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Final Regulation
Agency Background Document

Agency name	DEPT. OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) Chapter 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
VAC Chapter 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	9/16/2019

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1VAC7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

This action concerns the redesign of three of DMAS' 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 for these three waivers are being repealed and new combined regulations, located in new Chapter 122 (12 VAC 30-122-10 et seq.)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.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

BI = Building Independence Waiver
CL = Community Living Waiver
DBHDS = Department of Behavioral Health and Developmental Services
DMAS = Department of Medical Assistance Services
FIS = Family and Individual Supports Waiver

Statement of Final Agency Action

Provide a statement of the final action taken by the agency including: 1) the date the action was taken; 2) the name of the agency taking the action; and 3) the title of the regulation.

I hereby approve the foregoing Regulatory Review Summary entitled "Three Waivers Redesign" and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012, of the Administrative Process Act.

9/16/2019
Date

/signature/
Jennifer S. Lee, M.D., Director
Dept. of Medical Assistance Services

Mandate and Impetus

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding the mandate for this regulatory change, and any other impetus that specifically prompted its initiation. If there are no changes to previously reported information, include a specific statement to that effect.

The Code of Virginia § 32.1 325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance and to promulgate regulations. The Code of Virginia § 32.1-324, grants the Director of the Department of Medical Assistance Services the authority of the Board when it is not in session.

The *2016 Appropriation Act, Item 306 CCCC and 2017 Appropriation Act, 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."

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter

number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

The Code of Virginia § 32.1 325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance and to promulgate regulations. The Code of Virginia § 32.1-324, grants the Director of the Department of Medical Assistance Services the authority of the Board when it is not in session.

As noted in the previous section, this regulatory action was required by the 2016 Appropriation Act, Item 306 CCCC and the 2017 Appropriation Act, Item 306 CCCC. The 2018 Appropriation Act, Item 303 I 3 states: "Upon approval by the Centers for Medicare and Medicaid Services of the application for renewal of the CL, FIS and BI waivers, expeditious implementation of any revisions shall be deemed an emergency situation pursuant to § 2.2-4002 of the Administrative Process Act. Therefore, to meet this emergency situation, the Department of Medical Assistance Services shall promulgate emergency regulations to implement the provisions of this Act." This language is replicated in the 2019 Appropriation Act, Item 303 I 3.

Purpose

Explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it's intended to solve.

The 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 protects the health, safety, and welfare of individuals with disabilities by making changes 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.

Substance

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.

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).

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.

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.

ISSUES

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.

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.

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.

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.

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 within the DMAS section of the Administrative Code, are organized into sections of general information that apply across all DD programs followed by specific sections for each covered service.

The general information 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 are sections for each covered service that contain: (i) service description; (ii) criteria and allowed activities; (iii) service units and limits; (iv) provider qualifications and requirements, and; (v) service documentation requirements.

Issues

Identify the issues associated with the regulatory change, 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, include a specific statement to that effect.

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. The primary advantages to the public, the Agency, the Commonwealth, and Medicaid members are that the redesign effort will:

- 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;

There are no disadvantages to the public or the Commonwealth as a result of these changes.

Requirements More Restrictive than Federal

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding any requirement of the regulatory change which is more restrictive than applicable federal requirements. If there are no changes to previously reported information, include a specific statement to that effect.

There are no changes to the previously-reported information: there are no requirements in this regulation that are more restrictive than applicable federal requirements.

Agencies, Localities, and Other Entities Particularly Affected

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding any other state agencies, localities, or other entities that are particularly affected by the regulatory change. If there are no changes to previously reported information, include a specific statement to that effect.

There are no changes to the previously-reported information: no localities are particularly affected by this regulatory action as it applies statewide.

Public Comment

Summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency response. Include all comments submitted: including those received on Town Hall, in a public hearing, or submitted directly to the agency. If no comment was received, enter a specific statement to that effect.

Please see Appendix A, pages 33 through 288.

