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Proposed Regulation
Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation(s)	12 VAC 30-50-440, 490: CHANGING; 12 VAC 30-50-450 REPEALING; 12 VAC 30-120-700 et seq. REPEALING; 12 VAC 30-120-1000 et seq. REPEALING; 12 VAC 30-120-1500 et seq. REPEALING; Chapter 122: 12 VAC 30-122-10 et seq. ADDING
Regulation title(s)	Case Management; Waiver Services: Individual and Family Developmental Disabilities Support Waiver (Family and Individual Supports); Intellectual Disability Waiver (Community Living); Day Support Waiver for Individuals with Mental Retardation (Building Independence); Community Waiver Services for Individuals with Developmental Disabilities
Action title	Three Waivers Redesign
Date this document prepared	9/6/2017

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 17 (2014) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

Please provide a brief summary (preferably no more than 2 or 3 paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.

This action concerns the redesign of three of DMAS' existing home and community based waivers: Individual and Family Developmental Disabilities Support Waiver (12 VAC 30-120-700 *et seq*.) is changing to the Family and Individual Supports Waiver (FIS); Intellectual Disability Waiver (12 VAC 30-120-1000 *et seq*.) is changing to the Community Living Waiver (CL), and; the Day Support Waiver for Individuals with Mental Retardation (12 VAC 30-120-

1500 *et seq*.) is changing to the Building Independence Waiver (BI). The existing regulations (12 VAC 30-120-700 et seq., 12 VAC 30-120-1000 et seq., and 12 VAC 30-120-1500 et seq.) for these three waivers are being repealed and new combined regulations, located in new Chapter 122 (12 VAC 30-122-10 et seq.) are being promulgated.

This redesign effort, which was a collaboration among DMAS, DBHDS, consultants, and stakeholders, combines the target populations of individuals with intellectual disabilities and other developmental disabilities and offers new services that are designed to promote improved community integration and engagement. This redesign is intended to: (i) better support individuals with disabilities to live integrated and engaged lives in their communities by covering services that promote community integration and engagement; (ii) standardize and simplify access to services; (iii) improve providers' capacity and quality to render covered services; (iv) achieve better outcomes for individuals supported in smaller community settings, and; (v) facilitate meeting the Commonwealth's commitments under the community integration mandate of the American with Disabilities Act (42 USC 12101 *et seq*.), the Supreme Court's *Olmstead* Decision, and the 2012 DOJ Settlement Agreement between the Commonwealth and the U.S. Department of Justice.

Significant input throughout the redesign process has been collected from individuals, their families, affected providers, advocates and other stakeholders as well as national experts. Extensive data has been collected to redesign the current DD waiver system in order to more closely link medical/support needs with expenditures. For individuals with intellectual/developmental disabilities and their families, the system will be accessed via a single local point of entry, the local Community Services Boards/Behavioral Health Authorities (CSB/BHAs).

An expanded array of service options over those currently covered in the existing waivers is recommended to enable individuals with disabilities to successfully live in their communities. New services include: (i) crisis support (including center-based and community-based) services; (ii) shared living supports; (iii) independent living supports; (iv) supported living residential; (v) community engagement supports; (vi) community coaching supports; (vii) community guide supports; (viii) workplace assistance services; (ix) private duty nursing; and (x) electronic home based supports.

Some currently existing services are being modified and one existing service (prevocational services) is being repealed. Current services being retained with modifications include: (i) skilled nursing services; (ii) therapeutic consultation; (iii) personal emergency response systems; (iv) assistive technology; (v) environmental modifications; (vi) personal assistance services; (vii) companion services; (viii) respite services; (ix) group day services; (x) group home services; (xi) sponsored residential services; (xii) individual and family caregiver training; (xiii) supported living; (xiv) supported employment; (xv) transition services, and; (xvi) services facilitation.

DMAS and DBHDS recommend retaining the consumer-direction model of service delivery for personal assistance, companion, and respite services as currently permitted with no further expansion of this model to any of the other existing or new services.

Information gathered via the three-part Virginia Individual Developmental Disabilities Eligibility Survey (VIDES) and the Virginia Supplemental Questions plus financial eligibility determination, will be combined with the Supports Intensity Scale® (SIS®) service needs assessment instrument through the person centered planning process to develop each individual's unique Individual Service Plan. Both the SIS® and the VIDES provide for age-appropriate individual data gathering.

In certain services, seven levels of supports will be established for the purpose of creating the most equitable distribution of funding for core waiver services. Common definitions of intellectual disability and developmental disability are recommended. Standards for a uniform waiting list are also recommended as well as criteria for how individuals on the waiting list will be provided their choice of available services. Since these three waivers' target populations are being merged under the single definition of developmental disability, the regulations' individual eligibility sections are also being merged into a single set of regulations at 12 VAC 30-122-30, -122-50, and -122-60.

DMAS' current case management regulations (12 VAC 30-50-440, 12 VAC 30-50-450 and 12 VAC 30-50-490) are being repealed and replaced with updated case management regulations to be located at 12 VAC 30-50-455.

DMAS' longstanding regulations titled 'Criteria for care in facilities for mentally retarded persons' (12 VAC 30-60-360) was renamed as 'Criteria for care in facilities for individuals with developmental disabilities' in the emergency regulation stage. One phrase was removed from this regulation ('or waivered rehabilitative services for the mentally retarded' (12 VAC 30-60-360 B)).

During the course of developing these proposed stage regulations, DMAS and DBHDS determined that the Level of Functioning (LOF) criteria set out in 12 VAC 30-60-360 for institutional (ICF/IID) placement should be replaced with the criteria contained in the Virginia Individual Developmental Disabilities Eligibility Survey (VIDES) form. Replacing the current, but outdated, criteria for institutional placement with the new VIDES criteria re-establishes the same applied criteria for both community and institutional placements without making a substantive difference in the numbers of individuals meeting the criteria. This change is being recommended via a separate free-standing regulatory action and therefore, 12 VAC 30-60-360 has been removed from this proposed stage.

The issue of there not being enough emergency and reserve slots for this waiver cannot be resolved by DMAS in this rule making action. The adequacy of the number of slots depends on appropriations from the General Assembly. The agency requests additional waiver slots in each budget cycle and the General Assembly funds them as it determines to be appropriate.

Legal basis

Please identify the (1) the agency (includes any type of promulgating entity) and (2) the state and/or federal legal authority for the proposed regulatory action, including the most relevant citations to the Code of Virginia or General Assembly chapter number(s), if applicable. Your citation should include a specific

provision, if any, authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

The *Code of Virginia* (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The *Code of Virginia* (1950) as amended, § 32.1-324, authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Medicaid authority as established by § 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services.

