2-1509 and ~~63.1-248.3,~~ 63.2-1606 of the Code of Virginia, if a participating provider knows or suspects that a home and community-based ~~care~~ waiver service ~~recipient~~ individual 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~~ agency, as applicable, ~~and~~ as well as to DMAS~~.~~, and, if applicable, to DMHMRSAS Offices of Licensing and Human Rights.

16. Adherence to provider ~~contract~~ participation agreement 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 individual provider ~~contracts~~ participation agreements and in the DMAS provider manual.

17. Direct marketing. Providers are prohibited from performing any type of direct marketing activities to Medicaid individuals or their family/caregivers.

12VAC30-120-740. 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~~ provider participation agreements with home and community based ~~care~~ waiver providers, the following standards shall be met:

1. For services that have licensure and certification requirements, licensure ~~Licensure~~ and certification requirements pursuant to 42 CFR § 441.352.

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

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

C. Adherence to provider ~~contract~~ participation agreements 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~~ participation agreements.

D. ~~Recipient~~ Individual choice of provider ~~agencies~~ entities. The ~~recipient~~ individual will have the option of selecting the provider ~~agency~~ of his choice. The case manager must inform the individual of all available waiver service providers in the community in which he desires services, and he shall have the option of selecting the provider of his choice.

E. Review of provider participation standards and renewal of ~~contracts~~ provider participation agreements. 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~~ agreement renewal with DMAS to provide home and community-based waiver services. A provider's non-compliance with DMAS policies and procedures, as required in the provider's ~~contract~~ participation agreement, 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.~~ DMAS may terminate at will a provider's participation agreement on 30 days' written notice as specified in the DMAS participation agreement. DMAS may also immediately terminate a provider's participation agreement if the provider is no longer eligible to participate in the program as determined by DMAS. Such action precludes further payment by DMAS for services provided ~~to~~ for ~~recipients~~ individuals subsequent to the date of ~~specified in the~~ termination ~~notice~~.

G. Reconsideration of adverse actions. A provider shall have the right to appeal adverse action taken by DMAS. Provider appeals shall be considered pursuant to 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560. ~~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, et seq. 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~~ participation agreement upon conviction of a felony Section 32.1-325 ~~C~~ D(2) 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~~ participation agreement will occur as may be required for federal financial participation.

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

1. Home and community-based ~~care~~ waiver services are implemented.
2. ~~A recipient~~ An individual dies.
3. ~~A recipient~~ An individual is discharged or terminated from services.
4. Any other circumstances (including hospitalization) which cause home and community-based ~~care~~ waiver services to cease or be interrupted for more than 30 days.
5. A selection by the individual or family/caregiver of a different case management provider.

J. Changes or termination of care. It is the DMAS staff's responsibility to authorize any changes to supporting documentation of ~~a~~ an ~~recipient's~~ individual's ~~CSP~~ plan of care

based on the recommendations of the ~~support coordinator~~ case manager. ~~Agencies providing direct~~ Waiver service providers are responsible for modifying the supporting documentation ~~if the recipient or parent/legal guardian agrees~~ with the involvement of the individual or family/caregiver. The provider ~~will~~ shall submit the supporting documentation to the ~~support coordinator~~ case manager any time there is a change in the ~~recipient's~~ individual's condition or circumstances which may warrant a change in the amount or type of service rendered. The ~~support coordinator~~ case manager ~~will~~ shall review the need for a change and ~~will~~ shall sign the supporting documentation if he agrees to the changes. The ~~support coordinator~~ case manager ~~will~~ shall submit the revised supporting documentation 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'~~ individual's supporting documentation. DMAS shall notify the individual or family/caregiver in writing of their right to appeal the decision or decisions to reduce, terminate, suspend, or deny services pursuant to DMAS client appeals regulations, 12VAC30-110-10, *et seq*.

1. Non-emergency termination of home and community-based ~~care~~ waiver services by the participating provider. The participating provider shall give the ~~recipient~~ individual, ~~and~~ family/caregiver, and ~~support coordinator~~ case manager ten days' written notification of the intent to terminate services. The notification 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~~ waiver services by the participating provider. In an emergency situation when the health and safety

of the ~~recipient~~ individual or provider ~~agency personnel~~ is endangered, the ~~support coordinator~~ case manager and DMAS must be notified prior to termination. The ten-day written notification period shall not be required. ~~If~~ When appropriate, the local DSS adult protective services or child protective services agency must be notified immediately. DMHMRSAS Offices of Licensing and Human Rights must also be notified as required under the provider's license.

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

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

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

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

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

4. In the case of termination of home and community-based waiver services by DMAS staff:

a. individuals shall be notified of their appeal rights by DMAS pursuant to 12VAC30-110-10 *et seq.*

b. Individuals identified by the case manager who no longer meet the level of care criteria or for whom home and community-based waiver services must be referred by the case manager to DMAS for review.

CERTIFIED:

_____ _____

Date Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

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

A. Service Description. In-home residential support services shall be based primarily in the ~~recipient's~~ individual's home. The service shall be designed to enable ~~recipients~~ individuals ~~qualifying for~~ enrolled in the IFDDS waiver to be maintained in their homes and shall include: (i) training in or ~~reinforcement of~~ engagement and interaction with functional skills and appropriate behavior related to a ~~recipient's~~ individual's health and safety, personal care, activities of daily living and use of community resources; (ii) assistance with medication management and monitoring the ~~recipient's~~ individual's 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; and (vi) specialized supervision to ensure the individual's health and safety. Service providers shall be reimbursed only for the amount and type of in–home residential support services included in the ~~recipient's~~ individual's approved ~~CSP~~ plan of care. In–home residential support services shall not be authorized in the ~~CSP~~ plan of care unless the ~~recipient~~ individual requires these services and these services exceed services provided by the family or other caregiver. Services ~~will~~ are not ~~be~~

provided by paid staff of the In-Home Residential Supports provider for a continuous 24-hour period.

1. This service must be provided on ~~a~~ an ~~recipient~~ individual-specific basis according to the ~~CSP~~ plan of care, supporting documentation, and service setting requirements.

2. Individuals may have in-home residential, personal care, and respite care in their plans of care but cannot receive these services simultaneously. ~~This service may not be provided to any recipient who simultaneously 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 unpaid caregivers with whom the ~~recipient~~ individual lives.

B. Criteria.

1. All ~~recipients~~ individuals must meet the following criteria in order for Medicaid to reimburse providers for in-home residential support services. The ~~recipient~~ individual must meet the eligibility requirements for this waiver service as ~~herein~~ defined. The ~~recipient~~ individual 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 must be conducted to evaluate each ~~recipient~~ individual 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~~ an ~~recipient's~~ individual's

health and safety, there are specific requirements for the supervision and oversight of direct care staff providing in-home residential support as outlined below. For all in-home residential support services provided under a DMHMRSAS license or CARF accreditation: ~~For all in-home residential support services provided under a DMHMRSAS license:~~

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

b. The supervisor must have and document at least one supervisory contact ~~per month~~ with each direct care staff person per month regarding service delivery and direct care staff performance.

c. The supervisor must observe each direct care staff person delivering services at least semi-annually. Staff performance, ~~and~~ service delivery in accordance with ~~according to~~ the ~~CSP~~ plan of care, ~~should be documented, along with~~ and evaluation of and evidence of ~~recipient~~ the individual's satisfaction with service delivery by direct care staff must be documented.

d. ~~Providers of in-home residential supports~~ The supervisor must ~~also have~~ complete and document at least one monthly contact with the ~~recipient~~ individual or family/caregiver regarding satisfaction with services delivered by each direct care staff person.

~~with services delivered by each staff person. If the recipient has a guardian, the guardian should be contacted.~~

4. The in-home residential support supporting documentation must indicate the necessary amount and type of activities required by the ~~recipient~~ individual, the schedule of in-home residential support services, the total number of hours per day, and the total number of hours per week of in-home residential support. A formal, written behavioral program is required to address behaviors, including self injury, aggression or self stimulation.

5. Medicaid reimbursement is available only for in-home residential support services provided when the ~~recipient~~ individual 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 direct care staff is working directly with the ~~recipient~~ individual. Total monthly billing cannot exceed the total hours authorized in the ~~CSP~~ plan of care. The provider must maintain documentation of the date, ~~and~~ times, ~~that the services are provided~~, the services that were provided, and specific circumstances ~~which prevented~~ preventing the provision of ~~all of the~~ any scheduled services.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based ~~care~~ waiver services participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, each in-home residential support service provider must be licensed by DMHMRSAS as a provider of supportive residential services or have CARF ~~certification~~ accreditation. The provider must also have training in the characteristics of ~~developmental disabilities~~ individuals with related conditions and appropriate interventions,

strategies, and support methods for ~~persons with developmental disabilities~~ individuals with related conditions and functional limitations.

1. For DMHMRSAS licensed programs, a ~~CSP~~ plan of care and ongoing documentation of service delivery must be consistent with licensing regulations.

2. Documentation must confirm attendance and the individual's amount of time in services and provide specific information regarding the ~~recipient's~~ individual's response to various settings and supports as agreed to in the supporting documentation objectives. Assessment results must be available in at least a daily note or a weekly summary. Data must be collected as described in the ~~CSP~~ plan of care, analyzed, summarized, and then clearly addressed in the regular supporting documentation.

