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TO: **EMILY MCCELLAN**
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FROM: **MICHELLE A. L'HOMMEDIEU**
Assistant Attorney General

DATE: **November 2, 2015**

SUBJECT: **Emergency Regulations – Consumer Directed Services Facilitators (4046/6695)**

I am in receipt of the attached regulations to make amend the current regulations to supplement and establish education, experience, and competency requirements for consumer directed services facilitators. You have asked the Office of the Attorney General to review and determine if the Department of Medical Assistance Services ("DMAS") has the legal authority to promulgate these regulations and if they comport with state and federal law.

Based on that review, it is this Office's view that the Director, acting on behalf of the Board of Medical Assistance Services under Virginia Code §§ 32.1-324 and 325, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act ("APA"), and has not exceeded that authority.

Based on the need to address this situation, which was recognized by the General Assembly, DMAS is seeking emergency authority from the Governor's Office under Virginia Code § 2.2-4011(A). *See 2013 Acts of the Assembly*, Ch. 806, Item 307 XXX. Under Virginia Code § 2.2-4012, these emergency regulations shall be effective upon approval by the Governor and filing with the Registrar of Regulations as no later effective date has been specified.

These regulations shall remain effective for an 18-month period. The regulatory package includes a Notice of Intended Regulatory Action. If DMAS intends to continue regulating the subject matter beyond the 18-month period from the effective date, DMAS must replace these emergency regulations with regulations duly promulgated under Article 2 of the APA, and the

proposed regulations must be filed with the Registrar within 180 days after the effective date of the emergency regulations.

These regulations will not amend the State Plan; however, they will amend DMAS's waiver applications and approval by CMS is therefore required. It is my understanding that upon receiving regulatory approval, DMAS will work with CMS to obtain the necessary waiver approvals. If you have any questions or need additional information about these regulations, please contact me at 786-6005.

cc: Kim F. Piner, Esq.

Attachment

Project 3805 - Emergency/NOIRA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Consumer Directed Services Facilitators

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-50-130. Skilled nursing facility services, EPSDT, school health services and family planning.

A. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Service must be ordered or prescribed and directed or performed within the scope of a license of the practitioner of the healing arts.

B. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

1. Payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities, and the accompanying attendant physician care, in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination.

2. Routine physicals and immunizations (except as provided through EPSDT) are not covered except that well-child examinations in a private physician's office are covered for foster children of the local social services departments on specific referral from those departments.

3. Orthoptics services shall only be reimbursed if medically necessary to correct a visual defect identified by an EPSDT examination or evaluation. The department shall place appropriate utilization controls upon this service.

4. Consistent with the Omnibus Budget Reconciliation Act of 1989 § 6403, early and periodic screening, diagnostic, and treatment services means the following services: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Social Security Act § 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services and which are medically necessary, whether or not such services are covered under the State Plan and notwithstanding the limitations, applicable to recipients ages 21 and over, provided for by the Act § 1905(a).

5. Community mental health services. These services in order to be covered (i) shall meet medical necessity criteria based upon diagnoses made by LMHPs who are practicing within the scope of their licenses and (ii) are reflected in provider records and on providers' claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.

a. Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

"Activities of daily living" means personal care activities and includes bathing, dressing, transferring, toileting, feeding, and eating.

"Adolescent or child" means the individual receiving the services described in this section. For the purpose of the use of these terms, adolescent means an individual 12-20 years of age; a child means an individual from birth up to 12 years of age.

"Behavioral health services administrator" or "BHSA" means an entity that manages or directs a behavioral health benefits program under contract with DMAS.

"Care coordination" means collaboration and sharing of information among health care providers, who are involved with an individual's health care, to improve the care.

"Certified prescreener" means an employee of the local community services board or behavioral health authority, or its designee, who is skilled in the assessment and treatment of mental illness and has completed a certification program approved by the Department of Behavioral Health and Developmental Services.

"Clinical experience" means providing direct behavioral health services on a full-time basis or equivalent hours of part-time work to children and adolescents who have diagnoses of mental illness and includes supervised internships, supervised practicums, and supervised field experience for the purpose of Medicaid reimbursement of (i) intensive in-home services, (ii) day treatment for children and adolescents, (iii) community-based residential services for children and adolescents who are younger than 21 years of age (Level A), or (iv) therapeutic behavioral services (Level B). Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. The equivalency of part-time hours to full-time hours for the purpose of this requirement shall be as established by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

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

"DMAS" means the Department of Medical Assistance Services and its contractor or contractors.

"Human services field" means the same as the term is defined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Individual service plan" or "ISP" means the same as the term is defined in 12VAC30-50-226.

"Licensed mental health professional" or "LMHP" means a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist.

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling. For purposes of Medicaid reimbursement to their supervisors for services provided by such residents, they

shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology. For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

"Progress notes" means individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes. Individualized and member-specific progress notes are part of the minimum documentation requirements and shall convey the individual's status, staff interventions, and, as appropriate, the individual's progress, or lack of progress, toward goals and objectives in the ISP. The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units/hours required to deliver the service. The content of each progress note shall corroborate the time/units billed. Progress notes shall be documented for each service that is billed.

"Psychoeducation" means (i) a specific form of education aimed at helping individuals who have mental illness and their family members or caregivers to access clear and concise information about mental illness and (ii) a way of accessing and learning strategies to deal with mental illness and its effects in order to design effective treatment plans and strategies.

"Psychoeducational activities" means systematic interventions based on supportive and cognitive behavior therapy that emphasizes an individual's and his family's needs and focuses on increasing the individual's and family's knowledge about mental disorders, adjusting to mental illness, communicating and facilitating problem solving and increasing coping skills.

"Qualified mental health professional-child" or "QMHP-C" means the same as the term is defined in 12VAC35-105-20.

"Qualified mental health professional-eligible" or "QMHP-E" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-590.

"Qualified paraprofessional in mental health" or "QPPMH" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-1370.

"Service-specific provider intake" means the face-to-face interaction in which the provider obtains information from the child or adolescent, and parent or other family member or members, as appropriate, about the child's or adolescent's mental health status. It includes documented history of the severity, intensity, and duration of mental health care problems and issues and shall contain all of the following elements: (i) the presenting issue/reason for referral, (ii) mental health history/hospitalizations, (iii) previous interventions by providers and timeframes and response to treatment, (iv) medical profile, (v) developmental history including history of abuse, if appropriate, (vi) educational/vocational status, (vii) current living situation and family history and relationships, (viii) legal status, (ix) drug and alcohol profile, (x) resources and strengths, (xi) mental status exam and profile, (xii) diagnosis, (xiii) professional summary and clinical formulation, (xiv) recommended care and treatment goals, and (xv) the dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

b. Intensive in-home services (IIH) to children and adolescents under age 21 shall be time-limited interventions provided in the individual's residence and when clinically necessary in community settings. All interventions and the settings of the intervention shall be defined in the Individual Service Plan. All IIH services shall be designed to specifically improve family dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote psychoeducational benefits in the home setting of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the individual. These services provide crisis treatment; individual and family counseling; communication skills (e.g., counseling to assist the individual and his parents or guardians, as appropriate, to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); care coordination with other required services; and 24-hour emergency response.

(1) These services shall be limited annually to 26 weeks. Service authorization shall be required for Medicaid reimbursement prior to the onset of services. Services rendered before the date of authorization shall not be reimbursed.

(2) Service authorization shall be required for services to continue beyond the initial 26 weeks.

(3) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in this section.

(4) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

c. Therapeutic day treatment (TDT) shall be provided two or more hours per day in order to provide therapeutic interventions. Day treatment programs, limited annually to 780 units, provide evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal

skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group and family counseling.

(1) Service authorization shall be required for Medicaid reimbursement.

(2) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in this section.

(3) These services may be rendered only by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

d. Community-based services for children and adolescents under 21 years of age (Level A).

(1) Such services shall be a combination of therapeutic services rendered in a residential setting. The residential services will provide structure for daily activities, psychoeducation, therapeutic supervision, care coordination, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. The application of a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual® Criteria or an equivalent standard authorized in advance by DMAS, shall be required for this service.

(2) In addition to the residential services, the child must receive, at least weekly, individual psychotherapy that is provided by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

(3) Individuals shall be discharged from this service when other less intensive services may achieve stabilization.

(4) Authorization shall be required for Medicaid reimbursement. Services that were rendered before the date of service authorization shall not be reimbursed.

(5) Room and board costs shall not be reimbursed. DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.

(6) These residential providers must be licensed by the Department of Social Services, Department of Juvenile Justice, or Department of Behavioral Health and Developmental Services under the Standards for Licensed Children's Residential Facilities (22VAC40-151), Standards for Interim Regulation of Children's Residential Facilities (6VAC35-51); or Regulations for Children's Residential Facilities (12VAC35-46).

(7) Daily progress notes shall document a minimum of seven psychoeducational activities per week. Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, stress management, and any care coordination activities.

(8) The facility/group home must coordinate services with other providers. Such care coordination shall be documented in the individual's medical record. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

(9) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for intakes and ISPs are set out in 12VAC30-60-61.

(10) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH.

e. Therapeutic behavioral services (Level B).

(1) Such services must be therapeutic services rendered in a residential setting that provides structure for daily activities, psychoeducation, therapeutic supervision, care coordination, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be

expected to improve the child's condition or prevent regression so that the services will no longer be needed. The application of a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual® Criteria, or an equivalent standard authorized in advance by DMAS shall be required for this service.

(2) Authorization is required for Medicaid reimbursement. Services that are rendered before the date of service authorization shall not be reimbursed.

(3) Room and board costs shall not be reimbursed. Facilities that only provide independent living services are not reimbursed. DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.

(4) These residential providers must be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) under the Regulations for Children's Residential Facilities (12VAC35-46).

(5) Daily progress notes shall document that a minimum of seven psychoeducational activities per week occurs. Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. This service may be provided in a program setting or a community-based group home.

(6) The individual must receive, at least weekly, individual psychotherapy and, at least weekly, group psychotherapy that is provided as part of the program.

(7) Individuals shall be discharged from this service when other less intensive services may achieve stabilization.

(8) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services that are based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for intakes and ISPs are set out in 12VAC30-60-61.

(9) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH.

(10) The facility/group home shall coordinate necessary services with other providers. Documentation of this care coordination shall be maintained by the facility/group home in the individual's record. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

6. Inpatient psychiatric services shall be covered for individuals younger than age 21 for medically necessary stays for the purpose of diagnosis and treatment of mental health and behavioral disorders identified under EPSDT when such services are rendered by:

a. A psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or a psychiatric facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children or the Council on Quality and Leadership.

b. Inpatient psychiatric hospital admissions at general acute care hospitals and freestanding psychiatric hospitals shall also be subject to the requirements of 12VAC30-50-100, 12VAC30-50-105, and 12VAC30-60-25. Inpatient psychiatric admissions to residential treatment facilities shall also be subject to the requirements of Part XIV (12VAC30-130-850 et seq.) of Amount, Duration, and Scope of Selected Services.

c. Inpatient psychiatric services are reimbursable only when the treatment program is fully in compliance with 42 CFR Part 441 Subpart D, as contained in 42 CFR 441.151 (a) and (b) and 441.152 through 441.156. Each admission must be preauthorized and the treatment must meet DMAS requirements for clinical necessity.

7. Hearing aids shall be reimbursed for individuals younger than 21 years of age according to medical necessity when provided by practitioners licensed to engage in the practice of fitting or dealing in hearing aids under the Code of Virginia.

8. Services facilitators shall be required for all consumer-directed personal care services consistent with the requirements set out in 12VAC30-120-935.

C. School health services.

1. School health assistant services are repealed effective July 1, 2006.

2. School divisions may provide routine well-child screening services under the State Plan. Diagnostic and treatment services that are otherwise covered under early and periodic screening, diagnosis and treatment services, shall not be covered for school divisions. School divisions to receive reimbursement for the screenings shall be enrolled with DMAS as clinic providers.

a. Children enrolled in managed care organizations shall receive screenings from those organizations. School divisions shall not receive reimbursement for screenings from DMAS for these children.

b. School-based services are listed in a recipient's individualized education program (IEP) and covered under one or more of the service categories described in § 1905(a) of the Social Security Act. These services are necessary to correct or ameliorate defects of physical or mental illnesses or conditions.

3. Service providers shall be licensed under the applicable state practice act or comparable licensing criteria by the Virginia Department of Education, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them shall be performed by practitioners qualified to make those determinations within their licensed scope of practice, either as a member of the IEP team or by a qualified practitioner outside the IEP team.

a. Service providers shall be employed by the school division or under contract to the school division.

b. Supervision of services by providers recognized in subdivision 4 of this subsection shall occur as allowed under federal regulations and consistent with Virginia law, regulations, and DMAS provider manuals.

c. The services described in subdivision 4 of this subsection shall be delivered by school providers, but may also be available in the community from other providers.

d. Services in this subsection are subject to utilization control as provided under 42 CFR Parts 455 and 456.

e. The IEP shall determine whether or not the services described in subdivision 4 of this subsection are medically necessary and that the treatment prescribed is in accordance with standards of medical practice. Medical necessity is defined as services ordered by IEP providers. The IEP providers are qualified Medicaid providers to make the medical necessity determination in accordance with their scope of practice. The services must be described as to the amount, duration and scope.

4. Covered services include:

a. Physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. This coverage includes audiology services;

b. Skilled nursing services are covered under 42 CFR 440.60. These services are to be rendered in accordance to the licensing standards and criteria of the Virginia Board of Nursing. Nursing services are to be provided by licensed registered nurses or licensed practical nurses but may be delegated by licensed registered nurses in accordance with the regulations of the Virginia Board of Nursing, especially the section on delegation of nursing tasks and procedures. The licensed practical nurse is under the supervision of a registered nurse.