The *2016 Acts of the Assembly, Chapter 780, Item 306 CCCC and 2017 Acts of the Assembly, Chapter 836, Item 306 CCCC* also directed: "1. The Department of Medical Assistance Services shall adjust the rates and add new services in accordance with the recommendations of the provider rate study and the published formula for determining the SIS® levels and tiers developed as part of the redesign of the Individual and Family Developmental Disabilities Support (DD), Day Support (DS), and Intellectual Disability (ID) Waivers. The department shall have the authority to adjust provider rates and units, effective July 1, 2016, in accordance with those recommendations with the exception that no rate changes for Sponsored Residential services shall take effect until January 1, 2017. The rate increase for skilled nursing services shall be 25 percent."

"2. The Department of Medical Assistance Services shall have the authority to amend the Individual and Family Developmental Disabilities Support (DD), Day Support (DS), and Intellectual Disability (ID) Waivers, to initiate the following new waiver services effective July 1, 2016: Shared Living Residential, Supported Living Residential, Independent Living Residential, Community Engagement, Community Coaching, Workplace Assistance Services, Private Duty Nursing Services, Crisis Support Services, Community Based Crisis Supports, Center-based Crisis Supports, and Electronic Based Home Supports; and the following new waiver services effective July 1, 2017: Community Guide and Peer Support Services, Benefits Planning, and Non-medical Transportation. The rates and units for these new services shall be established consistent with recommendations of the provider rate study and the published formula for determining the SIS levels and tiers developed as part of the waiver redesign, with the exception that private duty nursing rates shall be equal to the rates for private duty nursing services in the Assistive Technology Waiver and the EPSDT program. The implementation of these changes shall be developed in partnership with the Department of Behavioral Health and Developmental Services."

"3. Out of this appropriation, $328,452 the first year and $656,903 the second year from the general fund and $328,452 the first year and $656,903 the second year from nongeneral funds shall be provided for a Northern Virginia rate differential in the family home payment for Sponsored Residential services. Effective January 1, 2017, the rates for Sponsored Residential services in the Intellectual Disability waiver shall include in the rate methodology a higher differential of 24.5 percent for Northern Virginia providers in the family home payment as compared to the rest-of-state rate. The Department of Medical Assistance Services and the Department of Behavioral Health and Developmental Services shall, in collaboration with sponsored residential providers and family home providers, collect information and feedback

related to payments to family homes and the extent to which changes in rates have impacted payments to the family homes statewide."

"4. For any state plan amendments or waiver changes to effectuate the provisions of paragraphs CCCC 1 and CCCC 2 above, the Department of Medical Assistance Services shall provide, prior to submission to the Centers for Medicare and Medicaid Services, notice to the Chairmen of the House Appropriations and Senate Finance Committees, and post such changes and make them easily accessible on the department's website."

"5. The department shall have the authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such changes."

Purpose

Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Describe the specific reasons the regulation is essential to protect the health, safety or welfare of citizens. Discuss the goals of the proposal and the problems the proposal is intended to solve.

The purposes of this action are to: (i) better support individuals with developmental disabilities to live integrated and engaged lives in their communities by covering services that promote community integration and engagement; (ii) standardize and simplify access to services; (iii) improve providers' capacity and quality to render covered services; (iv) achieve positive outcomes for individuals supported in smaller community settings, and; (v) facilitate meeting the Commonwealth's commitments under the community integration mandate of the American with Disabilities Act (42 USC § 12101 *et seq*.), the Supreme Court's *Olmstead* Decision, and the 2012 DOJ Settlement Agreement.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of changes" section below.

The regulations that are affected by this action are: Case Management (12 VAC 30-50-440; 12 VAC 30-50-450; 12 VAC 30-50-490 are repealed; 12 VAC 30-50-455 is added); the Individual and Family Developmental Disabilities Waiver (12 VAC 30-120-700 *et seq*. are repealed); the Intellectual Disability Waiver (12 VAC 30-120-1000 *et seq*. are repealed), and; the Day Support Waiver for Individuals with Mental Retardation (12 VAC 30-1500 *et seq*. are repealed). Chapter 122, Community Waiver Services for Individuals with Developmental Disabilities, is being added.

CURRENT POLICY

Individual and Family Developmental Disabilities Support (DD) Waiver

This waiver was originally developed in 2000 to serve the needs of individuals and their families, who require the level of care provided in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) (formerly Intermediate Care Facilities for the Mentally Retarded (ICF/MR)). Such individuals must be older than six years of age and have diagnoses of either autism or severe chronic disabilities identified in 42 CFR 435.1009 (cerebral palsy or epilepsy, any other condition (other than mental illness) that impairs general intellectual functioning, manifests itself prior to the individual's 22nd birthday, is expected to continue indefinitely, and results in substantial limitation of three or more areas of major life activity (self-care, language, learning, mobility, self-direction, independent living). The originally covered services were: (i) in-home residential support; (ii) day support; (iii) prevocational services; (iv) supported employment services; (v) therapeutic consultation; (vi) environmental modifications; (vii) skilled nursing; (viii) assistive technology; (ix) crisis stabilization; (x) personal care and respite (both agency directed and consumer directed); (xi) family/caregiver training; (xii) personal emergency response systems, and; (xiii) companion services (both agency directed and consumer directed).

In SFY 2015, this waiver served 913 individuals/families with expenditures of: $28,747,525. Non-waiver acute care costs for these individuals totaled $9,388,868 for the same time period.

Intellectual Disabilities (ID) Waiver

This waiver was originally developed in 1991 to serve the needs of individuals and their families, who are determined to require the level of care in an ICF/IID. Such individuals must have a diagnosis of intellectual disability or if younger than six years old, be at developmental risk of significant limitations in major life activities. The services covered in ID are: (i) assistive technology; (ii) companion services (both agency-directed and consumer-directed); (iii) crisis stabilization; (iv) day support; (v) environmental modifications; (vi) personal assistance and respite (both agency-directed and consumer-directed); (vii) personal emergency response systems; (viii) prevocational services; (ix) residential support services; (x) services facilitation (only for consumer-directed services); (xi) skilled nursing services; (xii) supported employment; (xiii) therapeutic consultation, and; (xiv) transition services.

In SFY 2015, this waiver served 10,174 individuals/families with expenditures of: $693,861,042. Non-waiver acute care costs for these individuals totaled $138,928,215 for the same time period.