3. The supporting documentation must be reviewed by the provider with the ~~recipient,~~ individual, and this written review submitted to the ~~support coordinator~~ case manager, at least semi-annually, with goals, objectives, and activities modified as appropriate.

4. Documentation must be maintained for routine supervision and oversight of all in-home residential support direct care staff. All significant contacts described in this section must be documented. A Qualified Developmental Disabilities Professional must provide supervision of direct service staff.

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

   a. Date of contact or observation~~.~~;

   b. Person or persons contacted monthly and ~~or~~ direct care staff observed~~.~~;

c. A ~~note regarding~~ summary about direct care staff performance and ~~supporting documentation~~ service delivery for monthly ~~contact~~ contacts and semi-annual home visits.

d. Semi-annual observation documentation must also address ~~recipient~~ individual satisfaction with service provision; and

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

f. Copy of the most recently completed DMAS-122 form. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

CERTIFIED:

_____ _____

Date Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12VAC 30-120-751. Reserved.

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

A. Service description. Day support services shall include a variety of training, assistance, support, and specialized supervision offered in a setting (other than the home or ~~recipient~~ individual residence), which allows peer interactions and community integration for the acquisition, retention, or improvement of self-help, socialization, and adaptive skills. When services are provided through alternative payment sources, the ~~consumer service~~ plan of care shall not authorize them as a waiver funded expenditure.

Service providers are reimbursed only for the amount and type of day support services included in the ~~recipient's~~ individual's approved plan of care ~~CSP~~ based on the setting, intensity, and duration of the service to be delivered. This does not include prevocational services.

B. Criteria. For day support services, ~~recipients~~ individuals must demonstrate the need for functional training, assistance, and specialized supervision ~~training~~ offered in settings other than the ~~recipient's~~ individual'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~~ individuals who ~~cannot~~ can benefit from supported employment services, ~~and~~ but who need the services as an appropriate alternative or in addition to supported employment services. ~~for: accessing in-home supported living services; 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~~ must be conducted by the provider to evaluate each ~~recipient~~ individual in his home environment and community settings.

2. ~~Levels~~ Types and levels of day support. The amount and type of day support included in the ~~recipient's~~ individual's ~~consumer service~~ plan of care is determined according to the services required for that ~~recipient~~ individual. There are two types of day support: center-based, which is provided ~~partly or entirely in a segregated setting,~~ primarily at one location/building; or non-center-based, which is provided ~~entirely~~ primarily 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~~ individual 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~~ meet at least one of the following criteria: (i) requires physical assistance to meet the basic personal care needs (toileting, feeding, etc.); (ii) has extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish his service goals; or (iii) 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~~ an ~~recipient's~~ individual's home or other residential setting (e.g., due to inclement weather or individual's illness) without prior written ~~prior~~ approval from DMAS. ~~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 or in Special Education services through § 602 (16) and (17) of the Individuals with Disabilities Act. When services are provided through these sources, the plan of care shall not authorize them as a waiver expenditure. Compensation for prevocational services can only be made when the individual's productivity is less than 50 percent of the minimum wage.~~ Non-center-based day support services must be separate and distinguishable from ~~either~~ both in-home

residential support services ~~or~~ and personal care services. There must be separate supporting documentation for each service and each must be clearly differentiated in documentation and corresponding billing. The supporting documentation must provide an estimate of the amount of day support required by the ~~recipient~~ individual. The maximum is 780 units per ~~calendar~~ plan of care year. If this service is used in combination with prevocational and/or supported employment services, the combined total units for these services can not exceed 780 units per plan of care 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.

Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

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

1. For DMHMRSAS programs licensed as day support programs, the ~~CSP~~ plan of care, supporting documentation and ongoing documentation must be consistent with licensing regulations. For programs ~~certified~~ accredited by CARF as day support programs, there must be supporting documentation, which contains, at a minimum, the following elements:

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

b. The ~~recipient's~~ individual'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~~ entities that will provide the services specified in the statement of services;

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

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

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

2. Documentation must confirm the ~~recipient's~~ individual's attendance, ~~and~~ the amount of the individual's time in services, and provide specific information regarding the ~~recipient's~~ individual's response to various settings and supports as agreed to in the supporting documentation objectives. Assessment results ~~shall~~ must be available in at least a daily note or a weekly summary.

a. The provider must review the supporting documentation ~~must be reviewed by the provider~~ with the ~~recipient~~ individual or family/caregiver, and this written review submitted to the ~~support coordinator~~ case manager, at least semi-annually, with goals, objectives,

and activities modified as appropriate. For the annual review and anytime the supporting documentation is modified, the revised supporting documentation must be reviewed with the individual or family/caregiver.

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 and regular or intensive level.

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

e. In instances where day support staff are required to ride with the individual to and from day support, the day support staff time may be billed as day support, provided that the billing for this time does not exceed 25% of the total time spent in the day support activity for that day. Documentation must be maintained to verify that billing for day support staff coverage during transportation does not exceed 25% of the total time spent in the day support for that day.

f. Copy of the most recently completed DMAS-122 form. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

3. Supervision of direct service staff must be provided by a Qualified \Developmental Disabilities Professional.

CERTIFIED:

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12 VAC 30-120-753. ~~Reserved.~~ Prevocational services.

A. Service Description. Prevocational services are services aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Prevocational services are provided for individuals who are not expected to be able to join the general work force without supports or to participate in a transitional, sheltered workshop within one year of beginning waiver services (excluding supported employment services or programs). Activities included in this service are not primarily directed at teaching specific job skills but at underlying rehabilitative goals such as accepting supervision, attendance, task completion, problem solving, and safety.

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

C. Service units and service limitations. Billing is for one unit of service. This service is limited to 780 units per plan of care year. If this service is used in combination with day support and/or supported employment services, the combined total units for these services cannot exceed 780 units per plan of care year. Prevocational services may be provided in center or non-center-based settings. There must be documentation about whether prevocational services are available in vocational rehabilitation agencies through §110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA). When services are provided through these sources to the individual, they will not be authorized as a waiver service. Prevocational services may only be provided when the individual's compensation is less than 50% of the minimum wage.

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.

Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based services participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, prevocational services providers must also meet the following requirements:

a. The prevocational services provider must be a vendor of extended employment services, long-term employment services, or supported employment services for DRS, or be licensed by DMHMRSAS as a day support services provider. Providers must

ensure and document that persons providing prevocational services have training in the characteristics of related conditions, appropriate interventions, training strategies, and support methods for individuals with related conditions and functional limitations.

b. Required documentation in the individual's record. The provider must maintain a record for each individual receiving prevocational services. At a minimum, the record must contain the following:

1. A functional assessment conducted by the provider to evaluate each individual in the prevocational environment and community settings.
2. A plan of care containing, at a minimum, the following elements: (New DMHMRSAS licensing regulations require the following for plans of care.)
    a. The individual's needs and preferences;
    b. Relevant psychological, behavioral, medical, rehabilitation, and nursing needs as indicated by the assessment;
    c. Individualized strategies including the intensity of services needed;
    d. A communication plan for individuals with communication barriers including language barriers; and
    e. The behavior treatment plan, if applicable.
3. The plan of care must be reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and with written results of these reviews submitted to the case manager. For the annual review and in cases where the plan of care is modified, the plan of care must be reviewed with the individual or family/caregiver.
4. Documentation must confirm the individual's attendance, amount of time spent in services, type of services rendered, and provide specific information

about the individual's response to various settings and supports as agreed to in the plan of care.

5. In instances where prevocational staff are required to ride with the individual to and from prevocational services, the prevocational staff time may be billed for prevocational services, provided that the billing for this time does not exceed 25% of the total time spent in prevocational services for that day. Documentation must be maintained to verify that billing for prevocational staff coverage during transportation does not exceed 25% of the total time spending the prevocational services for that day.

6. A copy of the most recently completed DMAS-122. The provider must clearly document efforts to obtain the completed DMAS-122 from the case manager.

CERTIFIED:

_____ _____

Date Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

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~~ an individual to maintain paid employment. Each supporting documentation must ~~contain documentation~~

~~regarding~~ confirm whether supported employment services are available to the individual 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 (IDEA). 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~~ individual's approved ~~CSP~~ plan of care 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~~ individual is in the supported employment environment.

2. Supported employment ~~can~~ may be provided in one of two models. ~~Recipient~~ Individual supported employment is defined as intermittent support, usually provided one on one by a job coach ~~to~~ for ~~a~~ an ~~recipient~~ individual in a supported employment position. Group supported employment is defined as continuous support provided by staff ~~to~~ for eight or fewer ~~recipients~~ individuals with disabilities in an enclave, work crew, or bench work/entrepreneurial model. The ~~recipient's~~ individual's assessment and ~~CSP~~ plan of care must clearly reflect the ~~recipient's~~ individual's need for training and supports.

B. Criteria for receipt of services.

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

2. In order to qualify for these services, the ~~recipient~~ individual 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~~ must be conducted to evaluate each ~~recipient~~ individual in his ~~home~~ work environment and related community settings.

4. The supporting documentation must ~~provide~~ document the amount of supported employment required by the ~~recipient~~ individual. Service providers are reimbursed only for the amount and type of supported employment included in the ~~recipient's~~ individual's ~~CSP~~ plan of care based on the intensity and duration of the service delivered.