Detail of Changes Made Since the Previous Stage

*List all changes made to the text since the previous stage was published in the Virginia Register of Regulations and the rationale for the changes. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. * Put an asterisk next to any substantive changes.*

Current chapter-	New chapter-section	New requirement from previous stage	Updated new requirement since previous stage	Change, intent, rationale, and likely impact of updated requirements

section number	number, if applicable			
12 VAC 30-50-440			***** A. Updated "state law" to specific Code of Virginia reference. A1. Added VAC reference to define ISP. Billing consistent with ISP. D1. Added VAC and federal citations. D3. Changing developing to identifying. E1. Removing mental illness references. E2e, f, g. Requirements for ISPs, health and safety, federal rules E2j Correction from "intellectual" to "developmental" E3 Correction from "or" to "and" E3a2; E3b5, 6, 7, and 8; c1 F, F1, F2	****** Provides more specific reference. Provides specific VAC reference. Clarifies that billing must be consistent with ISP. Provides specific VAC and federal requirements. Clarifying the requirement. MI references are not applicable to this service. Clarifying requirements. Correction Correction Changes made to reflect current practice and remove outdated language.
12VAC30-50-490			***** A. Reference to "six years of age" is removed and definition is added The order of paragraphs A1 and A2 is switched. A1. Text added relating to individuals meeting criteria.	***** Change in response to public comment – text is out of date. Definition added for clarity. Change in response to comments requesting clarity.

			A2. Three months changed to 90 calendar days. A3. Text added related to pre-discharge services. D. Added "DD waivers" D1 – added link to definition D7 – Language that had been stricken was returned. D8 – renumbered D9 – benefits planning removed. E4e, f, and g Requirements for ISPs, health and safety, federal rules E5, E6 a, b, and c E8 – Three months changed to 90 calendar days. F, F1, 2, and 3	Change in response to comments requesting consistent use of terms. Change in response to comments requesting clarity. Change made for clarity. This element is a required component of the service. This is not a component of the service. Clarifying requirements. Changes made to reflect current practice and remove outdated language. Change in response to comments requesting consistent use of terms. Clarifications and changes to reflect current practice.
12VAC30-122-10			A5 removed C2, 7, 19 – sections are no longer reserved C18 and 25 name updated C6 and 7 – incorrect citations were fixed. E, E1, E3	Unnecessary language removed. Correction. Correction. Clarifications.

12VAC30-122-20			Changes to "assistive technology"	Changes in response to comment for clarity that services are not limited to where individuals live.
			"Back-up plan" added	Definition added for clarity.
			Changes to "barrier crime" and "behavioral health authority:"	Corrections
			"Benefits planning" added	This service is no longer "reserved"
			Changes to "center based crisis support services" and "community based crisis supports"	Clarifications.
			Changes to "community engagement"	Changes in response to comment requesting clarity.
			"Community guide" added	This service is no longer "reserved"
			Changes to "companion services"	Correcting error.
			Changes in "customized rate and "DD Waivers"	Clarifications
			"Electronic visit verification" added	EVV is a new federal requirement.
			"Employment and community transportation" added	Name change for transportation service
			"Employment services organization" added	Term added for clarity.
			Changes to face-to-face visit	Changed to match the term used in the text.
			Changes to "family"	Change in response to comment requesting clarity
			Changes to "general supports"	Clarification of definition

			Changes to "group home residential services"	Updated to include relevant information.
			Changes to "immediate family member"	Broadens definition to cover all services.
			Changes to "ISP"	Removed vague term.
			Added "independent living"	Added for clarity when that term is used.
			Fixed typos in "individual"	
			Changes to "individual's responses to services"; "in home support services"; and "IADLs"	Clarifications
			Citation in "LMHP" changed.	Linked to DMAS definition.
			Added definition for "medically necessary"	Added for clarity when that term is used.
			"Peer mentor supports" added	This service is no longer reserved.
			Change to "personal assistance service"	Clarification requested in comments.
			Changes to "personal assistant"	Clarification requested in comments
			Changes to "positive behavior supports"	Clarification requested in comments
			Changes to "private duty nursing"	Changes made to synchronize with non-waiver services
			Changes to "progress notes"	Change requested in comments
			Changes to "skilled nursing service"	Changes made to synchronize with non-waiver services