Day Support (DS) Waiver

This waiver was originally developed in 2005 to serve the needs of individuals, along with their families, who have an intellectual disability and have been determined to require the level of care in an ICF/IID. This waiver was developed to address the overwhelming service demands of this population of individuals in the Commonwealth, because the ID waiver operated at capacity and was not funded for the higher numbers of individuals who required the covered services. This waiver was intended to be temporary measure while the individuals on the waiting list waited for an opening in the ID waiver. The services covered in DS are: (i) day support; (ii) prevocational services, and; (iii) supported employment.

In SFY 2015, this waiver served 271 individuals/families with expenditures of: $3,806,006. Non-waiver acute care costs for these individuals totaled $3,103,295 for the same time period.

ISSUES

The Commonwealth's three waivers have not been substantially updated in recent years. DMAS and DBHDS have undertaken this waiver redesign in consideration of recent federal policy changes to ensure that Virginia's system of services and supports fully embraces community inclusion and full community access for individuals who have disabilities. This redesign effort is important to:

Provide community-based services for individuals with significant medical and behavioral support needs;

Expand opportunities that promote smaller, more integrated independent living options with needed supports; and,

Enable providers to adapt their service provision and business model to support the values and expectations of the federally required community integration mandate.

Comply with DOJ Settlement Agreement elements requiring expansion of integrated residential/day services and employment options for persons with I/DD;

In Virginia, funding and payment for services are broadly related to individual support needs. DMAS has found that differing expenditures have become associated with people who have similar needs. Currently, an individual's level of need for resources and supports is often not correlated to waiver expenditures. Over time, DMAS and DBHDS expect that better correlating individuals' support levels with the costs of their needs will enable the Commonwealth to more precisely predict costs, thereby leading to improved budgeting, which is expected to enable serving more individuals within current appropriations.

RECOMMENDATIONS

DMAS and DBHDS recommend amending the three existing waivers into three distinct waivers that will support all individuals who are eligible and have a developmental disability by:

Integrating individuals with developmental disabilities into their communities by providing needed supports and resources
Standardizing and simplifying access to services
Offering services that promote community integration and engagement
Improving providers' capacities and quality by increasing reimbursements as quality improves and

Aligning this waiver redesign with recent research about supporting such individuals in smaller communities in order to achieve better outcomes.

Creating a statewide waiting list which DBHDS will maintain to replace multiple current waiting lists. Individuals will be ranked by priority based on the degree of jeopardy to their health and safety due to their unpaid caregivers' circumstances. Individuals and family/caregivers will have appeal rights for the priority assignment process but not the actual slot allocation determination.

DMAS and DBHDS believe that a combination of information gained via the application of the three part VIDES evaluation plus the individual's diagnosis with his financial eligibility determination establishes the best results to determine access to waiver services or, in the absence of a slot, a position on the waiver waiting list. Once determined eligible, the individual undergoes assessments via the Supports Intensity Scale (SIS®) and the Virginia Supplemental Questions to establish service needs that are then reflected in the Individual Support Plan.

DMAS and DBHDS believe that these recommendations will enable the Commonwealth to meet its obligations under the community integration mandate of the ADA, the Supreme Court's *Olmstead* Decision, and the 2012 Settlement Agreement with the U.S. Department of Justice.

Family and Individual Supports (FIS) Waiver (formerly the DD Waiver)

This amended waiver will continue to support individuals with disabilities who are living with their families, friends, or in their own residences. It will support individuals who have some medical or behavioral needs and will be open to children and adults. The following services will be added: (i) shared living; (ii) supported living residential; (iii) community coaching; (iv) community engagement; (v) workplace assistance services; (vi) private duty nursing; (vii) crisis support services; (viii) community-based crisis supports; (ix) center-based crisis supports; (x) electronic home based supports. (see 12 VAC 30-122-1020)

Community Living Waiver (formerly the ID Waiver)

This amended waiver will remain a comprehensive waiver that includes 24/7 residential support services for those who require this level of support. It will be open to children and adults with developmental disabilities who may require intense medical and/or behavioral supports. The following services will be added: (i) crisis support services; (ii) supported living residential; (iii) shared living; (iv) electronic home based support; (v) community engagement; (vi) community coaching; (vii) community- based and center-based crisis supports; (viii) individual and family/caregiver training; (ix) private duty nursing; and (x) workplace assistance services. (see 12 VAC 30-122-1030)

Building Independence Waiver (formerly DS Waiver)

This amended waiver will support adults (18 years of age and older) who are able to live in their communities and control their own living arrangements with minimal supports. The following services will be added: (i) assistive technology; (ii) community- and center-based crisis supports; (iii) environmental modifications; (iv) Personal Emergency Response Systems and electronic

home based supports; (v) transition services; (vi) shared living; (vii) independent living supports; (viii) community engagement; (ix) community coaching services. (see 12 VAC 30-122-1040)

Currently provided prevocational services (defined as preparing an individual for paid/unpaid employment such as accepting supervision, attendance, task completion, problem solving, and safety) is recommended for discontinuation as part of this redesign action.

A number of public comments were received during the comment period for the Notice of Intended Regulatory Action about the organizational structure of the emergency regulations, such as: (i) regulations need to be easy to understand for self-advocates; (ii) make regulations user friendly and easy to read; (iii) put regs in 'a, b, c' order; (iv) sections that mandate specific procedures that are sequential should be organized to follow the natural sequence; (v) combine the three sets of waiver regulations into one set to avoid significant cross referencing.

DMAS is repealing the three separate sets of waiver regulations and is promulgating a single set of regulations for the DD Waiver program. The single set of regulations, to be located in a new Chapter 122, are organized into sections of general information that apply across all DD programs followed by specific sections for each covered service.

The general information (Part I) includes topics such as definitions, waiver populations, covered services, aggregate cost effectiveness, individual costs, criteria for individuals, financial eligibility standards, assessment and enrollment, VIDES and SIS® requirements, waiting list priorities, slot assignment, provider enrollment, requirements, and termination, requirements for consumer-directed services and voluntary/involuntary disenrollment from consumer-directed services, professional competency requirements, Individual Support Plans, appeals, payment for covered services, and utilization review.

Following the general sections that apply across all three programs, Part II lists each covered service in its own section and contains: (i) service description; (ii) criteria and allowed activities; (iii) service units and limits; (iv) provider qualifications and requirements, and; (v) service documentation requirements.