C. Service units and service limitations.

1. Supported employment for ~~recipient~~ individual job placement ~~will be billed on an~~ is provided in one hour units ~~hourly basis~~. ~~Transportation cannot be billable as a supported employment service.~~

2. Group models of supported employment (enclaves, work crews, bench work, 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. Supported employment services are limited to 780 units per plan of care year. If used in combination with prevocational and/or day support services, the combined total units for these services cannot exceed 780 units per plan of care year.

~~3~~4. For the ~~recipient~~ individual job placement model, reimbursement of supported employment will be limited to actual documented interventions or collateral contacts by the provider, not the amount of time the ~~recipient~~ individual 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 as follows~~ supported employment providers must meet the following requirements:

1. Supported employment services shall be provided by agencies that are programs certified by CARF to provide supported employment services or are DRS vendors of supported employment services.

2. ~~Recipient~~ Individual ineligibility for supported employment services through DRS or ~~Special Education services~~ IDEA must be documented in the ~~recipient's~~ individual's record, as applicable. If the ~~recipient~~ individual is older than 22 years, and therefore not eligible for ~~Special Education~~ IDEA 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 manager's case notes, Consumer Profile/Social assessment or on the supported employment supporting documentation. Unless

the ~~recipient's~~ individual's circumstances change, the original verification ~~can~~ may be forwarded into the current record or repeated on the supporting documentation or revised ~~Consumer Profile/~~Social Assessment on an annual basis.

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

4. For non-DMHMRSAS-programs certified as supported employment programs, there must be supporting documentation that contains, at a minimum, the following elements:

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

   b. The ~~recipient's~~ individual'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~~ entities that will provide the services specified in the statement of services;

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

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

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

5. Documentation must confirm the individual's attendance, the amount of time the individual spent in services, and must provide specific information regarding the ~~recipient's~~ individual's response to various settings and supports as agreed to in the supporting documentation objectives. Assessment results should be available in at least a daily note or weekly summary.

6. The provider must review the supporting documentation ~~must be reviewed by the provider~~ with the ~~recipient~~ individual, and this written review submitted to the ~~support coordinator~~ case manager, at least semi-annually, with goals, objectives and activities modified as appropriate. For the annual review and in cases where the plan of care is modified, the plan of care must be reviewed with the individual or family/caregiver.

7. In instances where supported employment staff are required to ride with the individual to and from supported employment activities, the supported employment staff time may be billed for supported employment provided that the billing for this time does not exceed 25% of the total time spent in supported employment for that day. Documentation must be maintained to verify that billing supported employment staff coverage during transportation does not exceed 25% of the total time spent in supported employment for that day.

8. There must be a copy of the completed DMAS-122 form in the record. Providers must clearly document efforts to obtain the DMAS-122 form from the case manager.

CERTIFIED:

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12 VAC 30-120-755. Reserved.

12 VAC 30-120-756. Therapeutic consultation.

A. Service description. Therapeutic consultation provides expertise, training, and technical assistance in any of the following specialty areas to assist family members, caregivers, and service providers in supporting the individual. ~~is available under the waiver for Virginia licensed or certified practitioners in~~ The specialty areas include the following: psychology, social work, occupational therapy, physical therapy, therapeutic recreation, rehabilitation, psychiatry, psychiatric clinical nursing, behavioral consultation, and speech/language therapy. ~~Behavior consultation performed by these individuals may also be a covered waiver service.~~ These services may be provided, based on the ~~recipient's~~ individual's ~~CSP~~ plan of care, for those ~~recipients~~ individuals for whom specialized consultation is clinically necessary to enable their utilization of waiver services and who have additional challenges restricting their ability to function in the community. Therapeutic consultation services may be provided ~~in in-home residential or day support settings or in office settings in~~ in the individual's home, in other appropriate community settings, and in conjunction with another waiver service. Only behavior consultation may be offered in the absence of any other waiver services when the consultation provided to informal caregivers is determined to be necessary to prevent institutionalization. These services are intended to facilitate implementation of the individual's desired outcomes as identified in their plan of care. Therapeutic

consultation service providers are reimbursed according to the amount and type of service authorized in the ~~CSP~~ plan of care based on an hourly fee for service.

B. Criteria. In order to qualify for these services, the ~~recipient~~ individual shall have a demonstrated need for consultation in any of these services. Documented need must indicate that the ~~CSP~~ plan of care cannot be implemented effectively and efficiently without such consultation from this service.

1. The ~~recipient's~~ individual's ~~CSP~~ plan of care must clearly reflect the ~~recipient's~~ individual's needs, as documented in the social assessment, for specialized consultation provided to family/caregivers and providers in order to implement the ~~CSP~~ plan of care effectively.

2. Therapeutic consultation services may ~~neither~~ not include direct therapy provided to individuals receiving waiver services ~~recipients~~, or monitoring activities, and may not ~~nor~~ duplicate the activities of other services that are available to the ~~recipient~~ individual through the ~~State Plan of Medical Assistance~~ IFDDS Waiver.

C. Service units and service limitations. The unit of service shall equal one hour. The services must be explicitly detailed in the supporting documentation. 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 consultation

shall be rehabilitation engineers or certified rehabilitation specialists. Behavioral consultation may be performed by professionals based on the professional's knowledge, skills, and abilities as defined by DMAS.

1. Supporting documentation for therapeutic consultation. The following information is required in the supporting documentation:

   a. Identifying information: ~~recipient's~~ individual's name and Medicaid number; provider name and provider number; responsible person and telephone number; effective dates for supporting documentation; and semi-annual review dates, if applicable;

   b. Targeted objectives, time frames, and expected outcomes;

   c. Specific consultation activities; and

   d. ~~The expected outcomes~~ A written support plan detailing the interventions or support strategies.

2. Monthly and contact notes shall include:

   a. Summary of consultative activities for the month;

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

   c. Supporting documentation objectives addressed;

   d. Specific details of the activities conducted;

   e. Services delivered as planned or modified; and

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

3. Semi-annual reviews are required by the service provider if consultation extends three months or longer, are to be forwarded to the ~~support coordinator~~ case manager, and must include:

a. Activities related to the therapeutic consultation supporting documentation;

b. ~~Recipient~~ Individual status and satisfaction with services; and

c. Consultation outcomes and effectiveness of support plan.

4. If consultation services extend less than ~~3~~ three months, the provider must forward monthly contact notes or a summary of them to the ~~support coordinator~~ case manager for the semi-annual review.

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

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

a. Strategies utilized;

b. Objectives met;

c. Unresolved issues; and

d. Consultant recommendations.

CERTIFIED:

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

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.~~ Environmental modifications shall be defined as those physical adaptations to the individual's primary home or primary vehicle used by the individual, ~~required by~~ documented in the individual's ~~CSP~~ 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 primary 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~~ electrical and plumbing systems ~~which~~ that 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 the individual's primary home in accordance with applicable state or local building codes. All modifications must be prior authorized by the prior authorization agent. Modifications ~~can~~ may be made to a vehicle if it is the primary vehicle being used by the individual. This service does not include the purchase of vehicles.

B. Criteria. In order to qualify for these services, the ~~recipient~~ individual must have a demonstrated need for equipment or modifications of a remedial or medical benefit offered ~~primarily~~ in ~~a~~ an ~~recipient's~~ individual's primary home, primary vehicle used by the individual, community activity setting, or day program to specifically improve the

~~recipient's~~ individual's personal functioning. This service shall encompass those items not otherwise covered in the State Plan for Medical Assistance or through another program. Environmental modifications shall be covered in the least expensive, most cost-effective manner.

C. Service units and service limitations. Environmental modifications shall be available to individuals who are receiving case management services in addition to at least one other waiver service. A maximum limit of $5,000 may be reimbursed per ~~calendar~~ plan of care year. Costs for environmental modifications ~~shall not~~ cannot be carried over from year to year. All environmental modifications must be prior authorized by DMAS. Modifications shall not be used to bring a substandard dwelling up to minimum habitation standards. Also excluded are modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act, and the Rehabilitation Act.

Case managers must, upon completion of each modification, meet face-to-face with the individual and the individual's family as appropriate to ensure that the modification is completed satisfactorily and is able to be used by the individual.

D. Provider requirements. In addition to meeting the general conditions and requirements for ~~HCBC~~ home and community-based waiver services participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, environmental modifications must be provided in accordance with all applicable state or local building codes by contractors who have a provider agreement with DMAS. Providers may not be spouses or parents of the individual.

CERTIFIED:

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

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~~ individuals with serious medical conditions and complex health care needs ~~who~~ that 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.~~ It may include consultation and training for other providers.

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

C. Service units and service limitations. Skilled nursing services to be rendered by either registered or licensed practical nurses are provided in hourly units. Services must be explicitly detailed in the CSP and must be specifically ordered by a physician.

D. Provider requirements. Skilled nursing services shall be provided by ~~either~~ a DMAS ~~enrolled private duty nursing provider,~~ enrolled home care organization provider or a

home health provider, or ~~a~~ licensed registered nurse or a licensed practical nurse under the supervision of a licensed registered nurse that is contracted or employed by a ~~Community Services Board~~ DMHMRSAS licensed day support, respite, or residential provider. In addition to meeting the general conditions and requirements for home and community-based ~~care~~ waiver ~~-~~participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, and in order to be ~~approved for~~ enrolled as a skilled nursing ~~contracts~~ provider, the provider must:

1. If a home health agency, be certified by the VDH for Medicaid participation and have a current DMAS ~~contract~~ provider participation agreement for private duty nursing.