(1) The coverage of skilled nursing services shall be of a level of complexity and sophistication (based on assessment, planning, implementation and evaluation) that is consistent with skilled nursing services when performed by a licensed registered nurse or a licensed practical nurse. These skilled nursing services shall include, but not necessarily be limited to dressing changes, maintaining patent airways, medication administration/monitoring and urinary catheterizations.

(2) Skilled nursing services shall be directly and specifically related to an active, written plan of care developed by a registered nurse that is based on a written order from a physician, physician

assistant or nurse practitioner for skilled nursing services. This order shall be recertified on an annual basis.

c. Psychiatric and psychological services performed by licensed practitioners within the scope of practice are defined under state law or regulations and covered as physicians' services under 42 CFR 440.50 or medical or other remedial care under 42 CFR 440.60. These outpatient services include individual medical psychotherapy, group medical psychotherapy coverage, and family medical psychotherapy. Psychological and neuropsychological testing are allowed when done for purposes other than educational diagnosis, school admission, evaluation of an individual with ~~mental retardation~~ an intellectual disability prior to admission to a nursing facility, or any placement issue. These services are covered in the nonschool settings also. School providers who may render these services when licensed by the state include psychiatrists, licensed clinical psychologists, school psychologists, licensed clinical social workers, professional counselors, psychiatric clinical nurse specialist, marriage and family therapists, and school social workers.

d. Personal care services are covered under 42 CFR 440.167 and performed by persons qualified under this subsection. The personal care assistant is supervised by a DMAS recognized school-based health professional who is acting within the scope of licensure. This practitioner develops a written plan for meeting the needs of the child, which is implemented by the assistant. The assistant must have qualifications comparable to those for other personal care aides recognized by the Virginia Department of Medical Assistance Services. The assistant performs services such as assisting with toileting, ambulation, and eating. The assistant may serve as an aide on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

e. Medical evaluation services are covered as physicians' services under 42 CFR 440.50 or as medical or other remedial care under 42 CFR 440.60. Persons performing these services shall be

licensed physicians, physician assistants, or nurse practitioners. These practitioners shall identify the nature or extent of a child's medical or other health related condition.

f. Transportation is covered as allowed under 42 CFR 431.53 and described at State Plan Attachment 3.1-D. Transportation shall be rendered only by school division personnel or contractors. Transportation is covered for a child who requires transportation on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Transportation shall be listed in the child's IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

g. Assessments are covered as necessary to assess or reassess the need for medical services in a child's IEP and shall be performed by any of the above licensed practitioners within the scope of practice. Assessments and reassessments not tied to medical needs of the child shall not be covered.

5. DMAS will ensure through quality management review that duplication of services will be monitored. School divisions have a responsibility to ensure that if a child is receiving additional therapy outside of the school, that there will be coordination of services to avoid duplication of service.

D. Family planning services and supplies for individuals of child-bearing age.

1. Service must be ordered or prescribed and directed or performed within the scope of the license of a practitioner of the healing arts.

2. Family planning services shall be defined as those services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility nor services to promote fertility.

Part VIII

Individual and Family Developmental Disabilities Support Waiver

Article 1

General Requirements

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-120-700. Definitions.

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

"Appeal" means the process used to challenge adverse actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12VAC30-110, Eligibility and Appeals, 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 plan of care but not available under the State Plan for Medical Assistance that 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, or that are necessary to the proper functioning of the specialized equipment.

"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 Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 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 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 waiver services" or "waiver services" means 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~~ ICF/IID 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 Chapter 5 (§ 37.2-500 et seq.) of Title 37.2 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" means, for the purpose of these regulations, a person who provides companion services.

"Companion services" means nonmedical care, supervision and socialization provided to an adult (age 18 and older). The provision of companion services does not entail hands-on care. It is provided in accordance with a therapeutic goal in the plan of care and is not purely diversional in nature.

"Consumer-directed attendant" or "CD attendant" means, for purposes of these regulations, a person who provides, via the consumer-directed model of services, personal care, companion services, or respite care, or any combination of these three services, who is also exempt from workers' compensation.

"Consumer-directed employee" or "CD employee" means, for purposes of these regulations, a person who provides, via the consumer-directed model of services, personal care, companion services, or respite care, or any combination of these three services, who is also exempt from workers' compensation.

~~"Consumer-directed services" means personal care, companion services, and/or respite care services where the individual or his family/caregiver, as appropriate, is responsible for hiring, training, supervising, and firing of the employee or employees.~~

"Consumer-directed (CD) model of services" means the model of service delivery for which the individual enrolled in the waiver or the employer of record, as appropriate, is responsible for hiring, training, supervising, and firing of the person or persons who render the services that are reimbursed by DMAS.

~~"Consumer-directed (CD) services facilitator" means the provider enrolled with DMAS who is responsible for management training and review activities as required by DMAS for consumer-directed services.~~

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

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

"DARS" means the Department of Aging and Rehabilitative Services.

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

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means DMAS employees who perform utilization review, preauthorize service type and intensity, provide technical assistance, and review of 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 his family/caregiver, as appropriate, for example, monthly, quarterly, or annual giveaways as inducements to use the providers' services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of the providers' services or other benefits as a means of influencing the individual's or his family/caregiver's, as appropriate, use of the providers' services.

"Employer of record" or "EOR" means the person who performs the functions of the employer in the consumer-directed model of service delivery. The EOR may be the individual enrolled in the waiver, a family member, caregiver or another designated person.

"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 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 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 that 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 individuals receiving services in the IFDDS Waiver.

~~"Fiscal agent" means an entity handling employment, payroll, and tax responsibilities on behalf of individuals who are receiving consumer-directed services.~~

"Fiscal/employer agent" means a state agency or other entity as determined by DMAS that meets the requirements of 42 CFR 441.484 and the Virginia Public Procurement Act, § 2.2-4300 et seq. of the Code of Virginia.

"Home" means, for purposes of the IFDDS Waiver, an apartment or single family dwelling in which no more than four 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 waiver services" means a variety of home and community-based services reimbursed 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~~ ICF/IID placement.

~~"ICF/MR"~~ "ICF/IID" 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~~ Individuals with Intellectual Disabilities. These facilities must address the residents' total needs including physical, intellectual, social, emotional, and habilitation. An ~~ICF/MR~~ ICF/IID must provide active treatment, as that term is defined in 42 CFR 483.440(a).

"ID Waiver" means the waiver for individuals with intellectual disabilities.

"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.

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

"In-home residential support services" means support provided primarily in the individual's home, which includes training, assistance, and specialized supervision to enable the individual to maintain or improve his health; assisting in performing 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 meal preparation, shopping, housekeeping, laundry, and money management.

~~"Mental retardation" means a disability as defined by the American Association on Intellectual and Developmental Disabilities (AAIDD).~~

~~"MR Waiver" means the mental retardation waiver.~~

"LEIE" or "List of Excluded Individuals or Entitles" means a list prepared and maintained by the federal government of individuals and business entities who are barred from being enrolled as Medicare or Medicaid providers.

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

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

"Person-centered planning" means a process, directed by the individual or his family/caregiver, as appropriate, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual.

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

"Personal care services" means ~~long-term maintenance or~~ a range of support services necessary to enable individuals enrolled in this waiver to remain in or return to the community rather than enter an ~~Intermediate Care Facility for the Mentally Retarded~~ ICF/IID. 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. This does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated in accordance with 18VAC90-20-420 through 18VAC90-20-460.

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

"Plan of care" means ~~a document~~ the written plan developed by the individual or his family/caregiver, as appropriate, 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 of the service by the service provider.~~

"Primary caregiver" means the primary 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 developmental disabilities professional" or "QDDP" means a professional who (i) possesses 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) possesses the required Virginia or national license, registration, or certification in accordance with his profession, if applicable.

"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 persons with mental retardation, 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 for unpaid caregivers of eligible individuals who are unable to care for themselves and 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.

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

"Screening" means the process conducted by the IFDDS screening team to evaluate the medical, nursing, and social needs of individuals referred for screening and to determine eligibility for an ~~ICF/MR~~ ICF/IID level of care.

"Service authorization" means the designated DMAS contractor has authorized a service for initiation by the service provider.

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

"Services facilitator" means a DMAS-enrolled provider or DMAS-designated entity or one who is employed by or contracts with a DMAS-enrolled Services Facilitator, who is responsible for supporting the individual and the individual's family/caregiver or EOR, as appropriate, by ensuring the development and monitoring of the plans of care for consumer-directed model of services, providing employee management training and completing ongoing review activities as required by the DMAS-approved consumer directed model of services. Services facilitator shall be deemed to mean the same thing as consumer-directed services facilitator.

"Skilled nursing services" means nursing services (i) listed in the plan of care that do not meet home health criteria, (ii) required to prevent institutionalization, (iii) not otherwise available under the State Plan for Medical Assistance, (iv) provided within the scope of the state's Nursing Act (§ 54.1-3000 et seq. of the Code of Virginia) and Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia), and (v) 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.

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

"Supported employment" means work in settings in which persons without disabilities are typically employed. It includes training in specific skills related to paid employment and provision of ongoing or intermittent assistance and specialized supervision to enable 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 or behavior consultation to assist individuals, parents, family members, in-home residential support, day support and any other providers of support services in implementing a plan of care.

"Transition services" means set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. 12VAC30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service.

"VDH" means the Virginia Department of Health.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-120-770. Consumer-directed model of service delivery.

A. Criteria.

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

2. Individuals who are eligible for consumer-directed services must have the capability to hire, train, and fire their consumer-directed ~~employees~~ attendants and supervise the ~~employee's~~ attendant'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 (Employer of Record (EOR)) and is responsible for hiring, training, supervising, and firing ~~employees~~ persons who perform CD attendant duties. Specific duties of the EOR include checking references of ~~employees~~ attendants, determining that ~~employees~~ attendants meet basic qualifications, training ~~employees~~ attendants, supervising the ~~employees'~~ attendants' performance, and submitting timesheets to the fiscal agent on a consistent and timely basis. The individual or his family/caregiver, as appropriate, must have an emergency back-up plan in case the CD ~~employee~~ attendant does not show up for work.

4. DMAS shall contract for the services of a fiscal agent for consumer-directed personal care, companion, and respite care services. The fiscal agent will be paid by DMAS to perform certain tasks as an agent for the individual/employer who is receiving consumer-directed services. The fiscal agent will handle responsibilities for the 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~~ shall receive support from a CD services facilitator. Services facilitators assist the individual or his family/caregiver, as appropriate, as they

become employers for consumer-directed services. This function includes providing the individual or his family/caregiver, as appropriate, with management training, review and explanation of the ~~Employee Management~~ EOR 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~~ shall also complete the assessments, reassessments, and related supporting documentation necessary for consumer-directed services if the individual or his family/caregiver, as appropriate, 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 consumer-directed services for more than 60 consecutive calendar days, the case manager ~~must~~ shall notify DMAS so that consumer-directed services may be discontinued and the option given to change to agency-directed services.

6. If the services facilitator is not an RN, then, within 30 days from the start of such services, the services facilitator shall inform the primary health care provider for the individual enrolled in the waiver that consumer-directed services are being provided, and request consultation with the primary healthcare provider, as needed. This shall be done after the services facilitator secures written permission from the individual to contact the primary healthcare provider. The documentation of this written permission to contact the primary healthcare provider shall be retained in the individual's medical record. All contacts with the primary healthcare provider shall be documented in the individual's medical record.

B. Provider qualifications. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, services facilitators providers, whether employed or contracted by a DMAS enrolled Services Facilitator, ~~must~~ shall meet the following qualifications:

1. ~~To be enrolled as a Medicaid CD services facilitation provider and maintain provider status, the CD services facilitation provider must operate from a business office and have sufficient qualified staff who will function as CD services facilitators to perform the service facilitation and support activities as required. It is preferred that the employee of the CD services facilitation provider possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth. In addition, it is preferable that the CD services facilitator has two years of satisfactory experience in the human services field working with individuals with related conditions~~. To be enrolled as a Medicaid consumer-directed services facilitator and maintain provider status, the services facilitator shall have sufficient knowledge, skills and abilities to perform the activities required of such providers. In addition, the services facilitator shall have the ability to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, and details of the services provided.

2. Upon the effective date for the emergency regulations 12 VAC 30-120-770(B), all consumer-directed services facilitators shall:

a. Have a satisfactory work record as evidenced by two references from prior job experiences from any human services work; such references shall not include any evidence of abuse, neglect, or exploitation of the elderly or persons with disabilities or children;

b. Submit to a criminal background check being conducted. The results of such check shall contain no record of conviction of barrier crimes as set forth in § 32.1-162.9:1 of the COV. Proof that the criminal record check was conducted shall be maintained in the attendant's record. DMAS shall not reimburse the provider for any services provided by an attendant who has been convicted of committing a barrier crime as set forth in § 32.1-162.9:1 of the COV;

c. Submit to a search of the DSS Child Protective Services Central Registry. Such search shall not contain a founded complaint; and

d. Not be debarred, suspended, or otherwise excluded from participating in Federal health care programs, as listed on the federal List of Excluded Individuals/Entities (LEIE) database at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp;

3. The services facilitator shall not be compensated for services provided to the individual enrolled in the waiver effective on the date in which the record check verifies that the services facilitator either: (i) has been convicted of barrier crimes described in § 32.1-162.9:1 of the COV; (ii) has a founded complaint confirmed by the VDSS Child Protective Services Central Registry; or, (iii) is found to be listed on LEIE.