DMAS relies on its regulations for legal support in appeals and lawsuits. Making regulations 'user friendly' and 'easy to read for self advocates' can conflict with this agency requirement. In the alternative, DMAS and DBHDS has published, and will continue to do so, various manuals and guidance materials to more appropriately satisfy this information need in the disability community.

Issues

Please identify the issues associated with the proposed regulatory action, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, please indicate.

The Commonwealth's three waivers have not been substantially updated in recent years. DMAS and DBHDS have undertaken this waiver redesign in consideration of recent federal policy changes to ensure that Virginia's system of services and supports fully embraces community inclusion and full access for individuals who have disabilities. This redesign effort is important to:

Provide community-based services for individuals with significant medical and behavioral support needs;

Expand opportunities that promote smaller, more integrated independent living options with needed supports; and,

Enable providers to adapt their service provision and business model to support the values and expectations of the federally required community integration mandate.

Comply with Settlement Agreement elements requiring expansion of integrated residential/day services and employment options for persons with I/DD;

In Virginia, funding and payment for services are only broadly related to individual support needs. DMAS has found that differing expenditures have become associated with people who have similar needs. Currently, an individual's level of need for resources and supports is often not correlated to waiver expenditures. Over time, DMAS and DBHDS expect that better correlating individuals' support levels with the costs of their needs will enable the Commonwealth to more precisely predict costs, thereby leading to improved budgeting, which is expected to enable serving more individuals within current appropriations.

Requirements more restrictive than federal

Please identify and describe any requirement of the proposal which is more restrictive than applicable federal requirements. Include a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.

There are no requirements more restrictive than existing federal requirements deriving from the approved waivers and the DOJ settlement.

Localities particularly affected

Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

No localities are uniquely affected by this regulatory action as it applies statewide.

Public participation

Please include a statement that in addition to any other comments on the proposal, the agency is seeking comments on the costs and benefits of the proposal and the impacts of the regulated community.

In addition to any other comments, the [insert either: Board or agency] is seeking comments on the costs and benefits of the proposal and the potential impacts of this regulatory proposal. Also, the agency/board is seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include 1) projected reporting, recordkeeping and other administrative costs, 2) probable effect of the regulation on affected small businesses, and 3) description of less intrusive or costly alternative methods of achieving the purpose of the regulation.

Anyone wishing to submit written comments for the public comment file may do so by mail, email or fax to Ann Bevan, Director, Division of Developmental Disabilities and Behavioral Health, DMAS, 600 East Broad Street, Suite 1300, Richmond, VA 23219; Ann.Bevan@dmas.virginia.gov ; phone (804) 588-4887; fax (804) 786-1680. Comments may also be submitted through the Public Forum feature of the Virginia Regulatory Town Hall web site at: http://www.townhall.virginia.gov. Written comments must include the name and address of the commenter. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will not be held following the publication of this stage of this regulatory action.

Economic impact

Please identify the anticipated economic impact of the proposed new regulations or amendments to the existing regulation. When describing a particular economic impact, please specify which new requirement or change in requirement creates the anticipated economic impact.

Projected cost to the state to implement and enforce the proposed regulation, including: a) fund source / fund detail; and b) a delineation of one-time versus on-going expenditures	The proposed changes are expected to cost $26,309,320 total funds in state fiscal year 2017 and $46,099,134 in state fiscal year 2018. Impact to the general fund in SFY 2017 is $13,154,660 and impact to non-general funds (Federal funds) is $13,154,660. Impact to the General Fund and to Non-General Funds in SFY 2018 are both expected to be $23,049,567. This will be an ongoing expense and will increase or decrease with changes in waiver.
Projected cost of the new regulations or changes to existing regulations on localities.	16% of the new expenditures are expected to go to Community Service Boards/Behavioral Health Authorities (CSB/BHAs).
Description of the individuals, businesses, or other entities likely to be affected by the new regulations or changes to existing regulations.	16% of the new expenditures will go to CSB/BHAs. The rest will be paid to private providers for their services.
Agency's best estimate of the number of such entities that will be affected. Please include an	In SFY 2016 there were 554 providers of services affected by the rate changes in the regula-

estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	tions. Of them 37 were CSB/BHAs. DMAS does not collect information about the gross annual sales or numbers of employees of these providers but many providers are likely to be small businesses.
All projected costs of the new regulations or changes to existing regulations for affected individuals, businesses, or other entities. Please be specific and include all costs including: a) the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; and b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the proposed regulatory changes or new regulations.	DMAS does not expect any additional administrative costs for the affected providers. The rate methodologies were developed to recognize all provider reasonable costs. Most of the rate methodologies have been fully funded.
Beneficial impact the regulation is designed to produce.	Regulatory revisions have been designed to improve community access for individuals who have developmental disabilities and to facilitate the Commonwealth's compliance with the DOJ Settlement.

Alternatives

Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.

No other alternatives will meet the requirements of the legislative mandate.

Regulatory flexibility analysis

Pursuant to § 2.2-4007.1B of the Code of Virginia, please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.

There are no reporting requirements established for providers by these regulatory changes. Providers are required to maintain documentation adequate to support their claims for services rendered. This is not a new requirement for Medicaid providers but one which has existed since 1970. These regulatory changes do not impose performance standards on small businesses.

DMAS cannot exempt small businesses from these requirements as federal law requires uniform provider requirements as these statewide services. Health care providers are not required to become Medicaid providers but do so voluntarily.

Family Impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

These changes do not strengthen or erode the authority or rights of parents in the education, nurturing, and supervision of their children; nor discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents. They do not strengthen or erode the marital commitment, and are not likely to decrease disposable family income. These revised services may encourage some economic self-sufficiency and the assumption of more responsibility by the individuals who will be served by these improved waiver programs.

Public comment

Please summarize all comments received during the public comment period following the publication of the NOIRA, and provide the agency response.

DMAS' emergency regulations and Notice of Intended Regulatory Action (NOIRA) were submitted on August 24, 2016, to the Registrar of Regulations and published in the September 19, 2016, Virginia Register (VR 33:2). The NOIRA comment period began on September 19, 2016, and ended on October 24, 2016. Comments were received from the Virginia Association of Centers for Independent Living (VACIL). A summary of the comments received and the agency's responses follows:

Comment Summary	Agency response
General comments	
(i) Include the terms BI, CL, and FIS throughout the regulations as appropriate; (ii) alphabetize services, etc., as much as possible; (iii) where processes are set out, list them in chronological order; (iv) combine the 3 waivers into one set of regulations to avoid the use of cross references.	The terms are defined in the definitions sections of the regulations to ensure that there is consistency in the use of the terms throughout the regulations. The remaining comments and suggestions have already been included in the current approach to the final regulations.