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

3. Operate from a business office; and

4. If ~~Community Services Boards~~ community services boards or behavioral health authority employ or subcontract with and directly supervise 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 must 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.

CERTIFIED:

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12 VAC 30-120-761. Reserved.

12 VAC 30-120-762. Assistive technology.

A. Service description. Assistive technology (AT) is available to recipients who are receiving at least one other waiver service and may be provided in a residential or nonresidential setting. Assistive technology (AT) is the 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 individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items.

B. Criteria. In order to qualify for these services, the ~~recipient~~ individual must have a demonstrated need for equipment or modification for remedial or direct medical benefit primarily in ~~a~~ an ~~recipient's~~ individual's primary home, primary vehicle used by the individual, community activity setting, or day program to specifically serve to improve the ~~recipient's~~ individual's personal functioning. This shall encompass those items not otherwise covered under the State Plan for Medical Assistance. Assistive technology shall be covered in the least expensive, most cost-effective manner.

C. Service units and service limitations. Assistive technology (AT) is available to individuals receiving at least one other waiver service and may be provided in the individual's home or community setting. A maximum limit of $5,000 may be reimbursed per ~~calendar~~ plan of care year. Costs for assistive technology cannot be carried over from year to year and must be preauthorized each plan of care year. AT

will not be approved for purposes of convenience of the caregiver/provider or restraint of the individual. An independent, professional consultation must be ~~obtrained~~ obtained from qualified professionals who are knowledgeable of that item for each AT request prior to approval by DMAS. All assistive technology must be prior authorized by DMAS. Also excluded are modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act, and the Rehabilitation Act.

C. 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, assistive technology shall be provided by ~~agencies~~ providers ~~under contract with~~ having a current provider participation agreement with ~~the~~ DMAS as durable medical equipment and supply providers. Independent, professional consultants ~~shall be~~ include speech language therapists, physical therapists, occupational therapists, physicians, behavioral therapists, certified rehabilitation specialists, or rehabilitation engineers. Providers that supply assistive technology for an individual may not perform assessment/consultation, write specifications, or inspect the assistive technology for that individual. Providers of services may not be spouses or parents of the individual.

CERTIFIED:

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12 VAC 30-120-763. Reserved.

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

A. Service Description. Crisis stabilization services involve direct interventions which provide temporary, intensive services and supports that avert emergency, psychiatric hospitalization or institutional placement of individuals who are experiencing serious psychiatric or behavioral problems that jeopardize their current community living situation. Crisis stabilization services shall ~~provide~~ include, as appropriate, neuropsychological, psychiatric, psychological and other functional assessments and stabilization techniques, medication management and monitoring, behavior assessment and support, and intensive care coordination with other agencies and providers. This service is designed to stabilize the individual and strengthen the current living situation so that the individual remains in the community during and beyond the crisis period. These services shall be provided to:

1. Assist planning and delivery of services and supports to ~~maintain community placement of the recipient;~~ enable the individual to remain in the community.
2. Train family members, ~~and~~ other care givers, and service providers in ~~positive behavioral~~ supports to maintain the ~~recipient~~ individual in the community; and
3. Provide temporary crisis supervision to ensure the safety of the ~~recipient~~ individual and others.

B. Criteria.

1. In order to receive crisis stabilization services, the ~~recipient~~ individual must meet at least one of the following criteria:
   a. The ~~recipient~~ individual is experiencing marked reduction in psychiatric, adaptive, or behavioral functioning;

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

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

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

2. The ~~recipient~~ individual 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 health~~ developmental disabilities professional (QDDP).

1. The unit for each component of the service is one hour. ~~This~~ Each service may be authorized in 15 day increments but no more than 60 days in a ~~calendar~~ plan of care year may be used. The actual service units per episode shall be based on the documented clinical needs of the ~~recipients~~ individuals 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 as described in Part D of this section.

2. Crisis stabilization services may be provided directly in the following settings (the following examples below are not exclusive):

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

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

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

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

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

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.

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

D. Provider requirements. In addition to the general conditions and requirements for home and community-based ~~care~~ waiver services participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, the following ~~specific~~ crisis stabilization provider ~~qualifications~~ requirements apply:

1. Crisis stabilization services shall be provided by ~~agencies~~ entities licensed by DMHMRSAS as a provider of outpatient, residential, supportive ~~residential~~ in-home 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~~ for ~~recipients~~ individuals with ~~developmental disabilities~~ related conditions who ~~are~~ require crisis stabilization services ~~experiencing serious behavioral problems~~. Supervision of direct service staff must be provided by a QDDP. Crisis supervision providers must be licensed by DMHMRSAS as providers of residential services, supportive in-home services, or day support services.

2. Crisis stabilization supporting documentation must be developed (or revised, in the case of a request for an extension) and submitted to the ~~support coordinator~~ case manager for authorization within 72 hours of the face-to-face assessment or reassessment.

3. Documentation indicating the dates and times of crisis stabilization services, ~~and~~ the amount and type of service provided, and specific information about the individual's response to the services and supports as agreed to in the supporting documentation must be recorded in the ~~recipient's~~ individual's record.

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

CERTIFIED:

_____ _____

Date Patrick W. Finnerty, Director

12 VAC 30-120-765. Reserved.

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

A. Service description. Services may be provided either through an agency-directed or consumer-directed model.

1. Personal care services ~~may be~~ means services offered to ~~recipients~~ individuals in their homes and communities ~~as an alternative to more costly institutional care~~ to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Personal care services substitute for the absence, loss, diminution, or impairment of a physical, behavioral, or cognitive function. This service shall provide care to ~~recipients~~ individuals with activities of daily living (eating, drinking, personal hygiene, toileting, transferring and bowel/bladder control), instrumental activities of daily living (IADL), access to the community, monitoring of self-medication or other medical needs, ~~or~~ and the monitoring of health status or physical condition. In order to receive personal care services, the individual must require assistance with their ADLs. When specified in the plan of care, personal care services may include assistance with IADL. Assistance with IADL must be essential to the health and welfare of the individual, rather than the individual's family/caregiver. ~~Recipients shall be permitted to share service hours for no more than two individuals living in the same home.~~ An additional component to personal care is work or school-related personal care. This allows the personal care provider to provide assistance and supports for individuals in the workplace and for those individuals attending post-secondary educational institutions. Workplace or school supports through the IFDDS Waiver are not provided if they are services that should be provided by the Department of Rehabilitative Services, under IDEA, or if they

are an employer's responsibility under the Americans with Disabilities Act or Section 504 of the Rehabilitation Act. Work related personal care services cannot duplicate services provided under supported employment.

2. Respite care means services provided for unpaid caregivers of eligible individuals who are unable to care for themselves that are provided on an episodic or routine basis because of the absence of or need for relief of those unpaid persons who routinely provide the care.

B. Criteria.

1. In order to qualify for personal care ~~these~~ services, the individual must demonstrate a need ~~for such personal care~~ in activities of daily living~~.~~, reminders to take medication, or other medical needs, or monitoring health status or physical condition.

2. In order to qualify for respite care, individuals must have a primary unpaid caregiver living in the home who requires temporary relief to avoid institutionalization of the individual.

3. Individuals choosing the consumer-directed option must receive support from a CD services facilitator and meet requirements for consumer direction as described in 12VAC30-120-770.

C. Service units and service limitations.

1. The unit of service is one hour.

2. Respite care services are limited to a maximum of 720 hours per year. Individuals who are receiving services through both the agency-directed and consumer-directed models cannot exceed 720 hours per calendar year combined.

3. ~~Recipients~~ Individuals ~~can~~ may have personal care, respite care, and in-home residential support services in their ~~service~~ plan of care but cannot receive in-home residential supports and personal care or respite care services at the same time.

4. Each ~~recipient~~ individual receiving personal care services must have ~~an emergency~~ a back-up plan in case the personal care aide or consumer-directed (CD) employee does not show up for work as expected or terminates employment without prior notice.

5. Individuals must need assistance with ADLs in order to receive IADL care through personal care services.

6. Individuals shall be permitted to share personal care service hours with one other individual (receiving waiver services) who lives in the same home.

7. This service does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated in accordance with Virginia administrative regulations 18VAC90-20-420 through 18VAC90-20-460.

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 and respite care providers must meet ~~additional~~ the following provider requirements.

1. ~~Personal care services~~ Services shall be provided by:

a. For the agency-directed model, a DMAS ~~certified~~ enrolled personal care/respite care provider or by a DMHMRSAS licensed residential ~~support~~ supportive in-home provider. All personal care aides must pass an objective standardized test of knowledge, skills, and abilities approved by DMHMRSAS and administered according to DMHMRSAS' defined procedures. Providers must demonstrate a prior successful health care delivery business and operate from a business office.

b. For the consumer-directed model, a service facilitation provider meeting the requirements found in 12 VAC 30-120-770.

~~2. The personal care provider must:~~

~~a. Demonstrate a prior successful health care delivery business.~~

~~b. Operate from a business office.~~

2. For DMHMRSAS-licensed providers, a residential supervisor shall provide on-going supervision for all personal care aides. For DMAS-enrolled personal care/respite care providers, the provider must employ ~~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~~ must be currently licensed to practice in the Commonwealth and have at least 2 years of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/MR or nursing facility.