			Fixed incorrect references in "support coordinator" Changes in "supported living residential" Added: "tiers of reimbursement", "VIDES", "workplace assistance	Clarification requested in comments To provide clarity on terms used in regulatory text.
12VAC30-122-30			A – added "medically"	Added so that term is consistent throughout.
12VAC30-122-40			B – changes made C	Transition services may be provided within hospitals and other facilities. Also clarification and correction of citation. Clarification
12VAC30-122-50			Changes in paragraphs 1, 2, and 3. Changes in paragraphs 4 and 5.	Changes to clarify role of VIDES. Changes to clarify steps taken after slot assignment
12VAC30-122-60			Changes to B 3 a (1)	Remove bottom limit of 8 hours for employment.
12VAC30-122-70			B2 and D - corrections Edits to F New paragraph I	Corrections Clarifying relationship to 12 VAC 30-122-90 Clarification
12VAC30-122-80			***** New paragraph A, B, C, D, and E Remove F1 and F2 Edits to I and J, J2, J3, K1	***** Changes made in response to public comment.
12VAC30-122-90			***** New paragraph C Paragraphs re-lettered Changes to D, D1a Changes to D1b (1) and (2)	***** Accounts for individuals who accompany a parent or guardian who is deployed. Corrections

			Changes to D1d Changes to E2 and 3, F1c, F2b, G, G1, G1b, G3	Remove primary caregiver as individual who cannot manage the behaviors. Broadens language to include individuals who have expressed a desire to live independently. Changes made in response to public comment
12VAC30-122-100			A - clarification B3 – remove suspend D – corrections, added confidentiality rules F – added to comply with HB925 G - VIDES	Clarification Clarification – there are no appeal rights for suspensions Corrections and clarification For clarification
12 VAC 30-122-110			Changes to first paragraph	Added at request of OAG
12VAC30-122-120			***** New paragraphs 5, 6, and 7 A 8 and 9 A10d – late entries for progress notes clarified New A10e Paragraph A10g Old paragraph 13h moved up to be paragraph 13d A13e and f and A16 A16a and b New paragraphs A 20, 21, and 22	***** Requested by sister agency For clarification For consistency, in response to comments. For consistency across services Attendance log requirements clarified For clarification Updated to match barrier crime requirements Changes requested by sister agency

			Paragraph B Paragraph C Paragraph D	Clarifications Clarifying that "hospitals" includes psychiatric hospitals. Clarifies that services provided during ECOs and TDOs are not covered. Clarifications
12VAC30-122-150			A1 A2a, b, c A2e and f changes	Correction and unnecessary language removed Clarifications Changed to help prevent conflicts of interest
12VAC30-122-160			Changes to 1st paragraph and 2 b, c, d, 3c Paragraph 4 removed	Corrections and clarifications Vague language removed
12VAC30-122-170			***** Changes to A and B, removing B1-B8, removing C, D, E, and F	***** Changes made to match requirements
12VAC30-122-180			***** A, A1, A3 edited, A1d added, B removed, changes to new B1, B2, B4, B5, B6, remove D, changes to new C, C1-4, C7-9	***** Clarifications to DSP competency process, including adding deemed competency, clarification of personnel record documentation, replacing Levels 6 or 7 with Tier 4, and timelines for competency
12VAC30-122-190			A6 and 7 A8 changes B2 changes C1, C2c, C2f changes	Clarifications Clarification that support coordinators provide a copy of ISP. Insert paragraph letters, correction of citation Clarifications
12VAC30-122-200			***** A1 changes	***** Remove max age, clarify for younger than 5

			A2 changes New paragraphs A2d and e A3 and A4 changes B1 and 2 changes Changes to D	Add frequency for 22 and up. Re-letter pargraphs. Clarify for ages 16-21. Clarifications for SIS. Clarifications Clarifications and removal of chart, which had caused confusion Add fall risk and clarify exceptional levels Clarification of supports packages.
12VAC30-122-210			A3 changes A4, A4a, and A4e changes C3 and 4 changes	Clarification and shortened text Clarification on customized rates. Correction
12VAC 30-122-230			C	Language from 12 VAC 30-60-5 copied into this section to make it clear that this language applies to waiver services.
12VAC30-122-240			B2, 7, 14, 15, and 17 changes Changes in C	Corrections Changes requested by OAG
12VAC30-122-250			B2, 7, 13, 16, 17, and 23 changes C	Corrections Clarification
12VAC30-122-260			B2, 7, 16, 17, 22-28 C	Corrections Clarification
12VAC30-122-270			A changes B1 changes C2 changes D4 and D5 changes Renumbering in D E changes	Clarifications Clarification Clarification Removal of redundancy – already stated in C3 and C1 Clarifications
12VAC30-122-280			******	*****