12 AC 30-50-455: Case Management (CM)	
(i) 'Collateral contacts' is awkward; (ii) support given to the 90-day policy of covering case management prior to discharge from an institution; (iii) limiting case management to only the CSBs/BHAs, as opposed to private organizations, should be evaluated; (iv) need to better describe 'emergency services' that must be covered; (v) specify that local CSBs/ BHAs are responsible for case management for non-Medicaid eligible persons; (vi) persons should not be charged for specified case management functions; (vii) define what is meant by 'program philosophy of developmental disability'; (viii) the hierarchy of choice that an individual must go through before being permitted to choose a private case management organization is unfair; (ix) there is a perception that individuals will have to assert dissatisfaction with the CSB/BHA in order to receive private case management; (x) the hierarchy/intimidation should be removed from the permanent regulations; (xi) individual case managers should not be maintaining records as this is the responsibility of the case management organization; (xii) individuals' documentation should be duplicated between WAMS and the organization's record system; (xiii) the local CSB/BHA should not be supervising contractors' employees; (xiv) the requirement of a list of all available waiver service providers is impractical at this time as one does not exist; (xv) permanent regulation should clarify the responsibility for submitting the DMAS 225 form.	To ensure consistency in case management agencies, only licensed entities are being considered as a provider for the Medicaid service. Private organizations may still provide the service as contracted with the CSBs. Private providers will continue to be required to maintain the case management file as they are the contractor providing the service. CSBs have overall responsibility for the provision and review of services so may likewise have or require the same documentation. Other suggestions will be reviewed and considered during the review process for the permanent regulations.
12 VAC 30-80-110: Reimbursement for CM (i) The difference between payment rates for DD and ID case management require justification; (ii) permanent regulations should provide for 'conflict-free' case management (federal requirements).	The current system with enhancements and changes from the recent regulations is in compliance with the provision of conflict free case management. No changes were made for ID case management and the changes in DD case management have a rate methodology submitted

	with the state plan amendment and approval from CMS.
12 VAC 30-120-500: When 3 Waiver Re-design process was under way, the com-munity and policy makers were assured that the SIS would not be used to determine the level of supports individuals would receive. This still exists in the emergency regulation and needs to be corrected in the permanent regulations.	It was said that it would not solely determine the services received or available to the indiv-idual. The services and hours needed by the individual would also be determined in conjunct-tion with the PCP and other resources. No correction needed although the agencies will phrase it differently. The SIS produces a level of support index which does determine the tier for reimbursement.
12 VAC 30-120-510: comments were made about the definitions of (i) enroll, (ii) levels of support, (iii) support coordinator/case manager, and (iv) support package.	Suggestions are being reviewed and considered during the review process for the permanent reg-ulations.
12 VAC 30-120-514: (i) Add SF to list of providers not required to maintain certain documentation; (ii) need time by which a CPS search must be completed; (iii) need to change end date of compensation when a complaint is founded; (iv) subsequent CPS issues must be reported to the EOR and fiscal agent; (v) CD employees must consent to criminal background checks and CPS verifications; (vi) individual should have the right to appeal if the case manager fails to act on a request within a reasonable promptness; (vii) documentation requirements apply to service providers including SF; (viii) quarterly ISP updates apply to certain service providers; SF providers are not to supervise CD employees; (ix) requirement for objective written documentation should not apply to roommates in shared living; (xii) objective written documentation should be defined.	The language in this section applicable to SF providers will be clarified in the permanent regulations. Individuals already have the right to appeal (12 VAC 30-110-90) actions not taken with reasonable promptness so that provision is not being repeated here.
12 VAC 30-120-515: (i) Reserved section for support coordinators/case managers is misplaced; (ii) missing form numbers are needed; (iii) permanent regs should provide for the individual's discretion in the	Missing form numbers will be updated or added. Other suggestions will be reviewed and considered during the review process for the final regulations.

professionals that participate in the care plan's development and the process of reviewing the level of care; (iv) support coordinator/case manager should not be the one to determine if services are cost effective; (v) regs should detail the QMR process; costs of participation comment.	
12 VAC 30-120-520: (i) Section should be organized to reflect the order of the process as it occurs; (ii) costs of evaluations should not be the responsibility of the individual; (iii) exception to the waiting list should be included; (iv) CSB/BHA should provide notice of placement on waiting list/priority status/appeal rights and not case manager;(v) VACIL supports the annual contact by the case manager for individuals on the waiting list, however, the individual should not be billed for this and all perception that not paying for case management affects waiting list status or award of waiver slot should be avoided; (vi) all categories of case management should completely and accurately describe what is provided by each and how individuals in both categories are equally and fairly considered for slot assignment; (vii) regulations should set out which waiver an individual will be conserved for; (viii) regulations should have process to inform individual which waiver has a slot available and which waiver the individual will be enrolled in; (ix) individuals should be able to invite other persons to participate in all planning meetings; (x) requirement for a medical exam can be a barrier for some individuals who may not have private health insurance or who have to wait months for an appointment with a Medicaid provider; (xi) a copy of the ISP should be provided to the individual; (xii) regulations should clarify the enrollment process and the agency responsible for the DMAS-225;(xiii) regulations should provide factors that the case manager should consider when determining which provider should collect	DMAS will better organize the flow of information in the section as with changes are developed for the permanent regulations. In relation to the slot assignment equity, DMAS does anticipate more clarification being provided in the regulations related to how CM is provided for the two categories. Individuals, at this time, are considered for the waivers consistent to meet their needs and ensure health and safety. Once the individual is identified as being most in need of a slot by the WSAC and recommendation for slot approved by DBHDS, the individual would have choice of the available waiver slot(s) that is also consistent with supporting their needs. All waiver services require authorization. Other suggestions will be reviewed and considered during the review process for the final regulations.