~~(2)~~3. The RN supervisor or case manager/services facilitator must make ~~an~~ a ~~initial assessment comprehensive~~ home visit to conduct an initial assessment prior to the start of care for all ~~new recipients~~ individuals ~~admitted to~~ requesting ~~personal care~~ services. The RN supervisor or case manager/services facilitator must also perform any subsequent reassessments or changes to the supporting documentation. Under the consumer-directed model, the initial comprehensive visit is done only once upon the individual's entry into the service. If an individual served under the waiver changes CD services facilitation agencies, the new CD services facilitation provider must bill for a reassessment in lieu of a comprehensive visit.

~~(3)~~4. The RN ~~or LPN~~ supervisor or case manager/services facilitator must make supervisory visits as often as needed to ensure both quality and appropriateness of services. ~~The~~

(1) For personal care the minimum frequency of these visits is every 30 to 90 days depending on ~~recipient~~ individual needs. For respite care offered on a routine basis, the minimum frequency of these visits is every 30 to 90 days under the agency-directed model and every six months or upon the use of 300 respite care hours (whichever comes first) under the consumer-directed model.

(2) Under the agency-directed model, when respite care services are not received on a routine basis, but are episodic in nature, the RN is not required to conduct a supervisory visit every 30 to 90 days.

Instead, the RN supervisor must 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 to 90 day supervisory visit conducted for personal care may serve as the RN supervisor or case manager/service facilitator visit for respite care. However, the RN supervisor or case manager/services facilitator must document supervision of respite care separately. For this purpose, the same record can be used with a separate section for respite care documentation.

5. Under the agency-directed model, the supervisor shall identify any gaps in the aide's ability to provide services as identified in the individual's plan of care and provide training as indicated based on continuing evaluations of the aide's performance and the individual's needs.

~~(4)~~6. The supervising RN or case manager/services facilitator ~~or LPN~~ must maintain current documentation. This may be done as a summary and must note:

a.~~(a)~~ Whether personal and respite care services continue to be appropriate;

b.~~(b)~~ Whether the ~~plan~~ supporting documentation is adequate to meet the individual's ~~need~~ needs or if changes are indicated in the ~~plan~~ supporting documentation;

c.~~(c)~~ Any special tasks performed by the aide/CD employee and the aide's/CD employee's qualifications to perform these tasks;

d.~~(d)~~ ~~Recipient's~~ Individual's satisfaction with the service;

e.~~(e)~~ Any hospitalization ~~Hospitalization~~ or change in the individual's medical condition or functioning status;

f.~~(f)~~ Other services received and their amount; and

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

~~(5)~~7. Qualification of aides/CD employees. ~~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 DMAS.~~ Each aide/CD employee must:

a.~~(a)~~ Be 18 years of age or older and possess a valid social security number;

b.~~(a)~~ For the agency-directed model, be~~Be~~ able to read and write English to the degree necessary to perform the tasks required. For the consumer-directed model, possess basic math, reading and writing skills;

c. Have the required skills to perform services as specified in the individual's plan of care;

d. Not be the parents of individuals who are minors, or the individual's spouse. Payment will not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers available to provide the care. Family members who are approved to be reimbursed for providing this service must meet the qualifications. In addition, under the consumer-directed model, family/caregivers acting as the employer on behalf of the individual may not also be the CD employee;

e.~~(b)~~ Additional aide requirements under the agency-directed model:

(1) ~~Have completed~~ Complete ~~40 hours of~~ an appropriate aide training curriculum consistent with ~~the~~ DMAS standards. Prior to assigning an aide to ~~a recipient~~ an individual, the provider ~~agency~~ must ensure that the aide has satisfactorily completed a training program consistent with DMAS standards~~;~~. DMAS requirements may be met in any of the following ways:

(a) Registration as a certified nurse aide (DMAS enrolled personal care/respite care providers);

(b) Graduation from an approved educational curriculum that offers certificates qualifying the student as a nursing assistant, geriatric assistant or home health aide (DMAS enrolled personal care/respite care providers);

(c) Completion of provider-offered training that is consistent with the basic course outline approved by DMAS (DMAS enrolled personal care/respite care providers);

(d) Completion and passing of the DMHMRSAS standardized test (DMHMRSAS licensed providers).

~~(c) Be physically able to do the work;~~

(2)~~(d)~~ 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

~~(e) Not be a member of the recipient's family (family is defined as parents of minor children, spouses, or legally responsible relatives. Payment will not be made for services furnished by other family members unless there is objective written documentation as to why there are no other providers available to provide the care.~~

(3) Be evaluated in his job performance by the supervisor.

f. Additional CD employee requirements under the consumer-directed model:

(1) Submit to a criminal records check and, if the individual is a minor, the child protective services registry. The employee will not be compensated for services provided to the individual if the records check verifies the employee has been convicted of crimes described in § 37.2-314 of the Code of Virginia or if the employee has a complaint confirmed by the DSS child protective services registry.

(2) Be willing to attend training at the individual's or family caregiver's request;

(3) Understand and agree to comply with the DMAS consumer directed services requirements; and

(4) Receive an annual TB screening.

~~3~~8. Provider inability to render services and substitution of aides (agency-directed model).

a. When an ~~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~~ the ~~agency~~ provider may either obtain another aide, obtain a substitute aide from another ~~agency~~ provider if the lapse in coverage is to be less than two weeks in duration, or transfer the ~~recipient~~ individual's services to another ~~agency.~~ provider.

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

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

~~(2) The agency providing the substitute aide must 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 must bill DMAS for services rendered by the substitute aide.~~

~~c. If a provider agency secures a substitute aide, the provider agency is 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.~~

9. Retention, hiring, and substitution of employees (consumer-directed model). Upon the individual's request, the CD services facilitator shall provide the individual or family caregiver with a list of consumer-directed employees on the consumer directed employee registry that may provide temporary assistance until the employee returns or the individual or family caregiver is able to select and hire a new employee. If an individual or family caregiver is consistently unable to hire and retain an employee to provide consumer-directed services, the services facilitator must contact the case manager and DMAS to transfer the individual, at the individual's or family caregiver's choice, to a provider which provides Medicaid-funded agency-directed personal care or respite care services. The CD services facilitator will make arrangements with the case manager to have the individual transferred.

~~4~~10. Required documentation in ~~recipients'~~ individuals' records. The provider ~~agency~~ must maintain all records of each individual receiving services ~~personal care recipient~~. Under the agency-directed model, these records must be separated from those of other non-waiver services, such as home health services. At a minimum these records must contain:

a. The most recently updated ~~CSP~~ plan of care and supporting documentation, all provider ~~agency~~ documentation, and all DMAS-122 forms;

~~b. All the DMAS utilization review forms;~~

~~c~~b. Initial assessment by the RN supervisory nurse or case manager/services facilitator completed prior to or on the date services are initiated, ~~and~~ subsequent reassessments, and changes to the supporting documentation by the RN supervisory nurse or case manager/services facilitator;

~~d~~c. ~~Nurses~~ Nurses' or case manager/services facilitator summarizing notes recorded and dated during any contacts with the ~~personal care~~ aide or CD employee and during supervisory visits to the ~~recipient's~~ individual's home;

~~e~~d. All correspondence to the ~~recipient~~ individual and to DMAS;

~~f. Reassessments made during the provision of services; and~~

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

~~h~~f. Under the agency-directed model, All ~~personal care~~ aide records. The ~~personal care~~ aide record must contain:

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

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

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

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

~~i.~~(5) 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.

(6) Copies of all aide records shall be subject to review by state and federal Medicaid representatives.

g. Additional documentation requirements under the consumer-directed model:

(1) All management training provided to the individuals or family caregivers, including the individual's or family caregiver's responsibility for the accuracy of the timesheets.

(2) All documents signed by the individual or the individual's family caregivers that acknowledge the responsibilities of the services.

CERTIFIED:

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12 VAC 30-120-767. Reserved.

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

Service description. Respite care means services specifically designed to provide a temporary but periodic or routine relief to the unpaid primary caregiver of a recipient who is incapacitated or dependent due to physical or cognitive disability. Respite care services include 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.

~~Criteria. Respite care may only be offered to recipients who have a primary unpaid 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~~.

~~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, providers must meet the following qualifications:~~

~~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 must employ or subcontract with and directly supervise an RN or an LPN who will provide ongoing supervision of all respite care aides.~~

~~a. The RN and LPN must 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 or LPN supervisor shall identify any gaps in~~

~~the aides' ability to function competently and shall provide training as indicated.~~

~~c. The RN supervisor must make an initial assessment visit prior to the start of care for any recipient admitted to respite care. The RN supervisor must also perform any subsequent reassessments or changes to the supporting documentation.~~

~~d. The RN or LPN must 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 to 90 days.~~

~~(2) When respite care services are not received on a routine basis, but are episodic in nature, the RN or LPN is not required to conduct a supervisory visit every 30 to 90 days. Instead, the nurse supervisor must 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 to 90 day supervisory visit conducted for personal care may serve as the RN or LPN visit for respite care. However, the RN or LPN supervisor must 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 must document in a summary note:

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

(2) Whether the supporting documentation 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 the 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 must:

a. Be able to read and write ;

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

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

d. Be physically able to do the work;

e. 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. Not be a member of the recipient's family (family is defined as parents of minor children, spouses). or legally responsible relatives. Payment will not be made for services furnished by other family members unless there is objective, written documentation as to why there are no other providers available to provide the care.