4. Upon the effective date for the emergency regulations 12 VAC 30-120-770(B), all consumer-directed services facilitators shall possess the required degree and experience, as follows:

a. Prior to initial enrollment by the department as a consumer-directed services facilitator or being hired by a Medicaid-enrolled Services Facilitator provider, all new applicants shall possess, at a minimum, either: (i) an associate's degree from an accredited college in a health or human services field or be a registered nurse currently licensed to practice in the Commonwealth, and possess a minimum of two years of satisfactory direct care experience supporting individuals with disabilities or older adults; or, (ii) a bachelor's degree in a non-health or human services field and possess a minimum of three years of satisfactory direct care experience supporting individuals with disabilities or older adults.

b. Persons who are consumer-directed services facilitators prior to the effective date for the emergency regulations 12 VAC 30-120-770(B) shall not be required to meet the degree and experience requirements of 12 VAC 30-120-770(B)(4)(a) unless required to submit a new application to be a consumer-directed services facilitator after the effective date for emergency regulations 12 VAC 30-120-770(B).

5. Within 90 days of the effective date of the emergency regulation 12 VAC 30-120-770(B), all consumer-directed services facilitators shall complete required training and competency assessments. Satisfactory competency assessment results shall be kept in the service facilitator's record.

a. All new consumer-directed services facilitators shall complete the DMAS-approved Consumer Directed Services Facilitator training and pass the corresponding competency assessment with a score of at least 80% prior to being enrolled and approved as a consumer directed services facilitator.

b. Persons who are consumer-directed services facilitators upon the effective date for the emergency regulations 12 VAC 30-120-770(B) shall be required to complete the DMAS-approved Consumer Directed Services Facilitator training and pass the corresponding competency assessment with a score of at least 80%

in order to continue being reimbursed for or working with waiver individuals for the purpose of Medicaid reimbursement.

6. Failure to satisfy the competency assessment requirements and meet all other requirements shall result in the retraction of Medicaid payment or the termination of the provider agreement, or both or require the termination of a consumer-directed services facilitator employed by or contracted with Medicaid enrolled services facilitators.

7. As a component of the renewal of the Medicaid provider agreement, all consumer-directed services facilitators shall take and pass the competency assessment every five years and achieve a score of at least 80%.

8. The consumer-directed services facilitator shall have access to a computer with secure internet access for the electronic exchange of information. Electronic exchange of information shall include, for example, checking individual eligibility, submission of service authorizations, submission of information to the fiscal employer agent, and billing for services.

~~2.~~ 9. The 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) Various long-term care program requirements, including nursing home, ~~ICF/MR~~ ICF/IID, and assisted living facility placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal care services;

(2) DMAS consumer-directed services requirements, and the administrative duties for which the individual will be responsible;

(3) Interviewing techniques;

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

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

(6) General principles of record documentation.

(7) ~~For CD services facilitators who also conduct~~ How to conduct assessments and reassessments, thus requiring the following additional ~~is also required. Knowledge of~~ knowledge:

(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; and,

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

b. Skills in:

(1) Negotiating with individuals or their family/caregivers, as appropriate, 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 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 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;

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

(7) Interview.

~~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.~~

~~4.~~ 10. Initiation of services and service monitoring.

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 must~~ facilitator shall make an initial comprehensive visit with the individual or his family/caregiver, as appropriate, 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 facilitation providers, the new CD services facilitator ~~must~~ shall bill for a regular management training in lieu of initial management training.

(2) After the initial visit, two routine visits must occur within 60 days of the initiation of care or the initial visit to monitor the employment process.

(3) For personal care services, the CD services facilitation provider will continue to monitor on an as needed basis, not to exceed a maximum of one routine visit every 30 calendar days but no less than the minimum of one routine visit every 90 calendar days per 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.

~~5.~~ 11. The CD services facilitator ~~must~~ shall be available to the individual or his family/caregiver, as appropriate, 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.~~ 12.The ~~CD services fiscal contractor for~~ DMAS contracted fiscal/employer agent ~~must~~ shall submit a criminal record check within 15 calendar days of employment pertaining to the consumer-directed ~~employee~~ attendant on behalf of the individual or family/caregiver and report findings of the criminal record check to the individual or his family/caregiver, as appropriate.

~~7.~~ 13. The CD services facilitator shall verify bi-weekly timesheets signed by the ~~individual or his family caregiver , as appropriate,~~ employer of record and the ~~employee~~ attendant to ensure that the number of plan of care approved hours are not exceeded. If discrepancies are identified, the CD services facilitator ~~must~~ shall contact the individual or family/caregiver to resolve discrepancies and ~~must~~ shall notify the fiscal employer agent. If an individual is consistently being identified as having discrepancies in his timesheets, the CD services facilitator ~~must~~ shall contact the case manager to resolve the situation. Failure to conduct such time sheet verifications and maintain the documentation of such verifications shall result in DMAS' recovery of payments made.

~~8.~~ 14. Consumer-directed ~~employee~~ attendant registry. The CD services facilitator ~~must~~ shall maintain a consumer-directed ~~employee~~ attendant registry, updated on an ongoing basis.

~~9.~~ 15. Required documentation in individuals' records. CD services facilitators responsible for individual assessment and reassessment ~~must~~ shall maintain records as described in 12VAC30-120-766 and 12VAC30-120-776. For CD services facilitators conducting management training, the following documentation is required in the individual's record:

a. All copies of the plan of care, all supporting documentation related to consumer-directed services, and all ~~DMAS-122~~ DMAS-225 forms.

b. CD services facilitator's notes recorded and dated at the time of service delivery.

c. All correspondence to the individual, others concerning the individual, and to DMAS.

~~d. All training provided to the consumer-directed employees on behalf of the individual or his family/caregiver, as appropriate.~~

~~e.~~d. All management training provided to the ~~individuals or his family/caregivers~~ EOR~~, as appropriate~~, including the responsibility for the accuracy of the timesheets.

~~f.~~e. All documents signed by the ~~individual or his family/caregiver~~ EOR, ~~as appropriate,~~ that acknowledge the responsibilities of the services.

f. (1) Such monitoring verifications shall be documented in the individual's medical record.

(2) Failure to conduct such verifications and maintain the required documentation of all verifications and contacts with the individual and all healthcare providers about the individual shall result in DMAS' recovery of payments made.

Statutory Authority

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

Part IX

Elderly or Disabled with Consumer Direction Waiver

12VAC30-120-900. Definitions.

The following words and terms when used in this part shall have the following meanings unless the context clearly indicates otherwise:

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

"Adult day health care " or "ADHC" means long-term maintenance or supportive services offered by a DMAS-enrolled community-based day care program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those waiver individuals who are elderly or who have a disability and who are at risk of placement in a nursing facility (NF). The program shall be licensed by the Virginia Department of Social Services (VDSS) as an adult day care center (ADCC). The services offered by the center shall be required by the waiver individual in order to permit the individual to remain in his home rather than entering a nursing facility. ADHC can also refer to the center where this service is provided.

"Agency-directed model of service" means a model of service delivery where an agency is responsible for

providing direct support staff, for maintaining individuals' records, and for scheduling the dates and times of the direct support staff's presence in the individuals' homes for personal and respite care.

"Americans with Disabilities Act" or "ADA" means the United States Code pursuant to 42 USC § 12101 et seq.

"Annually" means a period of time covering 365 consecutive calendar days or 366 consecutive days in the case of leap years.

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

"Assistive technology" or "AT" means specialized medical equipment and supplies including those devices, controls, or appliances specified in the plan of care but not available under the State Plan for Medical Assistance that enable waiver individuals who are participating in the Money Follows the Person demonstration program pursuant to Part XX (12VAC30-120-2000 et seq.) to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live, or that are necessary to the proper functioning of the specialized equipment.

"Barrier crime" means those crimes as defined at § 32.1-162.9:1 of the Code of Virginia that would prohibit the continuation of employment if a person is found through a Virginia State Police criminal record check to have been convicted of such a crime.

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

"Cognitive impairment" means a severe deficit in mental capability that affects a waiver individual's areas of functioning such as thought processes, problem solving, judgment, memory, or comprehension that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, or impulse control.

~~"Conservator" means a person appointed by a court to manage the estate and financial affairs of an incapacitated individual.~~

"Consumer-directed attendant" means, for purposes of these regulations, a person who provides, via the consumer-directed model of services, personal care, companion services, or respite care, or any combination of these three services, who is also exempt from workers' compensation.

"Consumer-directed (CD) model of service" means the model of service delivery for which the ~~waiver~~ individual enrolled in the waiver or the individual's employer of record, as appropriate, ~~are~~ is responsible for hiring, training, supervising, and firing of the ~~person or persons~~ attendant or attendants who ~~actually~~ render the services that are reimbursed by DMAS.

"Consumer-directed (CD) services facilitator" or "facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual and family/caregiver by ensuring the development and monitoring of the consumer-directed services plan of care, providing attendant management training, and completing ongoing review activities as required by DMAS for consumer-directed personal care and respite services.

"DARS" means the Department of Aging and Rehabilitative Services.

"Day" means, for the purposes of reimbursement, a 24-hour period beginning at 12 a.m. and ending at 11:59 p.m.

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

"Direct marketing" means any of the following: (i) conducting either directly or indirectly door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; (ii) using direct mailing;

(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) providing 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.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means persons employed by the Department of Medical Assistance Services.

"Elderly or Disabled with Consumer Direction Waiver" or "EDCD Waiver" means the CMS-approved waiver that covers a range of community support services offered to waiver individuals who are elderly or who have a disability who would otherwise require a nursing facility level of care.

"Employer of record" or "EOR" means the person who performs the functions of the employer in the consumer-directed model of service delivery. The EOR may be the individual enrolled in the waiver, a family member, caregiver, or another person.

"Environmental modifications" or "EM" means physical adaptations to an individual's primary home or primary vehicle or work site, when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act (42 USC § 1201 et seq.), which are necessary to ensure the individual's health and safety or enable functioning with greater independence and shall be of direct medical or remedial benefit to individuals who are participating in the Money Follows the Person demonstration program pursuant to Part XX (12VAC30-120-2000 et seq.). Such physical adaptations shall not be authorized for Medicaid payment when the adaptation is being used to bring a substandard dwelling up to minimum habitation standards.

"Fiscal/employer agent" means a state agency or other entity as determined by DMAS that meets the requirements of 42 CFR 441.484 and the Virginia Public Procurement Act, § 2.2-4300 et seq. of the Code of Virginia.

"Guardian" means a person appointed by a court to manage the personal affairs of an incapacitated individual pursuant to Chapter 20 (§ 64.2-2000 et seq.) of Title 64.2 of the Code of Virginia.

"Health, safety, and welfare standard" means, for the purposes of this waiver, that an individual's right to receive an EDCD Waiver service is dependent on a determination that the waiver individual needs the service based on appropriate assessment criteria and a written plan of care, including having a backup plan of care, that demonstrates medical necessity and that services can be safely provided in the community or through the model of care selected by the individual.

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

"Individual" means the person who has applied for and been approved to receive these waiver services.

"Instrumental activities of daily living" or "IADLs" means tasks such as meal preparation, shopping, housekeeping and laundry. An individual's degree of independence in performing these activities is a part of determining appropriate service needs.

"Level of care" or "LOC" means the specification of the minimum amount of assistance an individual requires in order to receive services in an institutional setting under the State Plan or to receive waiver services.

"License" means proof of official or legal permission issued by the government for an entity or person to perform an activity or service such that, in the absence of an official license, the entity or person is debarred from performing the activity or service.

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

"Live-in caregiver" means a personal caregiver who resides in the same household as the individual who is receiving waiver services.

"Long-term care" or "LTC" means a variety of services that help individuals with health or personal care needs and activities of daily living over a period of time. Long-term care can be provided in the home, in the community, or in various types of facilities, including nursing facilities and assisted living facilities.

"Medicaid Long-Term Care (LTC) Communication Form" or "DMAS-225" means the form used by the long-term care provider to report information about changes in an individual's eligibility and financial circumstances.

"Medication monitoring" means an electronic device, which is only available in conjunction with Personal Emergency Response Systems, that enables certain waiver individuals who are at risk of institutionalization to be reminded to take their medications at the correct dosages and times.

"Money Follows the Person" or "MFP" means the demonstration program, as set out in 12VAC30-120-2000 and 12VAC30-120-2010.

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

"Patient pay amount" means the portion of the individual's income that must be paid as his share of the long-term care services and is calculated by the local department of social services based on the individual's documented monthly income and permitted deductions.

"Personal care agency" means a participating provider that provides personal care services.

"Personal care aide" or "aide" means a person employed by an agency who provides personal care or unskilled respite services. The aide shall have successfully completed an educational curriculum of at least 40 hours of study related to the needs of individuals who are either elderly or who have disabilities as further set out in 12VAC30-120-935. Such successful completion may be evidenced by the existence of a certificate of completion, which is provided to DMAS during provider audits, issued by the training entity.

"Personal care attendant" or "attendant" means a person who provides personal care or respite services that are directed by a consumer, family member/caregiver, or employer of record under the CD model of service delivery.

"Personal care services" means a range of support services necessary to enable the waiver individual to remain at or return home rather than enter a nursing facility and that includes assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), access to the community, self-administration of medication, or other medical needs, supervision, and the monitoring of health status and physical condition. Personal care services shall be provided by aides, within the scope of their licenses/certificates, as appropriate, under the agency-directed model or by personal care attendants under the CD model of service delivery.

"Personal emergency response system" or "PERS" means an electronic device and monitoring service that enables certain waiver individuals, who are at least 14 years of age, at risk of institutionalization to secure help in an emergency. PERS services shall be limited to those waiver individuals who live alone or who are alone for significant parts of the day and who have no regular caregiver for extended periods of time.

"PERS provider" means a certified home health or a personal care agency, a durable medical equipment provider, a hospital, or a PERS manufacturer that has the responsibility to furnish, install, maintain, test, monitor, and service PERS equipment, direct services (i.e., installation, equipment maintenance, and services calls), and PERS monitoring. PERS providers may also provide medication monitoring.