			Benefits planning service text added	This service was implemented in 2018, and public commenters have requested that it be added to regulations.
12VAC30-122-290			A changes D5 and D6 changes E1c changes E2 changes	Correction Clarification of role and training of DSP Clarification – link to 120 Clarification of documentation
12VAC30-122-300			A changes B5 changes C1 changes D changes E1c changes E1 d changes	Clarifications Clarification Clarification Clarification Clarification – link to 120 Removal of redundancy
12VAC30-122-310			B5 changes B6 added D4 changes E1c changes E1e changes E2 changes E2e changes	Clarification Clarification Rewording Clarification – link to 120 Clarification Clarification of documentation Covered in E1e
12VAC30-122-320			B2 changes B2c C3 changes D4 changes E1c changes E1e changes E2 changes	Rewording Clarification Clarification of community settings and groups Rewording Clarification – link to 120. Clarification Clarification of documentation

			E2e changes	Covered in E1e
12VAC30-122-330			***** Community guide service text added	***** This service was implemented in 2018, and public commenters have requested that it be added to regulations.
12VAC30-122-340			A, B2 changes C2, C3, D2 changes D3g, D4b and c changes D4g D5 changes E1c changes E1e changes E1i (5) changes	Clarification Clarification Clarification Clarification about backup plan Rewording Clarification – link to 120 Clarification Covered in E1e
12VAC30-122-350			B1 changes C1 and C1a, b, and c changes D3 changes D4 changes E1e changes E2 changes	Clarification Clarification Correction and clarification Clarification Clarification – link to 120 Clarification of documentation
12VAC30-122-360			B changes C3 changes D changes E1a changes	Clarification Clarification Clarification Clarification
12VAC30-122-370			A changes E1a changes	Clarification Clarification
12VAC30-122-380			B1e changes B1h D5 changes D5 changes	Clarification of allowable activities. Clarification of safety supports Correction

			D6 changes E1b E1c changes E1 e changes	Clarification of documentation Rewording Correction Clarification – link to 120 Clarification
12VAC30-122-390			A changes C3 changes D4 changes D5 changes E1c changes E1e changes	Clarification on number of licensed beds Clarification re: leases Rewording Clarification on documentation Clarification – link to 120 Clarification
12VAC30-122-400			A2 and A3a changes B1 changes C3 changes C4 changes C6a, C7 changes After D4 E1c changes E1e changes E1f and I changes	Clarification Clarification Clarification Clarification Clarification Definition is not needed here Clarification – link to 120 Clarification Clarification
12VAC30-122-410			A changes B4 changes Re-lettering C2 changes C5 changes D3 changes D4 changes	Clarification This is not the only service that provides episodic supports Rewording Clarification re: backup plan Rewording

			E1c changes E1e changes	Clarification on documentation Clarification – link to 120 Clarification
12VAC30-122-420			A changes B1 changes Renumbering D4 changes D5 changes E1c changes E1e changes	Clarifications Clarification Rewording Clarification re: documentation Clarification – link to 120 Clarification
12VAC30-122-430			B2 changes	Clarification – link to 20
12VAC30-122-440			***** Employment and community transportation service text added	***** This service was implemented in 2018, and public commenters have requested that it be added to regulations.
12VAC30-122-450			***** Peer support service text added	***** This service was implemented in 2018, and public commenters have requested that it be added to regulations.
12VAC30-122-460			A1 changes A3 changes B1 changes B4e changes B4g changes B4i C2 C3, C5 changes C7 a and b changes C10 removed	Clarification Clarification re: supported employment Clarification Correction Clarification Clarification re: forms Clarification re: max hours Clarification Clarifications Unnecessary text

			D4b changes D6, D7 D7d1 D8 changes D9 changes E1 changes	Correction Clarification re: backup plan Clarification: service auth Rewording Clarification of requirements Clarification
12VAC30-122-470			E1a changes	Clarification
12VAC30-122-480			A changes B3 changes E1b, d, e, g, i changes	Clarifications re: overlap with other services Clarification re: activities Clarification
12VAC30-122-490			***** A1-3 changes B3 – allowable activities paragraph moved up B5 changes C2, C3 changes, remove C5 D2, D3 changes D4 changes D5, D6 changes D7 changes D9 changes D10 changes D12, D13	***** Clarifications in service description Clarifications on role of parent caregiver Clarification on limits Clarifications Clarifications re: documentation Clarification re: qualifications Clarification re: supervision Clarification re: agency directed services in the home Requirements simplified Clarification re: safety and backup plans