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 apply:

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

~~(2) The respite care agency having recipient care responsibility must 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 must be in the recipient's record. The documentation of the substitute aide's qualifications must also be obtained and recorded in the personnel files of the agency having recipient care responsibility. The two agencies involved are responsible for negotiating the financial arrangements of paying the substitute aide.~~

~~(3) Only the provider agency having recipient responsibility may bill 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 must 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 must maintain all records of each respite care recipient. These records must be separated from those of other non-waiver services, such as home health services. These records will be reviewed periodically by the DMAS staff. At a minimum these records must contain:~~

~~(a) The most recent CSP and supporting documentation, all respite care assessments, and all DMAS-122 forms;~~

~~(b) All DMAS utilization review forms;~~

~~(c) Initial assessment by the RN supervisory nurse completed prior to or on the date services are initiated and subsequent reassessments and changes to supporting documentation by the RN supervisory nurse;~~

~~(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 DMAS;~~

~~(f) Reassessments made during the provision of services; and~~

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

~~6. Respite care aide record of services rendered and recipient's responses. The aide record must 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 must include, at a minimum, 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.~~

~~(c) 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.~~

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

CERTIFIED:

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12 VAC 30-120-769. Reserved.

12 VAC 30-120-770. Consumer-directed model of service delivery. ~~services: Attendant care, companion care, and respite care.~~

~~A. Service definition.~~

~~1. (a) Attendant services include hands-on care specific to the needs of a recipient . Attendant care includes assistance with ADLs, bowel/bladder programs, range of motion exercises, routine wound care that does not include sterile technique, and external catheter care. Supportive services are those that substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. When specified, supportive services may include assistance with instrumental activities of daily living (IADLs) that are incidental to the care furnished, or that are essential to the health and welfare of the recipient . Attendant care does not include either practical or professional nursing services or those practices regulated in Chapters 30 and 34of 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 receive these two services simultaneously.~~

~~(b) An additional component to Attendant Care will be work -related Attendant Services. This service will extend the ability of the personal attendant to provide assistance in the workplace. These services include filing, retrieving work materials that are out of reach; providing travel assistance for a consumer with a mobility impairment; helping a consumer with organizational skills; reading handwritten mail to a consumer with a visual impairment; or ensuring that a sign language interpreter is present during staff meetings to accommodate an employee with a hearing impairment.~~

2. Consumer-directed respite care means services specifically designed to provide a temporary but periodic or routine relief to the primary unpaid 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. 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.

A. Criteria.

1. The IFDDS Waiver has three services, companion, personal care, and respite, which may be provided through a consumer-directed model.

2. Individuals who are eligible for consumer-directed services must have the capability to hire and train their consumer-directed employees and supervise the employee’s work performance. If an individual is unable to direct his own care or is under 18 years of age, a family caregiver may serve as the employer on behalf of the individual.

3. Responsibilities as employer. The individual, or if the individual is unable, then a family caregiver, is the employer in this service, and is responsible for hiring, training, supervising, and firing

employees. Specific duties include checking references of employees, determining that employees meet basic qualifications, training employees, supervising the employees' performance, and submitting timesheets to the fiscal agent on a consistent and timely basis. The individual or family caregiver must have an emergency back-up plan in case the employee does not show up for work.

4. DMAS shall contract for the services of a fiscal agent for ~~attendant~~ consumer-directed personal care, companion ~~care~~, and ~~consumer-directed~~ respite care services. The fiscal agent will be paid ~~reimbursed~~ by DMAS to perform certain tasks as an agent for the ~~recipient~~ individual/employer who is receiving consumer-directed services. The fiscal agent will handle responsibilities for the ~~recipient~~ individual 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.

5. Individuals choosing consumer-directed services must receive support from a CD services facilitator. CD services facilitators assist the individual or family/caregiver as they become employers for consumer directed services. This function includes providing the individual or family/caregiver with management training, review and explanation of the Employee Management Manual, and routine visits to monitor the employment process. The CD services facilitator assists the individual/employer with employer issues as they arise. The services facilitator meeting the stated qualifications may also complete the assessments, reassessments, and related supporting documentation necessary for consumer-directed services if the individual or family/caregiver chooses for the CD services facilitator to perform these tasks rather than the case manager. Services facilitation services are provided on an as needed basis as determined by the individual, family/caregiver, and CD services facilitator. This must be documented in the supporting documentation for consumer-directed services and the services facilitation provider bills accordingly. If an individual enrolled in consumer-directed services has a lapse in service facilitation services for more than sixty consecutive days, the case manager must

notify DMAS so that consumer-directed services may be discontinued and the option given to change to agency-directed services.

~~B. Criteria~~

~~1. In order to qualify for attendant care services, the recipient must demonstrate a need for personal care in activities of daily living, medication, or other medical needs, or monitoring health status or physical condition.~~

~~2. Consumer-directed respite care may only be offered to recipients who have a primary unpaid caregiver living in the home who requires temporary relief to avoid institutionalization of the recipient, and it is designed to focus on the need of the caregiver for temporary relief.~~

~~3. The inclusion of companion care in the CSP 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.~~

~~4. Attendant care, companion care, and consumer-directed respite services are available to recipients who would otherwise require the level of care provided in an ICF/MR. Recipients who are eligible for consumer-directed services must have the capability to hire and train their own personal attendants or companions and supervise the attendant's or companion's performance. Recipients with cognitive impairments will not be able to manage their own care. If a recipient is unable to direct his own care, a family caregiver may serve as the employer on behalf of the recipient. Recipients are permitted to share hours for no more than two individuals living in the same home.~~

~~5. Responsibilities as employer. The recipient, or if the recipient is unable, then a family caregiver, is the employer in this service, and is responsible for hiring, training, supervising, and firing personal attendants and companions. Specific duties include checking references of personal attendants/companions, determining that personal attendants/companions meet basic qualifications,~~

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

C. Service units and service limitations.

1. Consumer-directed respite care services are limited to a maximum of 30 days or 720 hours per calendar year.

2. The amount of companion care time included in the CSP 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 CSP exceed eight hours per day.

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

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

The attendant/companion must meet the following requirements:

a. Be 18 years of age or older;

b. Have the required skills to perform consumer-directed services as specified in the recipient's supporting documentation;

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

d. Possess a valid Social Security number;

e. Submit to a criminal records check and, if the recipient is a minor, the child protective services registry. The personal attendant/companion will not be compensated for services provided to the recipient if the records check verifies the personal attendant/companion has been convicted of crimes

~~described in § 32.1-162.9:1 the Code of Virginia or if the personal attendant/companion has a complaint confirmed by the DSS child protective services registry.~~

~~f. Be willing to attend training at the recipient's or family caregiver's request;~~

~~g. Understand and agree to comply with the DMAS IFDDS waiver requirements;~~

~~h. Receive periodic TB screening, CPR training and an annual flu ; and~~

~~i. Be willing to register in a personal attendant registry which will be maintained by the consumer-directed services facilitator chosen by the recipient or recipient's parent or guardian.~~

~~5. Restrictions. Attendants cannot be spouses, parents of minor children, or legally responsible relatives. Payment will not be made for services furnished by other family members unless there is objective written documentation as to why there are no other providers available to provide the care.~~

~~6. Retention, hiring, and substitution of attendants. Upon the recipient's request, the CD services facilitation provider shall provide the recipient or family caregiver with a list of persons on the personal attendant registry who can provide temporary assistance until the attendant returns or the recipient or family caregiver is able to select and hire a new personal attendant. If a recipient or family caregiver 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 or family caregiver's choice, to a provider which provides Medicaid-funded agency-directed personal care, companion care, or respite care services. The CD services facilitation provider will make arrangements with the support coordinator to have the recipient transferred.~~

B~~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, CD services facilitators ~~provider~~ must meet the following qualifications:

1. To be enrolled as a Medicaid CD services ~~facilitation provider~~ facilitator and maintain provider status, the CD services ~~facilitation provider~~ facilitator must operate from a business office and have sufficient qualified staff who will function as CD services facilitators to perform the ~~needed plans of care development and monitoring, reassessments,~~ service ~~coordination,~~ facilitation and support activities as required.

It is preferred that the employee of the CD services ~~facilitation provider~~ facilitator possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth. In addition, it is preferable that the ~~individual~~ CD services facilitator ~~have~~ has two years of satisfactory experience in the human services field working with ~~persons~~ individuals with ~~developmental disabilities~~ related conditions.

2. The ~~individual~~ CD services facilitator must 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 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 developmental disabilities, 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 developmental disabilities that reduces the need for human help and improves safety;~~

(~~4~~1) Various long-term care program requirements, including nursing home, ICF/MR, and assisted living facility placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal care services;

(~~5~~2) ~~IFDDS waiver~~ DMAS consumer directed services requirements, ~~as well as~~ and the administrative duties for which the ~~recipient~~ individual will be responsible;

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

(~~7~~3) Interviewing techniques;

(~~8~~4) The ~~recipient's~~ individual'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~~ employee;

(~~9~~5) The principles of human behavior and interpersonal relationships; and

(~~10~~6) General principles of record documentation.