"Plan of care" or "POC" means the written plan developed collaboratively by the waiver individual and the waiver individual's family/caregiver, as appropriate, and the provider related solely to the specific services necessary for the individual to remain in the community while ensuring his health, safety, and welfare.

"Preadmission screening" means the process to: (i) evaluate the functional, nursing, and social supports of individuals referred for preadmission screening for certain long-term care services requiring NF eligibility; (ii) assist individuals in determining what specific services the individuals need; (iii) evaluate whether a service or a combination of existing community services are available to meet the individuals' needs; and (iv) provide a list to individuals of appropriate providers for Medicaid-funded nursing facility or home and community-based care for those individuals who meet nursing facility level of care.

"Preadmission Screening Team" means the entity contracted with DMAS that is responsible for performing preadmission screening pursuant to § 32.1-330 of the Code of Virginia.

"Primary caregiver" means the person who consistently assumes the primary role of providing direct care and support of the waiver individual to live successfully in the community without receiving compensation for providing such care. Such person's name, if applicable, shall be documented by the RN or services facilitator in the waiver individual's record. Waiver individuals are not required to have a primary caregiver in order to participate in the EDCD waiver.

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

"Respite care agency" means a participating provider that renders respite services.

"Respite services" means services provided to waiver individuals who are unable to care for themselves that are furnished on a short-term basis because of the absence of or need for the relief of the unpaid primary caregiver who normally provides the care.

"Services facilitation" means a service that assists the waiver individual (or family/caregiver, as appropriate) for directing, training, and managing services provided through the consumer-directed model of services.

"Services facilitator" means a DMAS-enrolled provider or DMAS-designated entity or one who is employed or contracted by a DMAS enrolled Services Facilitator, who is responsible for supporting the individual and the individual's family/caregiver or EOR, as appropriate, by ensuring the development and monitoring of the CD services plans of care, providing attendant management training, and completing ongoing review activities as required by DMAS for consumer-directed personal care and respite services. Services facilitator shall be deemed to mean the same thing as consumer-directed services facilitator.

"Service authorization" or "Srv Auth" means the process of approving either by DMAS, its service authorization contractor, or DMAS-designated entity, for the purposes of reimbursement for a service for the individual before it is rendered or reimbursed.

"Service authorization contractor" means DMAS or the entity that has been contracted by DMAS to perform service authorization for medically necessary Medicaid covered home and community-based services.

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

"Services facilitator" means a DMAS-enrolled provider or DMAS-designated entity that is responsible for supporting the individual and the individual's family/caregiver or EOR, as appropriate, by ensuring the development and monitoring of the CD services plans of care, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed personal care and respite services. Services facilitator shall be deemed to mean the same thing as consumer-directed services facilitator.

"Skilled respite services" means temporary skilled nursing services that are provided to waiver individuals who need such services and that are performed by a LPN for the relief of the unpaid primary caregiver who normally provides the care.

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

"Transition coordinator" means the person defined in 12VAC30-120-2000 who facilitates MFP transition.

"Transition services" means set-up expenses for individuals as defined at 12VAC30-120-2010.

"VDH" means the Virginia Department of Health.

"VDSS" means the Virginia Department of Social Services.

"Virginia Uniform Assessment Instrument" or "UAI" means the standardized multidimensional comprehensive assessment that is completed by the Preadmission Screening Team or approved hospital discharge planner that assesses an individual's physical health, mental health, and psycho/social and functional abilities to determine if the individual meets the nursing facility level of care.

"Weekly" means a span of time covering seven consecutive calendar days.

12VAC30-120-935. Participation standards for specific covered services.

A. The personal care providers, respite care providers, ADHC providers, and CD services facilitators shall develop an individualized POC that addresses the waiver individual's service needs. Such plan shall be developed in collaboration with the waiver individual or the individual's family/caregiver/EOR, as appropriate.

B. Agency providers shall employ appropriately licensed professional staff who can provide the covered waiver services required by the waiver individuals. Providers shall require that the supervising RN/LPN be available by phone at all times that the LPN/attendant and consumer-directed services facilitators, as appropriate, are providing services to the waiver individual.

C. Agency staff (RN, LPNs, or aides) or CD ~~employees (attendants)~~ attendants shall not be reimbursed by DMAS for services rendered to waiver individuals when the agency staff or the CD ~~employee~~ attendant is either (i) the spouse of the waiver individual or (ii) the parent (biological, adoptive, legal guardian) or other legal guardian of the minor child waiver individual.

1. Payment shall not be made for services furnished by other family members living under the same roof as the individual enrolled in the waiver receiving services unless there is objective written documentation completed by the services facilitator as to why there are no other providers available to render the personal services. The consumer-directed services facilitator shall initially make this determination and document it fully in the individual's record.

2. Family members who are approved to be reimbursed for providing personal services shall meet the same qualifications as all other CD attendants.

D. Failure to provide the required services, conduct the required reviews and meet the documentation standards as stated herein may result in DMAS charging audited providers with overpayments and requiring the return of the overpaid funds.

E. In addition to meeting the general conditions and requirements, home and community-based services participating providers shall also meet the following requirements:

1. ADHC services provider. In order to provide these services, the ADCC shall:

a. Make available a copy of the current VDSS license for DMAS' review and verification purposes prior to the provider applicant's enrollment as a Medicaid provider;

b. Adhere to VDSS' ADCC standards as defined in 22VAC40-60 including, but not limited to, provision of activities for waiver individuals; and

c. Employ the following:

(1) A director who shall be responsible for overall management of the center's programs and employees pursuant to 22VAC40-60-320. The director shall be the provider contact person for DMAS and the designated Srv Auth contractor and shall be responsible for responding to communication from DMAS and the designated Srv Auth contractor. The director shall be responsible for ensuring the development of the POCs for waiver individuals. The director shall assign either himself, the activities director if there is one, RN, or therapist to act as the care coordinator for each waiver individual and shall document in the individual's medical record the identity of the care coordinator. The care coordinator shall be responsible for management of the waiver individual's POC and for its review with the program aides and any other staff, as necessary.

(2) A RN who shall be responsible for administering to and monitoring the health needs of waiver individuals. The RN may also contract with the center. The RN shall be responsible for the planning and implementation of the POC involving multiple services where specialized health care knowledge may be needed. The RN shall be present a minimum of eight hours each month at the center. DMAS may require the RN's presence at the center for more than this minimum standard depending on the number of waiver individuals who are in attendance and according to the medical and nursing needs of the waiver individuals who attend the center. Although DMAS does not require that the RN be a full-time staff position, there shall be a RN available, either in person or by telephone, to the center's waiver individuals and staff during all times that the center is in operation. The RN shall be responsible for:

(a) Providing periodic evaluation, at least every 90 days, of the nursing needs of each waiver individual;

(b) Providing the nursing care and treatment as documented in individuals' POCs; and

(c) Monitoring, recording, and administering of prescribed medications or supervising the waiver individual in self-administered medication.

(3) Personal care aides who shall be responsible for overall care of waiver individuals such as assistance with ADLs, social/recreational activities, and other health and therapeutic-related activities. Each program aide hired by the provider shall be screened to ensure compliance with training and skill mastery qualifications required by DMAS. The aide shall, at a minimum, have the following qualifications:

(a) Be 18 years of age or older;

(b) Be able to read and write in English to the degree necessary to perform the tasks expected and create and maintain the required waiver individual documentation of services rendered;

(c) Be physically able to perform the work and have the skills required to perform the tasks required in the waiver individual's POC;

(d) Have a valid social security number issued to the program aide by the Social Security Administration;

(e) Have satisfactorily completed an educational curriculum as set out in clauses (i), (ii), and (iii) of this subdivision E 1 c 3 (e). Documentation of successful completion shall be maintained in the aide's personnel file and be available for review by DMAS' staff. Prior to assigning a program aide to a waiver individual, the center shall ensure that the aide has either (i) registered with the Board of Nursing as a certified nurse aide; (ii) graduated from an approved educational curriculum as listed by the Board of Nursing; or (iii) completed the provider's educational curriculum, at least 40 hours in duration, as taught by an RN who is licensed in the Commonwealth or who holds a multi-state licensing privilege.

(4) The ADHC coordinator who shall coordinate, pursuant to 22VAC40-60-695, the delivery of the activities and services as prescribed in the waiver individuals' POCs and keep such plans updated, record 30-day progress notes concerning each waiver individual, and review the waiver individuals'

daily records each week. If a waiver individual's condition changes more frequently, more frequent reviews and recording of progress notes shall be required to reflect the individual's changing condition.

2. Recreation and social activities responsibilities. The center shall provide planned recreational and social activities suited to the waiver individuals' needs and interests and designed to encourage physical exercise, prevent deterioration of each waiver individual's condition, and stimulate social interaction.

3. The center shall maintain all records of each Medicaid individual. These records shall be reviewed periodically by DMAS staff or its designated agent who is authorized by DMAS to review these files. At a minimum, these records shall contain, but shall not necessarily be limited to:

a. DMAS required forms as specified in the center's provider-appropriate guidance documents;

b. Interdisciplinary POCs developed, in collaboration with the waiver individual or family/caregiver, or both as may be appropriate, by the center's director, RN, and therapist, as may be appropriate, and any other relevant support persons;

c. Documentation of interdisciplinary staff meetings that shall be held at least every three months to reassess each waiver individual and evaluate the adequacy of the POC and make any necessary revisions;

d. At a minimum, 30-day goal-oriented progress notes recorded by the designated ADHC care coordinator. If a waiver individual's condition and treatment POC changes more often, progress notes shall be written more frequently than every 30 days;

e. The daily record of services provided shall contain the specific services delivered by center staff. The record shall also contain the arrival and departure times of the waiver individual and shall be signed weekly by either the director, activities director, RN, or therapist employed by the center. The record shall be completed on a daily basis, neither before nor after the date of services delivery. At least once a week, a staff member shall chart significant comments regarding care given to the waiver individual. If the staff member writing comments is different from the staff

signing the weekly record, that staff member shall sign the weekly comments. A copy of this record shall be given weekly to the waiver individual or family/caregiver, and it shall also be maintained in the waiver individual-specific medical record; and

f. All contacts shall be documented in the waiver individual's medical record, including correspondence made to and from the individual with family/caregivers, physicians, DMAS, the designated Srv Auth contractor, formal and informal services providers, and all other professionals related to the waiver individual's Medicaid services or medical care.

F. Agency-directed personal care services. The personal care provider agency shall hire or contract with and directly supervise a RN who provides ongoing supervision of all personal care aides and LPNs. LPNs may supervise, pursuant to their licenses, personal care aides based upon RN assessment of the waiver individuals' health, safety, and welfare needs.

1. The RN supervisor shall make an initial home assessment visit on or before the start of care for all individuals admitted to personal care, when a waiver individual is readmitted after being discharged from services, or if he is transferred from another provider, ADHC, or from a CD services program.

2. During a home visit, the RN supervisor shall evaluate, at least every 90 days, the LPN supervisor's performance and the waiver individual's needs to ensure the LPN supervisor's abilities to function competently and shall provide training as necessary. This shall be documented in the waiver individual's record. A reassessment of the individual's needs and review of the POC shall be performed and documented during these visits.

3. The RN/LPN supervisor shall also make supervisory visits based on the assessment and evaluation of the care needs of waiver individuals as often as needed and as defined in this subdivision to ensure both quality and appropriateness of services.

a. The personal care provider agency shall have the responsibility of determining when supervisory visits are appropriate for the waiver individual's health, safety, and welfare. Supervisory visits shall be at least every 90 days. This determination must be documented in the waiver individuals' records by the RN on the initial assessment and in the ongoing assessment records.

b. If DMAS determines that the waiver individual's health, safety, or welfare is in jeopardy, DMAS may require the provider's RN or LPN supervisor to supervise the personal care aides more frequently than once every 90 days. These visits shall be conducted at this designated increased frequency until DMAS determines that the waiver individual's health, safety, or welfare is no longer in jeopardy. This shall be documented by the provider and entered into the individual's record.

c. During visits to the waiver individual's home, the RN/LPN supervisor shall observe, evaluate, and document the adequacy and appropriateness of personal care services with regard to the individual's current functioning status and medical and social needs. The personal care aide's record shall be reviewed and the waiver individual's or family's/caregiver's, or both, satisfaction with the type and amount of services discussed.

d. If the supervising RN/LPN must be delayed in conducting the regular supervisory visit, such delay shall be documented in the waiver individual's record with the reasons for the delay. Such supervisory visits shall be conducted within 15 calendar days of the waiver individual's first availability.

e. A RN/LPN supervisor shall be available to the personal care aide for conferences pertaining to waiver individuals being served by the aide.

(1) The RN/LPN supervisor shall be available to the aide by telephone at all times that the aide is providing services to waiver individuals.

(2) The RN/LPN supervisor shall evaluate the personal care aide's performance and the waiver individual's needs to identify any insufficiencies in the personal care aide's abilities to function competently and shall provide training as indicated. This shall be documented in the waiver individual's record.

f. Licensed practical nurses (LPNs). As permitted by his license, the LPN may supervise personal care aides. To ensure both quality and appropriateness of services, the LPN supervisor shall make supervisory visits of the aides as often as needed, but no fewer visits than provided in waiver

individuals' POCs as developed by the RN in collaboration with individuals and the individuals' family/caregivers, or both, as appropriate.

(1) During visits to the waiver individual's home, a LPN-supervisor shall observe, evaluate, and document the adequacy and appropriateness of personal care services, the individual's current functioning status and social needs. The personal care aide's record shall be reviewed and the waiver individual's or family/caregiver's, or both, satisfaction with the type and amount of services discussed.