			E2 b and d changes, E3, 4, 5, and H1, H2	Clarifications re: documentation
12VAC30-122-500			Title of section A changes B2 changes B3, B4, B8, C1 changes D2c2, D2d E2	Correction Clarification of which waivers can participate Clarification re: training Clarification Clarification re: background checks Clarification re: documentation
12VAC30-122-510			Title of section and A B1 changes B4a changes B6, E3 changes C2,C5, D3, D4 changes D5 changes E2 and E5 changes	Correction Clarification Added definition Clarification re: roommate Clarification Clarification re: backup Clarifications
12VAC30-122-520			***** A changes B changes C1 changes C4 changes D4 changes E changes	***** Clarification re: hours per week, overlap with private duty nursing Clarification re: allowable activities Clarification re: documentation Removal of EPSDT - doesn't apply here Clarification re: foster care Clarification re: documentation
12VAC30-122-530			D4 changes D5 changes D6 changes	Rewording Clarification re: supervision Clarification re: lease

			E1c changes E1e changes	Clarification – link to 120 Clarification – made similar to other services
12VAC30-122-540			A changes C2 changes D2 and 3 changes D4 changes D5 changes E1c changes	Clarification Already in section 120 Rewording Clarification re: supervision Clarification re: lease Clarification – link to 120
12VAC30-122-550			A changes B2e changes B2i changes C2 and 3 changes C5 a, b, and c D1 changes E1b changes E1c(1) and E1d changes E1e(1) and (2) changes	Correction Clarification re: plan Clarification re: video feed Clarification Clarification of requirements Correction Clarification re: plan for supports Clarification of requirements Clarification of requirements
12VAC30-122-560			B, C, D, and E changes	Corrections
12VAC30-122-570			A2 changes A3 changes D3 changes E1c changes E1d changes	Correction Clarification Rewording Clarification – link to 120 Clarification – made similar to other services

Detail of All Changes Proposed in this Regulatory Action

List all changes proposed in this action and the rationale for the changes. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. <u> Put an asterisk next to any substantive changes</u>.*

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 consulta-tion to be the same as established in the new CL waiver.
12 VAC 30-120-758		Covered services: environ-mental modifications	Covered services: environmental mod-ifications 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 30-120-1062		Provider requirements for companion, 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 30-120-1558		BI waiver: units and limits for covered services.
	12 VAC 30-120-1560		BI waiver: service-specific provider requirements
12 VAC 30-120-1580			BI waiver: payments for services

Changes between Emergency 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.

APPENDIX A – PUBLIC COMMENTS
COMMENTS ARE SHOWN IN ORDER OF REGULATORY SECTIONS

Comments related to Sections 12VAC30-40-450 and 490

No.	Commenter	Comment	Response
2.	Citizen	#3 Support coordination/case management services shall not be provided to the individual by: (i) parents, guardians, spouses, or any family living with the individual, or (ii) parents, guardians, spouses, or any family employed by an organization that provides support coordination/case management for the individual except in cases where the family member was employed by the case management entity prior to implementation of these regulations. - Concern that the final statement in this clause (ii), originally introduced in the emergency regs and redefined here, creates a hardship for the individuals with ID/DD in rural or semi-rural areas with little to no choice of case management providers. In many areas of the state, there may be only one CSB within driving distance. 12VAC30-50-490 also clearly states that individuals with ID/DD have the right to chose their case management provider, but if that individual has a family member who works for the local CSB in any capacity (mental health, early intervention, ID/DD services, etc), the main provider for ID/DD case management is eliminated as a choice for that individual. The initial part of this regulation (i), stating that support coordination should not be provided by family members of an individual, should be sufficient in ensuring authentic and ethical service delivery. - Please consider removing (ii) to ensure that all individuals with ID/DD have sufficient choice in CM regardless of where their family members are employed.	This issue has been addressed between the emergency and proposed stage regulations.