patient pay amounts; (xiv) patient pay should not be assigned for shared living; (xv) regulations should specify the services that do not require service authorization; (xvi) all 3 waivers have aggregate cost effectiveness so this reference should be removed from individual's ISP being cost effective.	
12 VAC 30-120-530: Regulations should indicate if private case managers will administer the VIDES.	Private case managers will act in accordance with their CSB contracts. All new screenings with the VIDES will be conducted by the CSBs.
12 VAC 30-120-570: Regulations should indicate which services will be associated with tiers.	DMAS will include in the permanent regulations where pertinent by service.
12 VAC 30-120-580: (i) Add 'currently' to qualify abilities of caregivers; (ii) regulations should require 3 times for priority level to be given to individual; (iii) regulations should provide process for individual to request reconsideration of priority level; (iv) regulations should provide for process for informed notice to individuals about priority levels, emergency slots and reserve slots; (v) regulations should provide that individuals be notified when their case is being submitted to waiver assignment committee for consideration; (vi) regulations should state how those individuals determined to be most in need are determined; (vii) to ensure impartiality, the CSB/BHA should not be the entity to make the final determination for slot allocation; (viii) regulations should clarify the source of emergency slots set aside for individuals newly known as needing supports; (ix) DBHDS should be required to advise individuals in writing about their placement on the reserve chronological list and individuals should be able to request their placement in the list; (x) DBHDS should be required to maintain a current waiting list, to be updated at least annually, of persons residing in VA who are waiting for waiver services.	DBHDS determines those individuals that will receive a slot based on recommendations from the WSAC. Clarification will be made for the source and use of emergency slots. The chronological waiting list no longer exists however the consolidated waiting list is maintained by DBHDS with input from the CSBs and updated as CSBs review individuals' current situations and find it necessary to modify previous status. Individuals' status is generally reviewed one time per year but could change more frequently if individuals change their status through communication with the case manager or the case manager determines reassessments are needed during their contacts with individuals. Individuals determined to be most in need are determined so through their priority levels. Other suggestions will be reviewed and considered during the review process for the final regulations.

12 VAC 30-120-700: (i) The definitions across all 3 waivers should be similar; (ii) definition of 'home' allows an individual to live in a residence that is offering sponsored residential services to other persons and the FIS waiver individual would not receive the sponsored residential services but would use the FIS companion, personal, and in-home supports. This should be continued.	DMAS will review for discrepancies in the use of the term and include changes as necessary in final regulations
12 VAC 30-120-710: Subsection D is misplaced.	All previous VAC sections and subsections are being reviewed and reordered within the planned newly recreated VAC Chapter.
12 VAC 30-120-735: Subsection B is inappropriate and does not allow for the individual to refuse services.	DMAS will review the recommendation for the final regulations.
12 VAC 30-120-759: (i) Duplicative of section 770, need to combine; (ii) the 30-60-90 day requirements not included; (iii) quarterly/90-day monitoring not required to be face-to-face; (iv) the SF should also be the case manager/ support coordinator; (v) should state via the DMAS-95 Addendum form that individual can be EOR;(vi) item does not accurately reflect the SF requirements that were previously established.	Permanent regulations will reflect current emergency regulations for services facilitation effective 1/11/16. DMAS will clarify that a SF may also serve as an individual's case manager/support coordinator. DMAS-95 Addendum will be added to the policy manual.
12 VAC 30-120-770: (i) Requirement that individual must receive services from SF conflicts with other regulation provisions; (ii) SF being provided on an 'as needed basis' conflicts with SF services being provided at specific times and situations; (iii) canceling CD services with no use after 60 days is a problem for individuals who only need it occasionally or on school breaks; (iv) the DMAS-225 form is not needed by the SF and should not be required to be part of the SF record;	DMAS will clarify that SF services may be chosen as a service option. Language will be clarified to indicate services shall be provided as needed in addition to basic service requirements. Clarification will be made to exclude the cancellation of CD services when they are only needed occasionally.
12 VAC 30-120-779: Regulations define family as someone who is not compensated	DMAS is unsure that this is an accurate interpretation of the regulation but will consider

which prevents a family member acting as a CD staff from benefiting from family/caregiver training services.	this issue in the permanent regulation action and make appropriate adjustments.
12 VAC 30-120-582: EHBS, AT and EM limits will be established on a calendar year. Previously this was on the individuals' service plan year. Guidance needs to be provided as to how handle the transition from service plan year to calendar year.	Limits will remain as a calendar year however, consideration will be given to including guidance related to transition in the provider manual
12 VAC 30-120-1000: Comments were made on various terms: (i) direct support professional, (ii) IADLs, parent, (iii) PERS, (iv) plan for supports, (v)qualified developmental disabilities professional, (vi)respite services, (vii) risk assessment.	Plans for support will be required for all waiver services including AT, PERS, EM, etc. Those plans maybe different than traditional plans provided for other services but it is important to capture and recognize the services being provided to the individual. Changes to the definition of QDDP are being considered for the final regulations as well as a Medicaid Memo prior to that time. The intent of respite services is to offer support to caregivers providing ongoing care to an individual in their home. If an individual presents with a support need, this should be addressed through other support services in their plans for support or with the addition of a new service that could support them appropriately. Other suggestions will be reviewed and considered during the review process for the final regulations.
12 VAC 30-120-1005: Reserved section C is misplaced.	All previous VAC sections and subsections are being reviewed and reordered within the planned newly recreated VAC Chapter.
12 VAC 30-120-1021: Guidance needs to be provided on how AT will change from plan year to calendar year for $5,000 expenditure limit.	Limits will remain as a calendar year however, consideration will be given to including guidance related to transition in the provider manual
12 VAC 30-120-1023: Final regulations should be expanded to clarify that residential support services are not the only services that can be coupled with companion services.	In DMAS' current approach to the final regulations, consideration is being made to include the delineation of services that are compatible or incompatible with other services
12 VAC 30-120-1024: Final regulations	Further consideration will be made regarding this

need to reference REACH services.	request. During the emergency regulatory stage, this was considered but not added to ensure that it was not perceived as only being available in the REACH program.
12 VAC 30-120-1025: Guidance needs to be provided on how EM will change from plan year to calendar year for $5,000 expenditure limit.	Limits will remain as a calendar year however, consideration will be given to including guidance related to transition in the provider manual
12 VAC 30-120-1029: Personal assistance indicates that it includes monitoring of self administration of medication. This needs to be modified to permit an assistant to physically place a medication in the individual's mouth when the individual is not capable of doing so himself. The permanent regulation needs to permit individuals to have consumer-directed services performed as permitted by COV §54.1-2901.	DMAS will review and modify the language if determined to be appropriate.

In November 2016 through January 2017 after the close of the NOIRA comment period, DMAS conducted four public forums (Lynchburg, Virginia Beach, Richmond, and Northern Virginia) for the purpose of meeting with and educating community entities (providers, advocacy groups, families, etc.) about DMAS' and DBHDS' efforts to re-design the three home and community based waivers for individuals with intellectual and developmental disability. Even though these public forums were not intended to receive public comments about regulations, a number of comments were received. There was considerable duplication of these comments effects between those received during the NOIRA comment period and at these four public forums. The same agency responses are appropriate for the comments regardless of whether the comments were made during the NOIRA comment period or the public forums.