(2) The LPN supervisor shall evaluate the personal care aide's performance and the waiver individual's needs to identify any insufficiencies in the aide's abilities to function competently and shall provide training as required to resolve the insufficiencies. This shall be documented in the waiver individual's record and reported to the RN supervisor.

(3) An LPN supervisor shall be available to personal care aides for conferences pertaining to waiver individuals being served by them.

g. Personal care aides. The agency provider may employ and the RN/LPN supervisor shall directly supervise personal care aides who provide direct care to waiver individuals. Each aide hired to provide personal care shall be evaluated by the provider agency to ensure compliance with qualifications and skills required by DMAS pursuant to 12VAC30-120-930.

4. Required documentation for waiver individuals' records. The provider shall maintain all records for each individual receiving personal care services. These records shall be separate from those of non-home and community-based care services, such as companion or home health services. These records shall be reviewed periodically by DMAS or its designated agent. At a minimum, the record shall contain:

a. All personal care aides' records (DMAS-90) to include (i) the specific services delivered to the waiver individual by the aide; (ii) the personal care aide's actual daily arrival and departure times; (iii) the aide's weekly comments or observations about the waiver individual, including observations of the individual's physical and emotional condition, daily activities, and responses to services

rendered; and (iv) any other information appropriate and relevant to the waiver individual's care and need for services.

b. The personal care aide's and individual's or responsible caregiver's signatures, including the date, shall be recorded on these records verifying that personal care services have been rendered during the week of the service delivery.

(1) An employee of the provider shall not sign for the waiver individual unless he is a family member or unpaid caregiver of the waiver individual.

(2) Signatures, times, and dates shall not be placed on the personal care aide record earlier than the last day of the week in which services were provided nor later than seven calendar days from the date of the last service.

G. Agency-directed respite care services.

1. To be approved as a respite care provider with DMAS, the respite care agency provider shall:

a. Employ or contract with and directly supervise either a RN or LPN, or both, who will provide ongoing supervision of all respite care aides/LPNs, as appropriate. A RN shall provide supervision to all direct care and supervisory LPNs.

(1) When respite care services are received on a routine basis, the minimum acceptable frequency of the required RN/LPN supervisor's visits shall not exceed every 90 days, based on the initial assessment. If an individual is also receiving personal care services, the respite care RN/LPN supervisory visit may coincide with the personal care RN/LPN supervisory visits. However, the RN/LPN supervisor shall document supervision of respite care separately from the personal care documentation. For this purpose, the same individual record may be used with a separate section for respite care documentation.

(2) When respite care services are not received on a routine basis but are episodic in nature, a RN/LPN supervisor shall conduct the home supervisory visit with the aide/LPN on or before the start of care. The RN/LPN shall review the utilization of respite services either every six months or upon the use of half of the approved respite hours, whichever comes first. If a waiver individual is

also receiving personal care services, the respite care RN/LPN supervisory visit may coincide with the personal care RN/LPN supervisory visit.

(3) During visits to the waiver individual's home, the RN/LPN supervisor shall observe, evaluate, and document the adequacy and appropriateness of respite care services to the waiver individual's current functioning status and medical and social needs. The aide's/LPN's record shall be reviewed along with the waiver individual's or family's/caregiver's, or both, satisfaction with the type and amount of services discussed.

(4) Should the required RN/LPN supervisory visit be delayed, the reason for the delay shall be documented in the waiver individual's record. This visit shall be completed within 15 days of the waiver individual's first availability.

b. Employ or contract with aides to provide respite care services who shall meet the same education and training requirements as personal care aides.

c. Not hire respite care aides for DMAS' reimbursement for services that are rendered to waiver individuals when the aide is either (i) the spouse of the waiver individual or (ii) the parent (biological, adoptive, legal guardian) or other guardian of the minor child waiver individual.

d. Employ an LPN to perform skilled respite care services. Such services shall be reimbursed by DMAS under the following circumstances:

(1) The waiver individual shall have a documented need for routine skilled respite care that cannot be provided by unlicensed personnel, such as an aide. These waiver individuals would typically require a skilled level of care involving, for example but not necessarily limited to, ventilators for assistance with breathing or either nasogastric or gastrostomy feedings;

(2) No other person in the waiver individual's support system is willing and able to supply the skilled component of the individual's care during the primary caregiver's absence; and

(3) The waiver individual is unable to receive skilled nursing visits from any other source that could provide the skilled care usually given by the caregiver.

e. Document in the waiver individual's record the circumstances that require the provision of services by an LPN. At the time of the LPN's service, the LPN shall also provide all of the services normally provided by an aide.

2. Required documentation for waiver individuals' records. The provider shall maintain all records for each waiver individual receiving respite services. These records shall be separate from those of non-home and community-based care services, such as companion or home health services. These records shall be reviewed periodically either by the DMAS staff or a contracted entity who is authorized by DMAS to review these files. At a minimum these records shall contain:

a. Forms as specified in the DMAS guidance documents.

b. All respite care LPN/aide records shall contain:

(1) The specific services delivered to the waiver individual by the LPN/aide;

(2) The respite care LPN's/aide's daily arrival and departure times;

(3) Comments or observations recorded weekly about the waiver individual. LPN/aide comments shall include, but shall not be limited to, observation of the waiver individual's physical and emotional condition, daily activities, the individual's response to services rendered, and documentation of vital signs if taken as part of the POC.

c. All respite care LPN records (DMAS-90A) shall be reviewed and signed by the supervising RN and shall contain:

(1) The respite care LPN/aide's and waiver individual's or responsible family/caregiver's signatures, including the date, verifying that respite care services have been rendered during the week of service delivery as documented in the record.

(2) An employee of the provider shall not sign for the waiver individual unless he is a family member or unpaid caregiver of the waiver individual.

(3) Signatures, times, and dates shall not be placed on the respite care LPN/aide record earlier than the last day of the week in which services were provided. Nor shall signatures be placed on the respite care LPN/aide records later than seven calendar days from the date of the last service.

~~H. Consumer-directed (CD) services facilitation for personal care and respite services.~~

~~1. Any services rendered by attendants prior to dates authorized by DMAS or the Srv Auth contractor shall not be eligible for Medicaid reimbursement and shall be the responsibility of the waiver individual.~~

~~2. The CD services facilitator shall meet the following qualifications:~~

~~a. To be enrolled as a Medicaid CD services facilitator and maintain provider status, the CD services facilitator shall have sufficient knowledge, skills, and abilities to perform the activities required of such providers. In addition, the CD services facilitator shall have the ability to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, and details of the services provided.~~

~~b. It is preferred that the CD services facilitator possess, at a minimum, 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 CD services facilitator have at least two years of satisfactory experience in a human services field working with individuals who are disabled or elderly. The CD services facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities described below in this subdivision H 2 b. Such knowledge, skills, and abilities must be documented on the CD services facilitator's application form, found in supporting documentation, or be observed during a job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:~~

~~(1) Knowledge of:~~

~~(a) Types of functional limitations and health problems that may occur in individuals who are elderly or individuals with disabilities, as well as strategies to reduce limitations and health problems;~~

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

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

~~(d) Various long-term care program requirements, including nursing facility and assisted living facility placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal care and respite services;~~

~~(e) Elderly or Disabled with Consumer-Direction Waiver requirements, as well as the administrative duties for which the services facilitator will be responsible;~~

~~(f) How to conduct assessments (including environmental, psychosocial, health, and functional factors) and their uses in services planning;~~

~~(g) Interviewing techniques;~~

~~(h) The individual's right to make decisions about, direct the provisions of, and control his consumer-directed services, including hiring, training, managing, approving time sheets of, and firing an aide;~~

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

~~(j) General principles of record documentation.~~

~~(2) Skills in:~~

~~(a) Negotiating with individuals, family/caregivers, and service providers;~~

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

~~(c) Identifying, developing, or providing services to individuals who are elderly or individuals with disabilities; and~~

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

(3) Abilities to:

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

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

(c) Be persistent and remain objective;

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

(e) Communicate effectively orally and in writing; and

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

c. If the CD services facilitator is not a RN, the CD services facilitator shall inform the waiver individual's primary health care provider that services are being provided and request consultation as needed. These contacts shall be documented in the waiver individual's record.

3. Initiation of services and service monitoring.

a. For CD services, the CD services facilitator shall make an initial comprehensive in-home visit at the primary residence of the waiver individual to collaborate with the waiver individual or family/caregiver to identify the needs, assist in the development of the POC with the waiver individual or family/caregiver, as appropriate, and provide employer of record (EOR) employee management training within seven days of the initial visit. The initial comprehensive home visit shall be conducted only once upon the waiver individual's entry into CD services. If the waiver individual changes, either voluntarily or involuntarily, the CD services facilitator, the new CD services facilitator must complete a reassessment visit in lieu of an initial comprehensive visit.

b. After the initial comprehensive visit, the CD services facilitator shall continue to monitor the POC on an as-needed basis, but in no event less frequently than every 90 days for personal care, and shall conduct face-to-face meetings with the waiver individual and may include the family/caregiver. The CD services facilitator shall review the utilization of CD respite services, either every six months or upon the use of half of the approved respite services hours, whichever comes first, and

~~shall conduct a face-to-face meeting with the waiver individual and may include the family/caregiver.~~

~~c. During visits with the waiver individual, the CD services facilitator shall observe, evaluate, and consult with the individual/EOR and may include the family/caregiver, and document the adequacy and appropriateness of CD services with regard to the waiver individual's current functioning, cognitive status, and medical and social needs. The CD services facilitator's written summary of the visit shall include, but shall not necessarily be limited to:~~

~~(1) A discussion with the waiver individual or family/caregiver/EOR concerning whether the service is adequate to meet the waiver individual's needs;~~

~~(2) Any suspected abuse, neglect, or exploitation and to whom it was reported;~~

~~(3) Any special tasks performed by the attendant and the attendant's qualifications to perform these tasks;~~

~~(4) The waiver individual's or family/caregiver's/EOR's satisfaction with the service;~~

~~(5) Any hospitalization or change in medical condition, functioning, or cognitive status; and~~

~~(6) The presence or absence of the attendant in the home during the CD services facilitator's visit.~~

~~4. DMAS, its designated contractor, or the fiscal/employer agent shall request a criminal record check and a check of the VDSS Child Protective Services Central Registry if the waiver individual is a minor child, in accordance with 12VAC30-120-930, pertaining to the attendant on behalf of the waiver individual and report findings of these records checks to the EOR.~~

~~5. The CD services facilitator shall review copies of timesheets during the face-to-face visits to ensure that the hours approved in the POC are being provided and are not exceeded. If discrepancies are identified, the CD services facilitator shall discuss these with the waiver individual or EOR to resolve discrepancies and shall notify the fiscal/employer agent. The CD services facilitator shall also review the waiver individual's POC to ensure that the waiver individual's needs are being met.~~

6. The CD services facilitator shall maintain records of each waiver individual that he serves. At a minimum, these records shall contain:

a. Results of the initial comprehensive home visit completed prior to or on the date services are initiated and subsequent reassessments and changes to the supporting documentation;

b. The personal care POC. Such plans shall be reviewed by the provider every 90 days, annually, and more often as needed, and modified as appropriate. The respite services POC shall be included in the record and shall be reviewed by the provider every six months or when half of the approved respite service hours have been used whichever comes first. For the annual review and in cases where either the personal care or respite care POC is modified, the POC shall be reviewed with the waiver individual, the family/caregiver, and EOR, as appropriate;

c. CD services facilitator's dated notes documenting any contacts with the waiver individual or family/caregiver/EOR and visits to the individual;

d. All contacts, including correspondence, made to and from the waiver individual, EOR, family/caregiver, physicians, DMAS, the designated Srv Auth contractor, formal and informal services provider, and all other professionals related to the individual's Medicaid services or medical care;

e. All employer management training provided to the waiver individual or EOR to include, but not necessarily be limited to (i) the individual's or EOR's receipt of training on their responsibilities for the accuracy of the attendant's timesheets and (ii) the availability of the Consumer-Directed Waiver Services Employer Manual available at www.dmas.virginia.gov;

f. All documents signed by the waiver individual or EOR, as appropriate, that acknowledge the responsibilities as the employer; and

g. The DMAS required forms as specified in the agency's waiver-specific guidance document.

7. Payment shall not be made for services furnished by other family members or caregivers who are living under the same roof as the waiver individual receiving services unless there is objective written

~~documentation by the CD services facilitator as to why there are no other providers or aides available to provide the required care.~~

~~8. In instances when either the waiver individual is consistently unable to hire and retain the employment of a personal care attendant to provide CD personal care or respite services such as, but not limited to, a pattern of discrepancies with the attendant's timesheets, the CD services facilitator shall make arrangements, after conferring with DMAS, to have the needed services transferred to an agency-directed services provider of the individual's choice or discuss with the waiver individual or family/caregiver/EOR, or both, other service options.~~

~~9. Waiver individual responsibilities.~~

~~a. The waiver individual shall be authorized for CD services and the EOR shall successfully complete consumer/employee management training performed by the CD services facilitator before the individual shall be permitted to hire an attendant for Medicaid reimbursement. Any services that may be rendered by an attendant prior to authorization by Medicaid shall not be eligible for reimbursement by Medicaid. Waiver individuals who are eligible for CD services shall have the capability to hire and train their own attendants and supervise the attendants' performance. Waiver individuals may have a family/caregiver or other designated person serve as the EOR on their behalf. The EOR shall be prohibited from also being the Medicaid-reimbursed attendant for respite or personal care or the services facilitator for the waiver individual.~~

~~b. Waiver individuals shall acknowledge that they will not knowingly continue to accept CD personal care services when the service is no longer appropriate or necessary for their care needs and shall inform the services facilitator of their change in care needs. If CD services continue after services have been terminated by DMAS or the designated Srv Auth contractor, the waiver individual shall be held liable for attendant compensation.~~

~~c. Waiver individuals shall notify the CD services facilitator of all hospitalizations or admissions, such as but not necessarily limited to, any rehabilitation facility, rehabilitation unit, or NF as CD~~

~~attendant services shall not be reimbursed during such admissions. Failure to do so may result in the waiver individual being held liable for attendant compensation.~~

~~d. Waiver individuals shall not employ attendants for DMAS reimbursement for services rendered to themselves when the attendant is the (i) spouse of the waiver individual; (ii) parent (biological, adoptive, legal guardian) or other guardian of the minor child waiver individual; or (iii) family/caregiver or caregivers/EOR who may be directing the waiver individual's care.~~

H. Consumer-directed (CD) services facilitation for personal care and respite services.

1. Any services rendered by attendants prior to dates authorized by DMAS or the Srv Auth contractor shall not be eligible for Medicaid reimbursement and shall be the responsibility of the waiver individual.