3.	Lucy Beadnell, Virginia Ability Alliance	1. The eligibility criteria listed to receive Support Coordination and other services for individuals with developmental disabilities states the child must be at least six years old. Given that the state has adopted the federal definition of developmental disability, which has no age minimum, the regulations should be adjusted to remove any age minimums for service access. 2. Under the proposed regulations, Community Service Boards (CSBs) are allowed to operate as service providers, even in cases when families have no choice but to select a CSB Support Coordinator. There is a clear conflict of interest if the person responsible for helping to evaluate and select service providers is also a provider. Recognizing that some areas have a dearth of service providers, we suggest a phase out period during which CSBs should step away from the direct provision of DD Waiver services and/or a move that would prohibit CSB Support Coordination if the CSB was also the Service Coordinator. 3. Early presentations on the redesign stated that a 10 day grace period would be offered for in-person visits, including Support Coordinators and Service Facilitators. That grace period is critical. There are times when a family experiences an emergency, weather intervenes, or a Support Coordinator must manage a crisis and a visit must be rescheduled. The 10 day grace period allows for those visits to be rescheduled without undue stress and burden on individuals and their support team. The grace period should only be used as needed and should include written justification for its usage. 4. Currently, if an individual moves from one CSB to another part of the state and begins to receive Support Coordination from their new CSB, their original Support Coordinator must continue to provide face to face visits until the individual stabilizes. Given the size of the state, in some cases this means Support Coordinators are spending more than a full day a month driving to do a single visit, sometimes for months on end. Additionally, for an individual moving a significant distance, a Support Coordination who is based near their old home cannot be available in person for crises and will be without a known network of support providers. The regulations should be adjusted to allow EITHER an immediate transfer from one Support Coordinator to another when an individual moves more than 100 miles (or equivalent distance in time) OR technology-based visits until such transfer can occur.	1. Already addressed. 2. CMS has reviewed and approved our state plan, and has not identified a conflict of interest. CSBs have firewalls in place to prevent conflicts of interest. 3. This will be addressed in the manual. 4. There is a transition protocol in place to address these issues.

4.	Harrison-Rockingham CSB/J Malone	For 12VAC30-50-440 E.3. , The qualifications for support coordinators for individuals with Intellectual disability are inconsistent with qualifications for support coordinators for individuals with a Developmental Disability listed in 12VAC30-50-490. E.6	The qualifications are different because there are two different state plan amendments filed with CMS.
5.	Harrison-Rockingham CSB/J Malone	For 12VAC30-50-490 A., This definition of the "Target group" needs to be clarified, as, by itself it does not exclude individuals with Intellectual Disabilities. Additionally, if that is indeed the intended definition, are we to then assume that all sections below 12VAC30-50-490 and up to 12VAC30-122 apply only to individuals without a diagnosis of Intellectual Disability?	Edits made to 12VAC30-50-490 A and A(4).
6.	Harrison-Rockingham CSB/J Malone	For 12VAC30-50-490 A.4, Clarification needed on what constitues a special service need.	Edit made to 12VAC30-50-490 A(4).
7.	MPNN CSB L. McCrobie	1. Qualifications for support coordinators for individuals with Intellectual disability are inconsistent with qualifications for support coordinators for individuals with a Developmental Disability listed in 12VAC30-50-490. E.6 2. There is no mention of requiring a degree to provide services	1. See Line 4. 2. This language must remain consistent with the state plan that is approved by CMS.
8.	MPNN CSB L. McCrobie	Clarification regarding what the expectation is for #2 Negotiating with individuals and service providers & #6 Coordinating the provision of services by diverse public & private providers.	DMAS believes that the language is sufficent.
9.	MPNN CSB L. McCrobie	1. This definition of the "Target group" needs to be clarified, as, by itself it does not exclude individuals with Intellectual Disabilities. Additionally, if that is indeed the intended definition, are we to then assume that all sections below 12VAC30-50-490 and up to 12VAC30-122 apply only to individuals without a diagnosis of Intellectual Disability? 2. Based on the definition, those under the age of 6 are excluded, does this mean those with DD under six cannot receive Waiver/be on Waitlist?	Edits made to 12VAC30-50-490 A. 2. Edits made.
10.	Loudoun CSB L. Snider	Definition of Services Inconsistent with 12VAC30-490D. Why are they different?	There are two different state plan amendments filed with CMS.
11.	Loudoun CSB L. Snider	Qualifications for support coordinators for individuals with Intellectual disability are inconsistent with qualifications for support coordinators for individuals with a Developmental Disability listed in 12VAC30-50-490. E.6 There is no mention of requiring a degree to provide services.	See Line 4.