Detail of changes

*Please list all changes that are being proposed and the consequences of the proposed changes; explain the new requirements and what they mean rather than merely quoting the proposed text of the regulation. If the proposed regulation is a new chapter, describe the intent of the language and the expected impact. Please describe the difference between existing regulation(s) and/or agency practice(s) and what is being proposed in this regulatory action. If the proposed regulation is intended to replace an emergency regulation, please list separately: (1) all differences between the **pre**-emergency regulation and this proposed regulation; and 2) only changes made since the publication of the emergency regulation.*

Changes in Emergency Regulation:

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, rationale, and likely impact of proposed requirements

12 VAC 30-50-440		Case management requirements for individuals with mental retardation.	REPEALING; being replaced with 12 VAC 30-50-455
12 VAC 30-50-450		Case management requirements for individuals with mental retardation and related conditions who participate in waiver.	REPEALING; being replaced with 12 VAC 30-50-455
12 VAC 30-50-490		Case management requirements for individuals with developmental disabilities including autism.	REPEALING; being replaced with 12 VAC 30-50-455
	12 VAC 30-50-455		Case management for individuals with developmental disabilities (DD) target group; statewide coverage; comparability of services waived; definition of services; provider qualifications, provider access without restriction; non-duplication of payments.
12 VAC 30-50-360		Criteria for care in facilities for mentally retarded persons	Phrase linking this regulation to level of functioning for individuals in waiver programs is removed; remaining changes are technical corrections to update a longstanding regulation to Registrar's current formatting and labeling standards.
12 VAC 30-80-110		Payment rates established in 2013 for case management for individuals with developmental disabilities.	Updates to 2016 the date that rates were established for case management for individuals with developmental disabilities.
	12 VAC 30-120-500		Waiver eligibility standards and waiting list requirements. SIS requirements; levels of services; reimbursement tiers established.
	12 VAC 30-120-510		Definition of terms used in this part.
	12 VAC 30-120-514		Provider enrollment, requirements, and termination rules for all waivers.
	12 VAC 30-120-515		Competencies, provider documentation, evaluation of service need, utilization review rules for all waivers.
	12 VAC 30-120-520		Eligibility standards for individuals approved for the FIS, CL, and BI waivers; criteria for services; assessment and enrollment requirements.
	12 VAC 30-120-530		Level of functioning standards for waiver eligibility (VIDES)
	12 VAC 30-120-540		SIS requirements
	12 VAC 30-120-570		Tiers of reimbursement requirements.
	12 VAC 30-120-580		Waiting list priorities; assignment process.
12 VAC 30-120-700		Individual and Family Developmental Disabilities (DD) waiver. Definitions.	Family and Individual Supports (FIS) waiver definitions to be the same as CL waiver and BI waiver where terms overlap.

12 VAC 30-120-710		General coverage and requirements for this waiver; lists covered services in this waiver; eligibility criteria for emergency access to waiver; standard appeal provision.	General coverage and requirements for this waiver; lists new and existing covered services in this waiver; eligibility criteria for access to waiver has been moved to 12 VAC 30-120-500 et seq. regulations; standard appeal provisions.
12 VAC 30-120-720		Qualification and eligibility requirements; intake process	REPEALING; same provisions appear in 12 VAC 30-120-520.
12 VAC 30-120-730		General requirements for participating providers.	REPEALING; same text in 12 VAC 30-120-514 and 515.
	12 VAC 30-120-735		New section for policies for voluntary/ involuntary disenrollment of consumer-directed services. Individual enrolled in waiver to be given choice of agency to provide personal assistance, respite and companion services.
12 VAC 30-120-740		Participation standards for waiver participating providers.	REPEALING; same text in 12 VAC 30-120-514 and 515.
12 VAC 30-120-750		Covered services: in-home residential support; supported living residential; in-home support	In-home support services; supported living residential services to be the same as established in new CL waiver.
12 VAC 30-120-751		Covered services: shared living supports	Covered services: shared living supports to be the same as established in the new CL waiver.
12 VAC 30-120-752		Covered services: day support services	Covered services: day support services to be the same as established in the new CL waiver.
12 VAC 30-120-753		Covered services: prevocational services	REPEALING; service does not meet the current national standards which encourage individuals with disabilities to be gainfully employed.
12 VAC 30-120-754		Covered services: supported employment services and workplace assistance	Covered services: supported employment for individuals or groups and workplace assistance to be the same as established in the new CL waiver.
12 VAC 30-120-755		Covered services: benefits planning	RESERVED for 2017.
12 VAC 30-120-756		Covered services: therapeutic consultation	Covered services: therapeutic consultation to be the same as established in the new CL waiver.
12 VAC 30-120-758		Covered services: environmental modifications	Covered services: environmental modifications to be the same as established in the new CL waiver.
12 VAC 30-120-760		Covered services: skilled nursing and private duty nursing services	Covered services: skilled nursing services and adding private duty nursing services; both to be the same as established in the new CL waiver.
	12 VAC 30-120-761		Covered services: community engagement and coaching to be the same as established in the new CL waiver.

12 VAC 30-120-762		Covered services: assistive technology	Covered services: assistive technology to be the same as established in the new CL waiver.
12 VAC 30-120-764		Covered services: crisis supports; center-based crisis supports; community-based crisis supports	Covered services: crisis supports; center-based crisis supports; community-based crisis supports to be the same as established in the new CL waiver.
12 VAC 30-120-766		Covered services: personal care and respite care	Covered services: personal care, respite care and companion services to be the same as established in the new CL waiver.
12 VAC 30-120-770		Covered services: services facilitation consumer-directed model of service delivery	Covered services: services facilitation to be the same as established in the new CL waiver.
	12 VAC 30-120-773		Covered services: electronic home-based supports to be the same as established in the new CL waiver.
12 VAC 30-120-774		Covered services: personal emergency response system (PERS)	Covered services: PERS to be the same as established in the new CL waiver.
	12 VAC 30-120-775		Covered services: transition services to be the same as established in the new CL waiver.
12 VAC 30-120-776		Covered services: companion services	REPEALING: A new section (777) is created to replace 776.
	12 VAC 30-120-777		Covered services: companion services (both agency and consumer-directed) to be the same as established in the new CL waiver.
	12 VAC 30-120-778		RESERVED: non-medical transportation for 2017.
	12 VAC 30-120-782	Payment for services	Section to be the same as established in the new CL waiver.
12 VAC 30-120-1000		Existing ID waiver definitions.	Waiver definitions for CL waiver to be same as for FIS and BI waivers where terms overlap.
12 VAC 30-120-1005		ID waiver: waiver description and legal authority.	CL waiver description and legal authority updated and unnecessary text removed.
12 VAC 30-120-1010		ID waiver: individual eligibility requirements	REPEALING: individual eligibility requirements moved to 12 VAC 30-120-500 et seq.
	12 VAC 30-120-1019		Covered services: services facilitiation.
12 VAC 30-120-1020		ID waiver: limits on covered services	CL waiver limits on covered services expanded to add new services to existing services; remainder of existing text stricken to move all services into separate sections.
	12 VAC 30-120-1021		CL waiver limits on covered services: assistive technology and benefits planning
	12 VAC 30-120-1022		CL waiver limits on covered services: community engagement, coaching