2. If the services facilitator is not an RN, then the services facilitator shall inform the primary health care provider for the individual who is enrolled in the waiver that services are being provided within 30 days from the start of such services and request consultation with the primary healthcare provider, as needed. This shall be done after the services facilitator secures written permission from the individual to contact the primary healthcare provider. The documentation of this written permission to contact the primary healthcare provider shall be retained in the individual's medical record. All contacts with the primary healthcare provider shall be documented in the individual's medical record.

3. The consumer-directed services facilitator, whether employed or contracted by a DMAS enrolled Services Facilitator, shall meet the following qualifications:

a. To be enrolled as a Medicaid consumer-directed services facilitator and maintain provider status, the consumer-directed services facilitator shall have sufficient knowledge, skills, and abilities to perform the activities required of such providers. In addition, the consumer-directed services facilitator shall have the ability to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, and details of the services provided.

b. Upon the effective date of emergency regulations 12 VAC 30-120-935 (H), all consumer-directed services facilitators shall:

(i) Have a satisfactory work record as evidenced by two references from prior job experiences from any human services work; such references shall not include any evidence of abuse, neglect, or exploitation of the elderly or persons with disabilities or children;

(ii) Submit to a criminal background check showing no barrier crimes as set forth in §32.1-162.9:1 of the Code of Virginia and retain proof of such background check in the employee's records. DMAS shall not reimburse the provider for any services provided by an employee who has been convicted of having committed a barrier crime as defined therein.

(iii) Submit to a search of the DSS Child Protective Services Central Registry which results in no founded complaint and :

(iv) Not be debarred, suspended, or otherwise excluded from participating in Federal health care programs, as listed on the federal List of Excluded Individuals/Entities (LEIE) database at http://www.olg.hhs.govfraud/exclusions/exclusions%20list.asp;

c. The services facilitator shall not be compensated for services provided to the individual enrolled in the waiver effective on the date in which the record check verifies that the services facilitator either (i) has been convicted of barrier crimes described in §32.1-162.9:1 of the Code of Virginia,(ii) has a founded complaint confirmed by the VDSS Child Protective Services Central Registry, or (iii) is found to be listed on LEIE.

d. Upon the effective date of emergency regulation 12 VAC 30-120-935 (H), consumer-directed services facilitators shall possess the required degree and experience, as follows:

(i) Prior to enrollment by the department as a consumer-directed services facilitator, all new applicants shall possess, at a minimum, either an associate's degree or higher from an accredited college in a health or human services field or be a registered nurse currently licensed to practice in Commonwealth, and possess a minimum of two years of satisfactory direct care experience supporting individuals with disabilities or older adults; or

(ii) Possess a bachelor's degree or higher in a non-health or human services field and have a minimum of three years of satisfactory direct care experience supporting individuals with disabilities or older adults.

(iii) Persons who are consumer-directed services facilitators prior to the effective date of the emergency regulation 12 VAC 30-120-935(H), shall not be required to meet the degree and experience requirements of 12 VAC 30-120-935(H) unless required to submit a new application to be a consumer-directed services facilitator after the effective date for emergency regulation 12 VAC 30-120-935(H).

e. Within 90 days of the effective date of the emergency regulation 12 VAC 30-120-935(H), all consumer-directed services facilitators shall complete required training and competency assessments. Satisfactory competency assessment results shall be kept in the employee's record.

(i) All new consumer-directed consumer directed services facilitators shall complete the DMAS approved Consumer Directed Services Facilitator training and pass the corresponding competency assessment with a score of at least 80% prior to being approved as a Consumer Directed Services Facilitator or being reimbursed for working with waiver individuals.

(ii) Persons who are consumer-directed services facilitators prior to the effective date of the emergency regulation 12 VAC 30-120-935 shall be required tocomplete the DMAS-approved Consumer Directed Services Facilitator training and pass the corresponding competency assessment with a score of at least 80% in order to continue being reimbursed for or working with waiver individuals for the purpose of Medicaid reimbursement.

f. Failure to satisfy the competency assessment requirements and meet all other requirements shall result in either a retraction of Medicaid payment or the termination of the provider agreement, or both.

g. Failure to satisfy the competency assessment requirements and meet all other requirements may also result in the termination of a CD services facilitator employed by or contracted with Medicaid enrolled services facilitator provider.

h. As a component of the renewal of the Medicaid provider agreement, all CD services facilitators shall pass the competency assessment every five years and achieve a score of at least 80%.

i. The CD services facilitator shall have access to a computer with secure internet access for electronic exchange of information, including checking individual eligibility, submission of service authorization requests, submission of information to the FEA, and billing for services.

j. The consumer-directed services facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills and abilities must be documented on the consumer-directed services facilitator's application form, found in supporting documentation, or be observed during a job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

(1) Knowledge of:

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

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

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

(d) Various long-term care program requirements, including nursing facility and assisted living facility placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal care and respite services;

(e) Elderly or Disabled with Consumer-Direction Waiver requirements, as well as the administrative duties for which the services facilitator will be responsible;

(f) How to conduct assessments (including environmental, psychosocial, health, and functional factors) and their uses in services planning;

(g) Interviewing techniques;

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

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

(j) General principles of record documentation.

(2) Skills in:

(a) Negotiating with individuals, family/caregivers and service providers;

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

(c) Identifying, developing, or providing services to individuals who are elderly or individuals with disabilities; and

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

(3) Abilities to:

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

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

(c) Be persistent and remain objective;

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

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

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

4. Initiation of services and service monitoring.

a. For consumer-directed model of services, the consumer-directed services facilitator shall make an initial comprehensive home visit at the primary residence of the individual to collaborate with the individual or the individual's family/caregiver, as appropriate, to identify the individual's needs, assist in the development of the POC with the waiver individual and individual's family/caregiver, as appropriate, and provide EOR management training within seven days of the initial visit. The initial comprehensive home visit shall be conducted only once upon the individual's entry into consumer-directed services. If the individual changes, either voluntarily or involuntarily, the consumer-directed services facilitator, the

new consumer-directed services facilitator shall complete a reassessment visit in lieu of a comprehensive visit.

b. After the initial comprehensive visit, the services facilitator shall continue to monitor the POC on an as-needed basis, but in no event less frequently than every 90 days for personal care, and shall conduct face-to-face meetings with the individual and may include the family/caregiver. The services facilitator shall review the utilization of consumer-directed respite services, either every six months or upon the use of half of the approved respite services hours, whichever comes first, and shall conduct a face-to-face meeting with the individual and may include the family/caregiver. Such monitoring reviews shall be documented in the individual's medical record.

c. During visits with the individual, the services facilitator shall observe, evaluate, and consult with the individual/EOR and may include the family/caregiver, and document the adequacy and appropriateness of CD services with regard to the individual's current functioning, cognitive status, and medical and social needs. The consumer-directed services facilitator's written summary of the visit shall include at a minimum:

(1) Discussion with the waiver individual or family/caregiver/EOR, as appropriate, concerning whether the service is adequate to meet the waiver individual's needs;

(2) Any suspected abuse, neglect, or exploitation and to whom it was reported;

(3) Any special tasks performed by the consumer-directed attendant and the consumer-directed attendant's qualifications to perform these tasks;

(4) The individual's or family/caregiver's/EOR's satisfaction with the service;

(5) Any hospitalization or change in medical condition, functioning, or cognitive status; and

(6) The presence or absence of the consumer-directed attendant in the home during the consumer-directed services facilitator's visit.

5. DMAS, its designated contractor, or the fiscal/employer agent shall request a criminal record check and a check of the VDSS Child Protective Services Central Registry if the waiver individual is a minor child, in

accordance with 12VAC30-120-930, pertaining to the consumer-directed attendant on behalf of the waiver individual and report findings of these records checks to the EOR.

6. The consumer-directed services facilitator shall review and verify copies of timesheets during the face-to-face visits to ensure that the hours approved in the POC are being provided and are not exceeded. If discrepancies are identified, the consumer-directed services facilitator shall discuss these with the individual or EOR to resolve discrepancies and shall notify the fiscal/employer agent. The consumer-directed services facilitator shall also review the individual's POC to ensure that the individual's needs are being met. Failure to conduct such reviews and verifications of timesheets and maintain the documentation of these reviews shall result in DMAS' recovery of payments made.

7. The services facilitator shall maintain records of each individual that he serves. At a minimum, these records shall contain:

a. Results of the initial comprehensive home visit completed prior to or on the date services are initiated and subsequent reassessments and changes to the supporting documentation;

b. The personal care POC. Such plans shall be reviewed by the provider every 90 days, annually, and more often as needed, and modified as appropriate. The respite services POC shall be included in the record and shall be reviewed by the provider every six monthsor when half of the approved respite service hours have been used whichever comes first. For the annual review and in cases where either the personal care or respite care POC is modified, the POC shall be reviewed with the individual, the family/caregiver, and EOR, as appropriate;

c. The consumer-directed services facilitator's dated notes documenting any contacts with the individual or family/caregiver/EOR and visits to the individual;

d. All contacts, including correspondence, made to and from the individual, EOR, family/caregiver, physicians, DMAS, the designated Srv Auth contractor, formal and informal services provider, and all other professionals related to the individual's Medicaid services or medical care;

e. All employer management training provided to the individual or EOR to include, but not necessarily be limited to (i) the individual's or EOR's receipt of training on their responsibilities for the accuracy of

the consumer-directed attendant's timesheets and (ii) the availability of the Consumer-Directed Waiver Services Employer Manual available at www.dmas.virginia.gov;

f. All documents signed by the individual or EOR, as appropriate, that acknowledge the responsibilities as the employer; and

g. The DMAS required forms as specified in the agency's waiver-specific guidance document.

h. Failure to maintain all required documentation shall result in DMAS' action to recover payments made. Repeated instances of failure to maintain documentation may result in cancellation of the Medicaid provider agreement.

8. In instances when the individual is consistently unable to either hire or retain the employment of a personal care consumer-directed attendant to provide consumer-directed personal care or respite services such as, for example, a pattern of discrepancies with the consumer-directed attendant's timesheets, the consumer-directed services facilitator shall make arrangements, after conferring with DMAS, to have the needed services transferred to an agency-directed services provider of the individual's choice or discuss with the individual or family/caregiver/EOR, or both, other service options.

9. Waiver individual, family/caregiver, and EOR responsibilities.

a. The individual shall be authorized for the consumer-directed model of services and the EOR shall successfully complete EOR management training performed by the consumer-directed services facilitator before the individual/EOR shall be permitted to hire a consumer-directed attendant for Medicaid reimbursement. Any services that may be rendered by a consumer-directed attendant prior to authorization by Medicaid shall not be eligible for reimbursement by Medicaid. Individuals who are eligible for consumer-directed services shall have the capability to hire and train their own consumer-directed attendants and supervise the consumer-directed attendants' performance. In lieu of handling their consumer-directed attendants themselves, individuals may have a family/caregiver or other designated person serve as the EOR on their behalf. The EOR shall be prohibited from also being the Medicaid-reimbursed consumer-directed attendant for respite or personal care or the services facilitator for the individual.

b. Individuals shall acknowledge that they will not knowingly continue to accept consumer-directed personal care services when the service is no longer appropriate or necessary for their care needs and shall inform the services facilitator of their change in care needs. If the consumer-directed model of services continue after services have been terminated by DMAS or the designated Srv Auth contractor, the individual shall be held liable for the consumer-directed attendant compensation.

c. Individuals shall notify the consumer-directed services facilitator of all hospitalizations or admissions, for example, to any rehabilitation facility rehabilitation unit or NF as consumer-directed attendant services shall not be reimbursed during such admissions. Failure to do so may result

l. Personal emergency response systems. In addition to meeting the general conditions and requirements for home and community-based waiver participating providers as specified in 12VAC30-120-930, PERS providers must also meet the following qualifications and requirements:

1. A PERS provider shall be either, but not necessarily limited to, a personal care agency, a durable medical equipment provider, a licensed home health provider, or a PERS manufacturer. All such providers shall have the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and service calls), and PERS monitoring;

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

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

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

activating devices, or medication monitoring unit and shall provide temporary equipment, as may be necessary for the waiver individual's health, safety, and welfare, while the original equipment is being repaired or replaced;

5. The PERS provider shall install, consistent with the manufacturer's instructions, all PERS equipment into a waiver individual's functioning telephone line or system within seven days of the request of such installation unless there is appropriate documentation of why this timeframe cannot be met. The PERS provider shall furnish all supplies necessary to ensure that the system is installed and working properly. The PERS provider shall test the PERS device monthly, or more frequently if needed, to ensure that the device is fully operational;

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

7. A PERS provider shall maintain a data record for each waiver individual at no additional cost to DMAS or the waiver individual. The record shall document all of the following:

a. Delivery date and installation date of the PERS equipment;

b. Waiver individual/caregiver signature verifying receipt of the PERS equipment;

c. Verification by a test that the PERS device is operational and the waiver individual is still using it monthly or more frequently as needed;

d. Waiver individual contact information, to be updated annually or more frequently as needed, as provided by the individual or the individual's caregiver/EOR;

e. A case log documenting the waiver individual's utilization of the system, all contacts, and all communications with the individual, caregiver/EOR, and responders;

f. Documentation that the waiver individual is able to use the PERS equipment through return demonstration; and

g. Copies of all equipment checks performed on the PERS unit;

8. The PERS provider shall have backup monitoring capacity in case the primary system cannot handle incoming emergency signals;

9. The emergency response activator shall be capable of being activated either by breath, touch, or some other means and shall be usable by waiver individuals who are visually or hearing impaired or physically disabled. The emergency response communicator shall be capable of operating without external power during a power failure at the waiver individual's home for a minimum period of 24 hours. The emergency response console unit shall also be able to self-disconnect and redial the backup monitoring site without the waiver individual resetting the system in the event it cannot get its signal accepted at the response center;

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

a. A primary receiver and a backup receiver, which shall be independent and interchangeable;

b. A backup information retrieval system;

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

d. A backup 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 backup response center; and

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

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

12. The PERS provider shall document and furnish within 30 days of the action taken, a written report for each emergency signal that results in action being taken on behalf of the waiver individual. This excludes test signals or activations made in error. This written report shall be furnished to (i) the personal care provider; (ii) the respite care provider; (iii) the CD services facilitation provider; (iv) in cases where the individual only receives ADHC services, to the ADCC provider; or (v) to the transition coordinator for the service in which the individual is enrolled; and

13. The PERS provider shall obtain and keep on file a copy of the most recently completed DMAS-225 form. Until the PERS provider obtains a copy of the DMAS-225 form, the PERS provider shall clearly document efforts to obtain the completed DMAS-225 form from the personal care provider, respite care provider, CD services facilitation provider, or ADCC provider.