12.	Loudoun CSB L. Snider	This definition of the "Target group" needs to be clarified, as, by itself it does not exclude individuals with Intellectual Disabilities. Additionally, if that is indeed the intended definition, are we to then assume that all sections below 12VAC30-50-490 and up to 12VAC30-122 apply only to individuals without a diagnosis of Intellectual Disability? Based on the definition, those under the age of 6 are excluded, does this mean those with DD under six cannot receive Waiver/be on Waitlist?	See Line 9.
13.	Loudoun CSB L. Snider	Indicates a Face-to-Face every 3 months; however, 12VAC30-440A.1. indicates Face-to-Face every 90 days. These need use same time frame/language for defining timeframe.	Edits made. Grace period will be addressed in the manual.
14.	Loudoun CSB L. Snider	This section states that individuals will be placed on a waiting list. If the intention is that section 12VAC30-50-490 applies only to Non-ID individuals, then these regulations provide no guidance that individuals with ID can be placed on the waiting list, as there is no corresponding text in 12CAC30-50-440	Add 1st sentence from 490 A2 to 440.
15.	Loudoun CSB L. Snider	States CSBs/BHAs SHALL contract with private support coordinators/case managers. This needs to be changed to MAY contract with private support coordinators/case managers; change to match language in 12VAC30-50-490 E.1. and 12VAC30-50-490 F. 1	This language has been reviewed and approved by CMS in a state plan amendment and cannot be changed at this time.
16.	Loudoun CSB L. Snider	Definition of Services Inconsistent with 12VAC30-440D. Why are they different?	See Line 10.
17.	Loudoun CSB L. Snider	"These sections list restrictions on who can provide support coordination, restrictions that do not appear under the qualification in section 12VAC30-50-440. Are we to assume these restrictions apply only to support coordinators providing services to individuals without an Intellectual Disability? What is meant by otherwise related by business or organization to the direct care staff person in E. 2 iii? This seems very broad and concerning with all DD support coordination being under the CSB. Does this mean if a person has a child needing Waiver services, the person will have to quite their job or refuse to get individual services at the CSB.	There are two different state plan amendments filed with CMS. Edits have been made to allow services to be provided at a CSB if family members work there.
18.	Loudoun CSB L. Snider	This section states that an individual providing support coordination needs to have a degree in human services. As this requirement is listed only under 12VAC30-50-490, and not under 12VAC30-50-440, are we to assume this is a requirement only for individuals providing support coordination for clients without an ID diagnosis?	There are two different state plan amendments filed with CMS.

19.	Loudoun CSB L. Snider	Qualifications for support coordinators for individuals with Intellectual disability are inconsistent with qualifications for support coordinators for individuals with a Developmental Disability listed in 12VAC30-50-440. E.3	There are two different state plan amendments filed with CMS.
20.	Loudoun CSB L. Snider	This section describes supervisory requirement, and there is no corresponding text in 12VAC30-50-440. Are we to assume these supervisory requirements apply only to support coordinators providing services to clients without an ID diagnosis? For E.7. a: please define Human Service Degree.	There are two different state plan amendments filed with CMS. "Human Services" is defined DBHDS licensing regulations and guidance documents.
21.	Loudoun CSB L. Snider	There is no corresponding section in 12VAC30-50-440 requiring one hour of documented supervision every 3 months. Are we to assume this requirement applies only to support coordinators providing services to clients without an ID diagnosis?	There are two different state plan amendments filed with CMS.
22.	Loudoun CSB L. Snider	There is no corresponding section in 12 VAC30-50-440 requiring support coordinators to receive 8 hours of training annually. Are we to assume this requirement applies only to support coordinators providing services to clients without an ID diagnosis?	There are two different state plan amendments filed with CMS.
23.	Dville/Pittvania CSB/S. Craddock	1. Qualifications for support coordinators for individuals with Intellectual disability are inconsistent with qualifications for support coordinators for individuals with a Developmental Disability listed in 12VAC30-50-490. E.6 2. There is no mention of requiring a degree to provide services.	There are two different state plan amendments filed with CMS.
24.	Dville/Pittvania CSB/S. Craddock	This definition of the "Target group" needs to be clarified, as, by itself it does not exclude individuals with Intellectual Disabilities. Additionally, if that is indeed the intended definition, are we to then assume that all sections below 12VAC30-50-490 and up to 12VAC30-122 apply only to individuals without a diagnosis of Intellectual Disability? Based on the definition, those under the age of 6 are excluded, does this mean those with DD under six cannot receive Waiver/be on Waitlist?	See Line 12.
25.	Dville/Pittvania CSB/S. Craddock	Indicates a Face-to-Face every 3 months; however, 12VAC30-440A.1. indicate Face-to-Face every 90 days. These need use same time frame/language for defining timeframe.	See Line 25.
26.	Dville/Pittvania CSB/S. Craddock	Clarification needing regarding what constitutes a special service need.	Edits made.