	12 VAC 30-120-1023		CL waiver limits on covered services: companion services (agency-directed and consumer-directed)
	12 VAC 30-120-1024		CL waiver limits on covered services: crisis support services; center-based crisis supports; community-based crisis supports.
	12 VAC 30-120-1025		CL waiver limits on covered services: electronic home-based supports; environmental modifications.
	12 VAC 30-120-1026		CL waiver limits on covered services: group day services (center-based; community-based)
	12 VAC 30-120-1027		CL waiver limits on covered services: group home residential.
	12 VAC 30-120-1028		CL waiver limits on covered services: individual and family/caregiver training; in-home support.
	12 VAC 30-120-1029		CL waiver limits on covered services: personal assistance services (agency-directed and consumer-directed).
12 VAC 30-120-1030		This section was reserved.	CL waiver limits on covered services: personal emergency response system.
	12 VAC 30-120-1032		CL waiver limits on covered services: respite services (agency-directed and consumer-directed).
	12 VAC 30-120-1033		CL waiver limits on covered services: services facilitation; consumer-directed model
	12 VAC 30-120-1034		CL waiver limits on covered services: shared living
	12 VAC 30-120-1035		CL waiver limits on covered services: supported employment.
	12 VAC 30-120-1036		CL waiver limits on covered services: supported living residential; sponsored residential.
	12 VAC 30-120-1037		CL waiver limits on covered services: therapeutic consultation.
	12 VAC 30-120-1038		CL waiver limits on covered services: transition services.
	12 VAC 30-120-1039		CL waiver limits on covered services: workplace assistance.
12 VAC 30-120-1040		General requirements for participating providers.	REPEALING: covered in 12 VAC 30-120-514 and 515.
	12 VAC 30-120-1059		Provider requirements: services facilitation.
12 VAC 30-120-1060		ID waiver participation standards for provision of services; providers requirements	REPEALING: covered in 12 VAC 30-120-514 and 515.
	12 VAC 30-120-1061		Provider requirements for AT, EHBS, EM, PERS
	12 VAC 30-		Provider requirements for companion,

	120-1062		personal assistance, respite services
	12 VAC 30-120-1063		Prov req'ts for crisis sup serv (crisis stabiliz); center-based crisis sup; community-based crisis sup
	12 VAC 30-120-1064		Prov req's for day sup serv; group home resid; independ liv sup; sponsored residential; sup'd living residential
	12 VAC 30-120-1065		Prov req's for comm'y engagem't; comm'y coaching
	12 VAC 30-120-1066		Prov req's for supported employment (ind & group); workplace assistance
	12 VAC 30-120-1067		Provider req's for skilled nursing and private duty nursing.
	12 VAC 30-120-1068		Provider req's for benefits planning; non-med transport; therapeutic consult; transition services
	12 VAC 30-120-1069		Provider requirements for shared living supports.
12 VAC 30-120-1070		ID waiver: payment for services	Updated to reflect new waiver components.
12 VAC 30-120-1080		ID waiver: utilization review; level of care reviews	REPEALING: covered in 12 VAC 30-120-514 and 515.
12 VAC 30-120-1088		ID waiver: waiver waiting list	REPEALING: covered in 12 VAC 30-120-500 et seq.
12 VAC 30-120-1090		ID waiver: appeals.	Updated terminology.
12 VAC 30-120-1500		Day support waiver: definitions	BI waiver: definitions to be the same as the FIS and CL waivers where terms overlap
12 VAC 30-120-1510		Day support waiver: general coverage and requirements.	BI waiver: general coverage and requirements.
12 VAC 30-120-1520		Day support waiver: individual eligibility requirements	BI waiver: language moved to 12 VAC 30-120-500 et seq. for consistency across all 3 waivers
12 VAC 30-120-1530		Day support waiver: general requirements for waiver providers	REPEALING: covered in 12 VAC 30-120-514 and 515.
12 VAC 30-120-1540		Day support waiver: participation standards for waiver providers	BI waiver: participation standards for waiver providers are updated with current agency names, form numbers.
12 VAC 30-120-1550		Day support waiver: services day support, prevocational and supported employment	REPEALING: new services are set out in following sections
	12 VAC 30-120-1552		BI waiver: covered services; service descriptions.
	12 VAC 30-120-1554		BI waiver: criteria for covered services.
	12 VAC 30-120-1556		BI waiver: types of activities required for covered services
	12 VAC 30-		BI waiver: units and limits for covered

	120-1558		services.
	12 VAC 30-120-1560		BI waiver: service-specific provider requirements
12 VAC 30-120-1580			BI waiver: payments for services

Changes between ER and Proposed Stage:

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, rationale, and likely impact of proposed requirements
12 VAC 30-50-440; 490		For case management services, establishes target group, statewide applicability, definition of services, qualifications of providers, freedom of choice assurance, no duplication of payment from multiple public sources, documentation requirements.	Updated requirements for case management.
12 VAC 30-50-455			Section removed – text incorporated into sections 440 and 490.
12 VAC 30-80-110		Reimbursement for case management services.	Updates the reimbursement methodology language to comport with waiver regulation changes for consistency across several regulations.
12 VAC 30-120-700		Regulations for the existing Individual and Family with Developmental Disabilities (DD) waiver.	Repeal and replace with new Chapter 122
12 VAC 30-120-1000		Regulations for the existing Individuals with Disabilities (ID) waiver.	Repeal and replace with new Chapter 122
12 VAC 30-120-1500		Regulations for the existing Day Support (DS) waiver.	Repeal and replace with new Chapter 122
	12 VAC 30-122-10 through -122-1370		Establishes the new combined DD waiver merging the Family and Individual Support waiver, the Community Living waiver and the Building Independence waiver in the new Chapter 122.