J. Assistive technology (AT) and environmental modification (EM) services. AT and EM shall be provided only to waiver individuals who also participate in the MFP demonstration program by providers who have current provider participation agreements with DMAS.

1. AT shall be rendered by providers having a current provider participation agreement with DMAS as durable medical equipment and supply providers. An independent, professional consultation shall be obtained, as may be required, from qualified professionals who are knowledgeable of that item for each AT request prior to approval by either DMAS or the Srv Auth contractor and may include training on such AT by the qualified professional. Independent, professional consultants shall include, but shall not necessarily be limited to, speech/language therapists, physical therapists, occupational therapists, physicians, behavioral therapists, certified rehabilitation specialists, or rehabilitation engineers. Providers that supply AT for a waiver individual may not perform assessment/consultation, write

specifications, or inspect the AT for that individual. Providers of services shall not be (i) spouses of the waiver individual or (ii) parents (biological, adoptive, foster, or legal guardian) of the waiver individual. AT shall be delivered within 60 days from the start date of the authorization. The AT provider shall ensure that the AT functions properly.

2. In addition to meeting the general conditions and requirements for home and community-based waiver services participating providers as specified in 12VAC30-120-930, as appropriate, environmental modifications shall be provided in accordance with all applicable state or local building codes by contractors who have provider agreements with DMAS. Providers of services shall not be (i) the spouse of the waiver individual or (ii) the parent (biological, adoptive, foster, or legal guardian) of the waiver individual who is a minor child. Modifications shall be completed within a year of the start date of the authorization.

3. Providers of AT and EM services shall not be permitted to recover equipment that has been provided to waiver individuals whenever the provider has been charged, by either DMAS or its designated service authorization agent, with overpayments and is therefore being required to return payments to DMAS.

K. Transition coordination. This service shall be provided consistent with 12VAC30-120-2000 and 12VAC30-120-2010.

L. Transition services. This service shall be provided consistent with 12VAC30-120-2000 and 12VAC30-120-2010.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

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

A. Covered services in the ID Waiver include: assistive technology, companion services (both consumer-directed and agency-directed), crisis stabilization, day support, environmental modifications, personal assistance services (both consumer-directed and agency-directed), personal emergency response systems (PERS), prevocational services, residential support services, respite services (both consumer-directed and

agency-directed), services facilitation (only for consumer-directed services), skilled nursing services, supported employment, therapeutic consultation, and transition services.

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

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

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

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

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

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

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

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

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

case manager, as appropriate, shall assist the individual with the change of services from consumer-directed to agency-directed.

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

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

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

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

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

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

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

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

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

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

6. All requests for this waiver's services shall be submitted to either DMAS or the service authorization contractor for service (prior) authorization.

B. Assistive technology (AT). Service description. This service shall entail the provision of specialized medical equipment and supplies including those devices, controls, or appliances, specified in the Individual Support

Plan but which are not available under the State Plan for Medical Assistance, that (i) enable individuals to increase their abilities to perform activities of daily living (ADLs); (ii) enable individuals to perceive, control, or communicate with the environment in which they live; or (iii) are necessary for life support, including the ancillary supplies and equipment necessary to the proper functioning of such technology.

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

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

a. The maximum funded expenditure per individual for all AT covered procedure codes (combined total of AT items and labor related to these items) shall be $5,000 per calendar year for individuals regardless of waiver for which AT is approved. The service unit shall always be one for the total cost of all AT being requested for a specific timeframe.

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

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

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

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

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

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

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

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

3. Service units and service limitations.

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

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

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

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

D. Crisis stabilization. Service description. These services shall involve direct interventions that provide temporary intensive services and support that avert emergency psychiatric hospitalization or institutional placement of individuals with ID who are experiencing serious psychiatric or behavioral problems that jeopardize their current community living situation. Crisis stabilization services shall have two components: (i) intervention and (ii) supervision. Crisis stabilization services shall include, as appropriate, neuropsychiatric, psychiatric, psychological, and other assessments and stabilization techniques, medication management and monitoring, behavior assessment and positive behavioral support, and intensive service coordination with other agencies and providers. This service shall be designed to stabilize the individual and strengthen the current living situation, so that the individual remains in the community during and beyond the crisis period.

1. These services shall be provided to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Service units and service limitations.

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

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

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

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

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

F. Environmental modifications (EM). Service description. This service shall be defined, as set out in 12VAC30-120-1000, as those physical adaptations to the individual's primary home, primary vehicle, or work site that shall be required by the individual's Individual Support Plan, that are necessary to ensure the health and welfare of the individual, or that enable the individual to function with greater independence. Environmental modifications reimbursed by DMAS may only be made to an individual's work site when the modification exceeds the reasonable accommodation requirements of the Americans with Disabilities Act. Such adaptations may include, but shall not necessarily be limited to, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the individual.

Modifications may be made to a primary automotive vehicle in which the individual is transported if it is owned by the individual, a family member with whom the individual lives or has consistent and ongoing contact, or a nonrelative who provides primary long-term support to the individual and is not a paid provider of services.

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

2. Service units and service limitations.

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

b. The maximum funded expenditure per individual for all EM covered procedure codes (combined total of EM items and labor related to these items) shall be $5,000 per calendar year for individuals regardless of waiver for which EM is approved. The service unit shall always be one, for the total cost of all EM being requested for a specific timeframe.

EM shall be available to individuals enrolled in the waiver who are receiving at least one other waiver service and may be provided in a residential or nonresidential setting. EM shall be prior authorized by the state-designated agency or its contractor for each calendar year with no carry-over across calendar years.

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

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

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

f. Excluded from coverage under this waiver service shall be those adaptations or improvements to the home that are of general utility and that are not of direct medical or remedial benefit to the individual enrolled in the

waiver, such as, but not necessarily limited to, carpeting, roof repairs, and central air conditioning. Also excluded shall be modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act, and the Rehabilitation Act. Adaptations that add to the total square footage of the home shall be excluded from this service. Except when EM services are furnished in the individual's own home, such services shall not be provided to individuals who receive residential support services.

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

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

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

b. Purchase or lease of a vehicle; and

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

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

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

3400 et seq.) of Title 54.1 of the Code of Virginia, as appropriate. This service shall not include skilled nursing services with the exception of skilled nursing tasks that may be delegated pursuant to 18VAC90-20-420 through 18VAC90-20-460.

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

3. Service units and service limitations.

a. The unit of service shall be one hour.

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

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

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

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

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

2. Service units and service limitations.

a. A unit of service shall include administrative costs, time, labor, and supplies associated with the installation, maintenance, monitoring, and adjustments of the PERS. A unit of service is the one-month rental price set by

DMAS. The one-time installation of the unit shall include installation, account activation, individual and caregiver instruction, and removal of PERS equipment.

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

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

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

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

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

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

per Individual Support Plan year. A block shall be defined as a period of time from one hour through three hours and 59 minutes.

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

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

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

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

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

Supports. There shall be two types of this service: congregate residential support and in-home supports. Residential support services shall be authorized for Medicaid reimbursement in the Plan for Supports only when the individual requires these services and when such needs exceed the services included in the individual's room and board arrangements with the service provider, or if these services exceed supports provided by the family/caregiver. Only in exceptional instances shall residential support services be routinely reimbursed up to a 24-hour period.

1. Criteria.

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

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

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

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

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

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

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

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

b. Congregate residential support shall not be provided to any individual enrolled in the waiver who receives personal assistance services under the ID Waiver or other residential services that provide a comparable level of care. Residential support services shall be permitted to be provided to the individual enrolled in the waiver in conjunction with respite services for unpaid caregivers;

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

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

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

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

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

2. Respite services shall be those that are normally provided by the individual's family or other unpaid primary caregiver. These covered services shall be furnished on a short-term, episodic, or periodic basis because of

the absence of the unpaid caregiver or need for relief of the unpaid caregiver or caregivers who normally provide care for the individual.

3. Criteria.

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

b. Respite services shall only be offered to individuals who have an unpaid primary caregiver or caregivers who require temporary relief. Such need for relief may be either episodic, intermittent, or periodic.

4. Service units and service limitations.

a. The unit of service shall be one hour. Respite services shall be limited to 480 hours per individual per state fiscal year. If an individual changes waiver programs, this same maximum number of respite hours shall apply. No additional respite hours beyond the 480 maximum limit shall be approved for payment. Individuals who are receiving respite services in this waiver through both the agency-directed and ~~CD~~ consumer-directed models shall not exceed 480 hours per year combined.

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

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

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

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

5. Consumer-directed and agency-directed respite services shall meet the same standards for service limits and authorizations.

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

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

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

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

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

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

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

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

5. A face-to-face meeting shall occur between the services facilitator and the individual at least every six months to reassess the individual's needs and to ensure appropriateness of any ~~CD~~ consumer-directed services received by the individual. During these visits with the individual, the services facilitator shall observe, evaluate, and consult with the individual, EOR, and the individual's family/caregiver, as appropriate, for the purpose of documenting the adequacy and appropriateness of ~~CD~~ consumer-directed services with regard to the individual's current functioning and cognitive status, medical needs, and social needs. The services facilitator's written summary of the visit shall include, but shall not necessarily be limited to:

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

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

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

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

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

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

g. Any other services received and the amount.

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

7. The services facilitator shall maintain a record of each individual containing elements as set out in 12VAC30-120-1060.

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

9. If a services facilitator is not selected by the individual, the individual or the family/caregiver serving as the EOR shall perform all of the duties and meet all of the requirements, including documentation requirements, identified for services facilitation. However, the individual or family/caregiver shall not be reimbursed by DMAS for performing these duties or meeting these requirements.

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

11. The ~~CD~~ consumer-directed services facilitator, who is to be reimbursed by DMAS, shall not be the individual enrolled in the waiver, the individual's case manager, a direct service provider, the

individual's spouse, a parent, including stepparents and legal guardians, of the individual who is a minor child, or the EOR who is employing the assistant/companion.

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

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

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

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

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

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

M. Skilled nursing services. Service description. These services shall be provided for individuals enrolled in the waiver having serious medical conditions and complex health care needs who do not meet home health criteria but who require specific skilled nursing services which cannot be provided by non-nursing personnel. Skilled

nursing services may be provided in the individual's home or other community setting on a regularly scheduled or intermittent basis. It may include consultation, nurse delegation as appropriate, oversight of direct support staff as appropriate, and training for other providers.

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

2. Service units and service limitations. Skilled nursing services shall be rendered by a registered nurse or licensed practical nurse as defined in 12VAC30-120-1000 and shall be provided in 15-minute units in accordance with the DMAS fee schedule as set out in DMAS guidance documents. The services shall be explicitly detailed in a Plan for Supports and shall be specifically ordered by a physician as medically necessary.

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

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

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

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

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

3. Criteria.

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

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

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

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

4. Service units and service limitations.

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

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

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

d. Group supported employment shall be limited to 780 blocks per individual, or its equivalent under the DMAS fee schedule, per Individual Support Plan year. A block shall be defined as a period of time from one hour through three hours and 59 minutes. Two blocks are defined as four hours to six hours and 59 minutes. Three blocks are defined as seven hours to nine hours and 59 minutes. If this service is used in combination with

prevocational and day support services, the combined total unit blocks for these three services shall not exceed 780 units, or its equivalent under the DMAS fee schedule, per Individual Support Plan year.

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

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

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

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

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

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

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

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

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

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

1. A completed copy of the DBHDS-approved SIS assessment form or its approved alternative form during the phase in period.