(7) For CD services facilitators who also conduct assessments and reassessments, the following is also required. Knowledge of:

(a) 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;

(b) Physical assistance typically required by people with developmental disabilities, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

(c) Equipment and environmental modifications commonly used and required by people with developmental disabilities that reduces the need for human help and improves safety;

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

b. Skills in:

(1) Negotiating with ~~recipients~~ individuals, family/caregivers, 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~~ individual'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~~ individuals and their families;

(3) Be persistent and remain objective;

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

(5) Communicate effectively, orally and in writing; ~~and~~

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

(7) Interview.

~~2. If the CD services facilitation staff employed by the CD services facilitation provider is not an RN, the CD services facilitation 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 and CD services facilitation providers on issues related to the health needs of the recipient.~~

3. If the CD services facilitator is not an RN, the CD services facilitator must inform the primary health care provider that services are being provided and request skilled nursing or other consultation as needed.

~~3~~4. Initiation of services and service monitoring.

~~a. Attendant care services.~~:

a. If the services facilitator has responsibility for individual assessments and reassessments, these must be conducted as specified in 12VAC30-120-766 and 12VAC30-120-776.

b. Management Training.

(1) The CD services ~~facilitation provider~~ facilitator must make an initial ~~comprehensive home~~ visit ~~to develop the supporting documentation~~ with the ~~recipient~~ individual or family caregiver ~~and~~ to provide management training. The initial management training is done only once upon the individual's entry into the service. If an individual served under the waiver changes CD services facilitators, the new CD services facilitator must bill for a regular management training in lieu of initial management training.

(2) 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 ~~supporting documentation~~ employment process.

(3) For personal care services, ~~The~~ the CD services ~~facilitation provider~~ facilitator will continue to monitor ~~the supporting documentation~~ 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~~ individual. After the initial visit, the CD services facilitator will periodically review the utilization of companion services at a minimum of every six months and for respite services, either every six months or upon the use of 300 respite care hours, whichever comes first.

~~The initial comprehensive visit is done only once upon the recipient's entry into the service. If a waiver recipient changes CD services facilitation agencies, the new CD services facilitation provider must bill for a reassessment in lieu of a comprehensive visit.~~

~~b. Consumer-directed respite and companion services.~~:

~~The CD services facilitation provider must make an initial comprehensive home visit to develop the supporting documentation with the recipient or family caregiver and will provide management training.~~

~~After the initial visit, the CD services facilitator will periodically review the utilization of companion services at a minimum of every six months or for respite services, either every six months or upon the use of 300 respite care hours, whichever comes first.~~

~~The initial comprehensive visit is done only once upon the recipient's entry into the service. If a waiver recipient changes CD services facilitation agencies, the new CD services facilitation provider must bill for a reassessment in lieu of a comprehensive visit.~~

~~4. CD services facilitator reassessments for consumer-directed services. 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 CD services facilitation provider must 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 CD services facilitation provider's summary must 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 service is adequate to meet the recipient's needs;~~

~~c. Any special tasks performed by the attendant/companion and the attendant's/companion'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 CD services facilitator's visit.~~

~~5~~4. The CD services ~~facilitation provider~~ facilitator must be available to the ~~recipient~~ individual or family/caregiver by telephone during normal business hours, have voice mail capability, and return phone calls within 24 hours or have an approved back-up CD services facilitator.

~~6~~5. The CD services ~~facilitation provider~~ facilitator must submit a criminal record check within 15 days of employment pertaining to the ~~personal attendant/companion~~ consumer-directed employees on behalf of the ~~recipient~~ individual or family/caregiver and report findings of the criminal record check to the ~~recipient~~ individual or the family/caregiver and the program's fiscal agent. ~~Personal attendants/companions 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 or if the personal attendant/companion has a confirmed record on the DSS Child Protective Services Registry. If the recipient is a minor, the personal attendant/companion must also be screened through the DSS child protective services registry.~~

~~7~~6. The CD services ~~facilitation provider~~ facilitator shall verify bi-weekly timesheets signed by the ~~recipient~~ individual or the family caregiver and the ~~personal attendant/companion~~ employee to ensure that the number of ~~CSP~~ plan of care approved hours are not exceeded. If discrepancies are identified, the CD services ~~facilitation provider~~ facilitator must contact the ~~recipient~~ individual to resolve discrepancies and must notify the fiscal agent. If ~~a recipient~~ an individual is consistently being identified as having discrepancies in his timesheets, the CD services ~~facilitation provider~~ facilitator must contact the ~~support coordinator~~ case manager to resolve the situation. ~~The CD services facilitation provider cannot verify timesheets for personal attendants/companions who have been convicted of crimes described in the § 32.1-162.9:1 of the Code of Virginia or who have a confirmed case with the DSS Child Protective Services Registry and must notify the fiscal agent.~~

~~8~~7. ~~Personal attendant~~ Consumer-directed employee registry. The CD services ~~facilitation provider~~ facilitator must maintain a ~~personal attendant~~ consumer-directed employee registry, updated on an ongoing basis.

~~9~~8. Required documentation in ~~recipients'~~ individuals' records. CD services facilitators responsible for individual assessment and reassessment must maintain records as described in 12VAC30-120-766 and 12VAC30-120-776. ~~The CD services facilitation provider must maintain all records of each recipient. At a minimum these records must contain~~ For CD services facilitators conducting management training, the following documentation is required in the individual's record:

a. All copies of the ~~CSP~~ plan of care, all supporting documentation related to consumer directed services, and all DMAS-122 forms.

~~b. All DMAS utilization review forms.~~

~~c~~b. CD services ~~facilitation provider~~ facilitator's notes ~~contemporaneously~~ recorded and dated at the time of service delivery. ~~during any contacts with the recipient and during visits to the recipient's home.~~

~~d~~c. All correspondence to the ~~recipient~~ individual, others concerning the individual, 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~~d. All training provided to the ~~personal attendant/companion or attendants/companions~~ consumer-directed employees on behalf of the ~~recipient~~ individual or family caregiver.

~~h~~e. All management training provided to the ~~recipients~~ individuals or family caregivers, including the ~~recipient's~~ individual's or family caregiver's responsibility for the accuracy of the timesheets.

~~i~~f. All documents signed by the ~~recipient~~ individual or the ~~recipient's~~ individual's family caregivers that acknowledge the responsibilities of the services.

CERTIFIED:

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12 VAC 30-120-771. Reserved.

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

A. Service Description. Family or caregiver training is a service which provides training and counseling services to families or caregivers of individuals receiving waiver services. ~~is 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~~ unpaid people who live with or provide care to ~~or support a waiver recipient~~ an individual served on the waiver, and may include a parent, spouse, children, relatives, ~~a legal guardian,~~ foster family, or in-laws. "Family" does not include ~~individuals~~ people who are employed to care for the ~~recipient~~ individual. All family/caregiver training must be included in the ~~recipient's~~ individual's written ~~CSP~~ plan of care.

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

C Service units and service limitations. Services will be billed hourly and must be prior authorized. ~~Recipients~~Family, as defined in this section, may receive up to 80 hours of family/caregiver training per ~~calendar~~ individual's plan of care year.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based ~~care~~ waiver services participating providers as specified in 12 VAC 30-120-730 and 12 VAC 30-120-740, family/caregiver training providers must meet the following ~~qualifications~~ requirements:

1. Family/caregiver training must be provided on an individual basis, in small groups or through seminars and conferences provided by ~~Medicaid~~ DMAS-~~certified~~ enrolled family and caregiver training providers.

2. Family/caregiver training must be provided by ~~individuals~~ providers with expertise in, ~~who work for an agency with~~ experience in, or demonstrated knowledge of the training topic identified in the plan of care, and who work for an agency or organization that ~~has~~ have a provider participation agreement with DMAS to provide these services. ~~Individuals~~ Providers must also have the appropriate licensure or certification as required for the specific professional field associated with the training area. ~~Licensed Practical Counselors, Licensed Clinical Social Workers, and Licensed Psychologists can enroll as individual practitioners with DMAS to provide family/ caregiver training.~~ Providers include the following: qualified staff of provider agencies; psychologists; licensed clinical social workers; and, licensed professional counselors. Qualified staff of provider agencies must be licensed and include occupational therapists, physical therapists, speech/language pathologists, physicians, psychologists, licensed clinical social workers, licensed professional counselors, registered

nurses, and special education teachers. Provision of services is monitored by the individual, family/caregiver, and/or the case manager.

CERTIFIED:

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12 VAC 30-120-773. Reserved.

12 VAC 30-120-774. Personal ~~Emergency~~ emergency ~~Response~~ response ~~System~~ system (PERS).

A. Service Description. PERS is a service which ~~electronically~~ monitors ~~recipient~~ individual safety in the home and provides access to emergency ~~crisis intervention~~ assistance for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the ~~recipient's~~ individual's home telephone line. PERS may also include medication monitoring devices.

B. Criteria. PERS ~~can~~ may be authorized when there is no one else is in the home who is competent ~~and~~ or 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, and adjustments of the PERS. A unit of service is one-month rental price set by DMAS. The one time installation of the unit includes installation, account activation, ~~recipient~~ individual and caregiver instruction, and removal of PERS equipment.

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

3. PERS cannot be used as a substitute for providing adequate supervision of the individual.

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, providers must also meet the following ~~qualifications~~ requirements:

1. A PERS provider is 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 who are capable of receiving signals for help from ~~a recipient's~~ an individual's PERS equipment 24-hours a day, 365, or 366 as appropriate,

days per year; of determining whether an emergency exists; and of notifying an emergency response organization or an emergency responder that the PERS ~~recipient~~ individual 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 has 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~~ individual'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~~ the functioning telephone line of an individual receiving PERS and must furnish all supplies necessary to ensure that the system is installed and working properly.