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

a. The individual's strengths, desired outcomes, required or desired supports or both, and skill-building needs;

b. The individual's support activities to meet the identified outcomes;

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

d. A timetable for the accomplishment of the individual's desired outcomes and support activities;

e. The estimated duration of the individual's needs for services; and

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

3. Documentation indicating that the Plan for Supports' desired outcomes and support activities have been reviewed by the provider quarterly, annually, and more often as needed. The results of the review must be

submitted to the case manager. For the annual review and in cases where the Plan for Supports is modified, the Plan for Supports shall be reviewed with and agreed to by the individual enrolled in the waiver and the individual's family/caregiver, as appropriate.

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

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

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

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

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

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

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

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

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

3. Documentation indicating that the Plan for Supports' desired outcomes and support activities have been reviewed by the provider quarterly, annually, and more often as needed. The results of the review must be submitted to the case manager. For the annual review and in cases where the Plan for Supports is modified,

the Plan for Supports shall be reviewed with and agreed to by the individual enrolled in the waiver and the individual's family/caregiver, as appropriate.

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

a. Whether companion services continue to be appropriate;

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

c. The individual's satisfaction with the service;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Assistive technology (AT). In addition to meeting the service coverage requirements in 12VAC30-120-1020 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-1040, AT shall be provided by DMAS-enrolled durable medical equipment (DME) providers or DMAS-enrolled CSBs/BHAs with an ID Waiver provider agreement to provide AT. DME shall be provided in accordance with 12VAC30-50-165.

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

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

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

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

a. Be at least 18 years of age;

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

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

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

e. Be capable of aiding in IADLs; and

f. Receive an annual tuberculosis screening.

4. Persons rendering companion services for reimbursement by DMAS shall not be the individual's spouse, parent (whether biological or adoptive), stepparent, or legal guardian. Other family members living under the same roof as the individual being served may not provide companion services unless there is objective written documentation completed by the services facilitator, or the EOR when the individual does not select services facilitation, as to why there are no other providers available to provide companion services.

a. Family members who are approved to be reimbursed by DMAS to provide companion services shall meet all of the companion training and ability qualifications as other persons who are not family members. Family members who are approved to be reimbursed for providing this service shall not be the family member/caregiver/EOR who is directing the individual's care.

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

5. For the agency-directed model, companions shall be employees of enrolled providers that have participation agreements with DMAS to provide companion services. Providers shall be required to have a companion services supervisor to monitor companion services. The companion services supervisor shall have a bachelor's degree in a human services field and have at least one year of experience working in the ID field, or be a licensed practical nurse (LPN) or a registered nurse (RN) with at least one year of experience working in the ID field. Such LPNs and RNs shall have the appropriate current licenses to either practice nursing in the Commonwealth or have multi-state licensure privilege as defined herein.

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

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

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

b. The companion's arrival and departure times;

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

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

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

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

b. Documentation of training provided to the companion by the individual or EOR, as appropriate;

c. Documentation of all employer management training provided to the individual enrolled in the waiver or the EOR, including the individual's and the EOR's, as appropriate, receipt of training on their legal responsibility for the accuracy and timeliness of the companion's timesheets; and

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

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

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

2. The provider shall employ or use QMRPs, licensed mental health professionals, or other qualified personnel who have demonstrated competence to provide crisis stabilization and related activities to individuals with ID who are experiencing serious psychiatric or behavioral problems.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. In instances where day support staff may be required to ride with the individual enrolled in the waiver to and from day support services, the day support staff transportation time may be billed as day support services and

documentation maintained, provided that billing for this time does not exceed 25% of the total time spent in day support services for that day.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. Be willing to attend training at the individual's and EOR's, as appropriate, request;

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

f. Receive an annual tuberculosis screening.

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

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

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

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

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

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

10. Personal assistants to be paid by DMAS shall not be the parents, stepparents, or legal guardians of individuals enrolled in the waiver who are minor children or the individuals' spouses.

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

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

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

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

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

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

(1) The service authorized provider shall provide the supervision for the substitute assistant;

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

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

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

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

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

b. The assistant's arrival and departure times;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Delivery date and installation date of the PERS;

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

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

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

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

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

10. All PERS equipment shall be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard for home health care signaling equipment in Underwriter's Laboratories Safety Standard 1637, Standard for Home Health Care Signaling Equipment, Fourth Edition, December 29, 2006. The UL listing mark on the equipment shall be accepted as evidence of the equipment's compliance with such standard. The PERS device shall be automatically reset by the response center after each activation, ensuring that subsequent signals can be transmitted without requiring manual reset by the individual enrolled in the waiver or family/caregiver, as appropriate.

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

12. The emergency response activator shall be able to be activated either by breath, by touch, or by some other means, and must be usable by individuals who are visually or hearing impaired or physically disabled. The emergency response communicator must be capable of operating without external power during a power failure at the individual's home for a minimum period of 24-hours and automatically transmit a low battery alert signal to the response center if the back-up battery is low. The emergency response console unit must also be

able to self-disconnect and redial the back-up monitoring site without the individual or family/caregiver resetting the system in the event it cannot get its signal accepted at the response center.

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

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

b. A back-up information retrieval system;

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

d. A back-up power supply;

e. A separate telephone service;

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

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

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

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

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

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

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

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

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

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

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

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

L. Residential support services.

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

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

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

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

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

1. For the agency-directed model, services shall be provided by an enrolled DMAS respite care provider or by a residential services provider licensed by the DBHDS that is also enrolled by DMAS. In addition, respite services may be provided by a DBHDS-licensed respite services provider or a local department of social

services-approved foster care home for children or by an adult foster care provider that is also enrolled by DMAS.

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

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

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

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

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

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

b. When respite services are routine in nature, that is occurring with a scheduled regularity for specific periods of time, and offered in conjunction with personal assistance, the supervisory visit conducted for personal assistance may serve as the supervisory visit for respite services. However, the supervisor or services

facilitator, as appropriate, shall document supervision of respite services separately. For this purpose, the same individual record shall be used with a separate section for respite services documentation.

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

8. Qualifications for respite assistants. The assistant shall:

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

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

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

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

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

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

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

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

b. Assistants shall have a satisfactory work record, as evidenced by two references from prior job experiences including no evidence of possible abuse, neglect, or exploitation of any person regardless of age or disability.

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

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

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

c. Receive an annual tuberculosis screening.

11. Assistants to be paid by DMAS shall not be the parents, (whether biological or adoptive), stepparents, or legal guardians, of individuals enrolled in the waiver who are minor children or the individuals' spouses. Payment shall not be made for services furnished by other family members living under the same roof as the individual who is receiving services unless there is objective written documentation completed by the services facilitator, or the case manager when the individual does not select services facilitation, as to why there are no other providers available to render the services required by the individual. Family members who are approved to be reimbursed for providing this service shall meet the same training and ability qualifications as all other respite assistants. Family members who are approved to be reimbursed for providing this service shall not be the family member/caregiver/EOR who is directing the individual's care.

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

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

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

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

(1) The service authorized provider shall provide the supervision for the substitute assistant;

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

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

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

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

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

b. The assistant's arrival and departure times;

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

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

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

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

~~2.~~1. To be enrolled as a Medicaid CD services facilitator and maintain provider status, the services facilitator provider shall have sufficient resources to perform the required activities, including the ability to maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided. All CD services facilitators, whether employed by or contracted with a DMAS enrolled Services Facilitator provider, shall meet all of the qualifications set out in this subsection. To be enrolled, the services facilitator shall also meet the combination of work experience and relevant education set out in this subsection that indicate the possession of the specific knowledge, skills, and abilities to perform this function. The services facilitator shall maintain a record of each individual containing elements as set out in this section.

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

a. If the services facilitator is not an RN, then, within 30 days from the start of such services, the services facilitator shall inform the primary health care provider for the individual enrolled in the waiver that consumer-directed services are being provided, and request skilled nursing or other consultation as needed by the individual. Prior to contacting the primary health care provider, the services facilitator shall obtain the individual's written consent to make such contact or contacts. All such contacts and

consultations shall be documented in the individual's medical record. Failure to document such contacts and consultations shall be subject to DMAS' recovery of payments made.

b. Upon the effective date of the emergency regulation 12 VAC 30-120-1060(N), prior to enrollment by DMAS as a consumer-directed services facilitator, applicants shall possess, at a minimum, either (i) an associate's degree from an accredited college in a health or human services field or be a registered nurse currently licensed to practice in Commonwealth, and two years of satisfactory direct care experience supporting individuals with disabilities or older adults or children or (ii) a bachelor's degree in a non-health or human services field and a minimum of three years of satisfactory direct care experience supporting individuals with disabilities or older adults.

c. Upon the effective date of the emergency regulation 12 VAC 30-120-1060(N), all consumer-directed services facilitators, shall:

(i) Have a satisfactory work record as evidenced by two references from prior job experiences from any human services work; such references shall not include any evidence of abuse, neglect, or exploitation of the elderly or persons with disabilities or children;

(ii) Submit to a criminal background check being conducted. The results of such check shall contain no record of conviction of barrier crimes as set forth in § 32.1-162.9:1 of the COV. Proof that the criminal record check was conducted shall be maintained in the employee's record. DMAS shall not reimburse the provider for any services provided by an employee who has been convicted of committing a barrier crime as set forth in § 32.1-162.9:1 of the COV;

(iii) Submit to a search of the DSS Child Protective Services Central Registry yielding no founded complaint; and,

(iv) Not be debarred, suspended, or otherwise excluded from participating in Federal health care programs, as listed on the federal List of Excluded Individuals/Entities (LEIE) database at http://www.olg.hhs.govfraud/exclusions/exclusions list.asp .

d. The services facilitator shall not be compensated for services provided to the waiver individual effective on the date in which the record check verifies that the services facilitator either (i) has been

convicted of barrier crimes described in §32.1-162.9.1 of the COV; (ii) has a founded complaint confirmed by the VDSS Child Protective Services Central Registry; or, (iii) is found to be listed on the LEIE.

e. Within 90 days of the effective date of the emergency regulation 12 VAC 30-120-1060(N), all consumer-directed services facilitators providers and staff employed by consumer-directed services facilitator providers, to function as a consumer-directed services facilitator, shall complete the DMAS approved Consumer Directed Services Facilitator training and pass the corresponding competency assessment with a score of at least 80% prior to being approved as a consumer directed services facilitator or being reimbursed for working with individuals. The competency assessment and all corresponding competency assessment shall be kept in the employee's record.

f. Failure to complete the competency assessment within the 90-day time limit and meet all other requirements shall result in a retraction of Medicaid payment or the termination of the provider agreement, or both or require the termination of a consumer-directed services facilitator employed by or contracted with Medicaid enrolled services facilitators to render Medicaid covered services.

g. As a component of the renewal of the provider agreement, all consumer-directed services facilitators shall take and pass the competency assessment every five years and achieve a score of at least 80%.

h. The consumer-directed services facilitator shall have access to a computer for secure electronic exchange of information, including timely checking individual eligibility, prompt submission of requests for service authorizations, timely submission of information to the fiscal employer agent, and prompt billing for services.

i. All consumer-directed services facilitators shall possess a demonstrable combination of work experience and relevant education which indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills and abilities shall be documented on the application form, found in supporting documentation, or be observed during the job interview. Observations during the interview shall be documented. The knowledge, skills and abilities include:

(1) Knowledge of:

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

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

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

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

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

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

(g) Interviewing techniques;

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

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

(j) General principles of record documentation.

(2) Skills in:

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

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

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

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

(3) Abilities to:

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

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

(c) Be persistent and remain objective;

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

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

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

2. The services facilitator's record about the individual shall contain:

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

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

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

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

2. Skilled nursing services providers shall not be the parents (natural, adoptive, or foster) or the legal guardians of individuals enrolled in the waiver who are minor children or the individual's spouse. Payment shall not be

made for services furnished by other family members who are living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers available to provide the care. Other family members who are approved to provide skilled nursing services ~~must~~ shall meet the same skilled nursing provider requirements as all other licensed providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

d. Documentation of nursing license/qualifications of providers;

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

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

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

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

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

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

3. In instances where supported employment staff are required to ride with the individual enrolled in the waiver to and from supported employment activities, the supported employment staff's transportation time (actual

transport time) may be billed as supported employment, provided that the billing for this time does not exceed 25% of the total time spent in supported employment for that day.

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

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

a. Identifying information;

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

c. Specific consultation activities.

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

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

4. If the consultation services extend three months or longer, written quarterly reviews are required to be completed by the service provider and shall be forwarded to the case manager. If the consultation service extends beyond one year or when there are changes to the Plan for Supports, the Plan shall be reviewed by the provider with the individual and family/caregiver, as appropriate. The Plan for Supports shall be agreed to by the individual and family/caregiver, as appropriate, and the case manager and shall be submitted to the case manager. All changes to the Plan for Supports shall be reviewed with and agreed to by the individual and the individual's family/caregiver, as appropriate.

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

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

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

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

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

b. An individual enrolled in the waiver dies.

c. An individual enrolled in the waiver is discharged from all ID Waiver services.

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

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

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

a. The initial comprehensive assessment, subsequent updated assessments, and all Individual Support Plans completed for the individual;

b. All Plans for Support from every provider rendering waiver services to the individual;

c. All supporting documentation related to any change in the Individual Support Plans;

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

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

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

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

1. All assessments and reassessments.

2. All Plans for Support developed for that individual and the written reviews.

3. Documentation of the date services were rendered and the amount and type of services rendered.

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

5. Any documentation to support that services provided are appropriate and necessary to maintain the individual in the home and in the community.

~~c.~~ 6. An individual's case manager shall not be the direct staff person or the immediate supervisor of a staff person who provides ~~MR/ID~~ ID Waiver services for the individual.

~~d. 6.~~ 7. Documentation shall be filed in the individual's record upon the documentation's completion but not later than two weeks from the date of the document's preparation. Documentation for an individual's record shall not be created or modified once a review or audit of that individual enrolled in the waiver has been initiated by either DBHDS or DMAS.