6. The PERS installation includes local seize line circuitry, which guarantees that the unit will 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 individual receiving PERS ~~recipient~~ at no additional cost to DMAS. The record must document all of the following:

a. Delivery date and installation date of the PERS;

b. ~~Enrollee~~ Individual or family/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~~ individual responder and contact information, as provided by the ~~recipient~~ individual or the ~~recipient's~~ individual's care provider, or case manager; and

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

11. A PERS provider must furnish education, data, and ongoing assistance to DMAS and case managers to familiarize staff with the service, allow for ongoing evaluation and refinement of the program, and must instruct the ~~recipient~~ individual, family/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~~ individual's home for a minimum period of 24-hours and automatically transmit a low battery alert signal to the response center if the back-up battery is low. The emergency response console unit must also be able to self-disconnect and redial the back-up monitoring site without the ~~recipient~~ individual 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 is the PERS provider's responsibility to ensure 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 multiple individuals' ~~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~~ individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;

d. A back-up power supply;

e. A separate telephone service;

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

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

14. The 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 within 30 days of the action taken a written report to the ~~support coordinator~~ case manager for each emergency signal that results in action being taken on behalf of the ~~recipient~~ individual. This excludes test signals or activations made in error.

16. The PERS provider is prohibited from performing any type of direct marketing activities.

CERTIFIED:

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12 VAC 30-120-775. Reserved.

12 VAC 30-120-776. Companion ~~Care~~ services ~~agency-directed model of care~~.

A. Service Description. Companion ~~care~~ services 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~~ people are available. This service may be provided either through an agency-directed or a consumer-directed model.

B. Criteria.

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

2. ~~Recipients~~ Individuals ~~who have~~ having a current, uncontrolled medical condition ~~which would make~~ making them unable to call for help during a rapid deterioration ~~can~~ may be approved for companion ~~care~~ services if there is documentation that the ~~recipient~~ individual has had recurring attacks during the two-month period prior to the authorization of companion ~~care~~ services. Companion

~~care~~ services shall not be covered if required only because the ~~recipient~~ individual does not have a telephone in the home or because the ~~recipient~~ individual does not speak English.

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

4. Individuals choosing the consumer-directed option must receive support from a CD services facilitator and meet requirements for consumer direction as described in 12VAC30-120-770.

C. Service units and service limitations.

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

2. A companion ~~care aide~~ cannot provide supervision to ~~recipients~~ individuals ~~who are~~ on ventilators, ~~or~~ requiring continuous tube feedings, or ~~those who require~~ requiring suctioning of their airways.

3. Companion ~~care~~ services will be authorized for family members to sleep either during the day or during the night when the ~~recipient~~ individual cannot be left alone at any time, due to the ~~recipient's~~ individual's severe agitation and/or physically wandering behavior. Companion ~~aide~~ services must be necessary to ensure the ~~recipient's~~ individual's safety if the ~~recipient~~ individual cannot be left unsupervised due to health and safety concerns.

4. Companion ~~care~~ services ~~can~~ may be authorized when no one else ~~is~~ in the home ~~who~~ is competent to call for help in an emergency.

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, companion service providers must meet the following ~~qualifications~~ requirements:

1. Companion services providers shall include:

a. For the agency-directed model: Companion providers include DMHMRSAS-licensed residential services providers; DMHMRSAS-licensed supportive, in-home residential service providers; DMHMRSAS-licensed day support service providers; DMHMRSAS-licensed respite service providers; and DMAS-enrolled personal care/respite care providers.

b. For the consumer-directed model: a services facilitator must meet the requirements found in 12VAC30-120-770.

~~1~~2. Companion ~~aide~~ qualifications. ~~Agencies must individuals to provide companion care who meet~~ Companions must meet the following requirements:

a. Be at least 18 years of age;

b. Possess basic math skills and English reading~~,~~ and writing skills, to the degree necessary to perform the tasks required ~~and math skills~~;

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

d. Submit to a criminal history record check and if providing services to a minor, submit to a record check under the State's Child Protective Services Registry. The companion will not be compensated for services provided to the ~~recipient~~ individual if the records check verifies the companion has been convicted of crimes described in § ~~32.1-162.9:1~~ 37.1-183.3 of the Code of Virginia;

e. Possess a valid Social Security number; and

f. Have the required skills to perform services as specified in the individual's plan of care. ~~Be capable of aiding in the activities of daily living or instrumental activities of daily living.~~

g. Additional CD employee requirements under the consumer-directed model:

(1) Be willing to attend training at the individual's or family caregiver's request;

(2) Understand and agree to comply with the DMAS consumer directed services requirements; and,

(3) Receive an annual TB screening.

3. Companions may not be the individual's spouse. Other family members living under the same roof as the individual being served may not provide companion services unless there is objective, written documentation as to why there are no other providers available to provide the services. Companion services shall not be provided by adult foster care/family care providers or any other paid caregivers.

4. Family members who are reimbursed to provide companion services must meet the companion qualifications.

~~2~~5. For the agency-directed model, companions~~Companions will be~~ are employees of ~~agencies~~ entities that ~~will contract~~ enroll with DMAS to provide companion services. ~~Agencies~~ Providers ~~will be~~ are required to have a companion ~~care~~ services 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, and have at least one year of experience working with individuals with related conditions; or must have a bachelor's degree in a human services field and at least one year of experience working with individuals with related conditions.

6. Retention, hiring, and substitution of companions (consumer-directed model). Upon the individual's request, the CD services facilitator shall provide the individual or family caregiver with a list of consumer-directed employees on the consumer directed employee registry that may provide temporary assistance until the companion returns or the individual or family caregiver is able to select and hire a new companion. If an individual or family caregiver is consistently unable to hire and retain a companion to provide consumer-directed services, the CD services facilitator must contact the case manager and DMAS to transfer the individual, at the individual's or family caregiver's choice, to a provider which provides Medicaid-funded agency-directed companion services. The CD services facilitator will make arrangements with the case manager to have the individual transferred.

~~3~~7. The provider or case manager/services facilitator~~agency~~ must conduct an initial home visit ~~within the first three days of~~ prior to initiating companion ~~care~~ services to document the efficacy and

appropriateness of services and to establish a ~~service~~ plan of care for the ~~recipient~~ individual. Under the agency-directed model, the ~~The~~ ~~agency~~ provider must provide follow-up home visits quarterly or as often as needed to monitor the provision of services ~~every four months or as often as needed~~. Under the consumer-directed model, the case manager/services facilitator will periodically review the utilization of companion services at a minimum of every six months or more often as needed. The ~~recipient~~ individual must be reassessed for services every six months.

8. Required documentation. The provider or case manager/services facilitator must maintain a record of each individual receiving companion services. At a minimum these records must contain the following:

a. An initial assessment completed prior to or on the date services are initiated and subsequent reassessments and changes to the supporting documentation.

b. The supporting documentation must be reviewed by the provider or case manager/services facilitator quarterly under the agency-directed model, semi-annually under the consumer-directed model, annually, and more often, as needed, modified as appropriate, and the written results of these reviews submitted to the case manager. For the annual review and in cases where the supporting documentation is modified, the plan of care must be reviewed with the individual or family/caregiver.

c. All correspondence to the individual, family/caregiver, case manager, and DMAS.

d. Contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.

e. The companion services supervisor or case manager/service facilitator must document in the individual's record a summary note following significant contacts with the companion and quarterly or semi-annual home visits with the individual. This summary must include the following at a minimum:

~~i.~~ (1) Whether companion services continue to be appropriate;

~~ii.~~ (2) Whether the plan is adequate to meet the individual's needs or changes are indicated in the plan;

~~iii.~~ (3) The individual's satisfaction with the service; and

iv. (4) The presence or absence of the companion during the visit.

f. A copy of the most recently completed DMAS-122 form. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

g. Additional documentation requirements under the consumer-directed model:

(1) All training provided to the companion on behalf of the individual or family caregiver.

(2) All management training provided to the individuals or family caregivers, including the individual's or family caregiver's responsibility for the accuracy of the timesheets.

(3) All documents signed by the individual or the individual's family caregivers that acknowledge the responsibilities of the services.

h. Under the agency-directed model, all companion records. The companion record must contain the following:

(1) The specific services delivered to the individual by the companion, dated the day of service delivery, and the individual's response;

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

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

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

CERTIFIED:

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12 VAC 30-120-777 through 12 VAC 30-120-~~779~~ 800. 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 CSP 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 supporting documentation and revisions to the CSP as indicated by the changing needs of the recipient. At a minimum, the support coordinator must review the CSP 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 CSP 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. DMAS shall complete an annual comprehensive reassessment, in coordination with the recipient, family, and service providers. If warranted, DMAS will coordinate a medical examination and a psychological evaluation for every waiver recipient. The reassessment must include an update of the assessment instrument and any other appropriate assessment data.

2. A medical examination must be completed for adults based on need identified by the provider, recipient, support coordinator, or DMAS staff. Medical examinations for children must 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 is 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.

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

c. All supporting documentation related to any change in the CSP.

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 supporting documentation developed for that recipient and maintained for a period of not less than five years.~~

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

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

CERTIFIED:

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

~~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~~

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

CERTIFIED:

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12 VAC 30-120-800 Reserved.