27.	Dville/Pittvania CSB/S. Craddock	This section states that individuals will be placed on a waiting list. If the intention is that section 12VAC30-50-490 applies only to Non-ID individuals, then these regulations provide no guidance that individuals with ID can be placed on the waiting list, as there is no corresponding text in 12VAC30-50-440	See Line 14.
28.	Dville/Pittvania CSB/S. Craddock	States CSBs/BHAs SHALL contract with private support coordinators/case managers. This needs to be changed to MAY contract with private support coordinators/case managers; change to match language in 12VAC30-50-490 E.1. and 12VAC30-50-490 F. 1	See Line 15.
29.	Dville/Pittvania CSB/S. Craddock	These sections list restrictions on who can provide support coordination, restrictions that do not appear under the qualification in section 12VAC30-50-440. Are we to assume these restrictions apply only to support coordinators providing services to individuals without an Intellectual Disability? What is meant by otherwise related by business or organization to the direct care staff person in E. 2 iii? This seems very broad and concerning with all DD support coordination being under the CSB. Does this mean if a person has a child needing Waiver services, the person will have to quit their job or refuse to get individual services at the CSB because that person is related by business or organization to the support coordinator?	See Line 17.
30.	Dville/Pittvania CSB/S. Craddock	This section states that an individual providing support coordination needs to have a degree in human services. As this requirement is listed only under 12VAC30-50-490, and not under 12VAC30-50-440, are we to assume this is a requirement only for individuals providing support coordination for clients without an ID diagnosis?	There are two different state plan amendments filed with CMS.
31.	Dville/Pittvania CSB/S. Craddock	Qualifications for support coordinators for individuals with Intellectual disability are inconsistent with qualifications for support coordinators for individuals with a Developmental Disability listed in 12VAC30-50-440. E.3	There are two different state plan amendments filed with CMS.
32.	Dville/Pittvania CSB/S. Craddock	This section describes supervisory requirement, and there is no corresponding text in 12VAC30-50-440. Are we to assume these supervisory requirements apply only to support coordinators providing services to clients without an ID diagnosis? For E.7. a: please define Human Service Degree.	There are two different state plan amendments filed with CMS.
33.	Dville/Pittvania CSB/S. Craddock	There is no corresponding section in 12VAC30-50-440 requiring one hour of documented supervision every 3 months. Are we to assume this requirement applies only to support coordinators providing services to clients without an ID diagnosis?	There are two different state plan amendments filed with CMS.

34.	Dville/Pittvania CSB/S. Craddock	There is no corresponding section in 12 VAC30-50-440 requiring support coordinators to receive 8 hours of training annually. Are we to assume this requirement applies only to support coordinators providing services to clients without an ID diagnosis?	There are two different state plan amendments filed with CMS.
35.	Harrison-Rock'ham CSB/ Slaughbaugh	States target group is individuals with Intellectual Disability; however, there is no definition of Intellectual Disability noted in the Regs	Edits made.
36.	Harrison-Rock'ham CSB/ Slaughbaugh	Definition of Services Inconsistent with 12VAC30-490D. Why are they different?	There are two different state plan amendments filed with CMS.
37.	Harrison-Rock'ham CSB/ Slaughbaugh	Qualifications for support coordinators for individuals with Intellectual disability are inconsistent with qualifications for support coordinators for individuals with a Developmental Disability listed in 12VAC30-50-490. E.6 There is no mention of requiring a degree to provide services.	There are two different state plan amendments filed with CMS.
38.	Harrison-Rock'ham CSB/ Slaughbaugh	Clarification regarding what the expectation is for #2 Negotiating with individuals and service providers & #6 Coordinating the provision of services by diverse public & private providers.	See Line 8.
39.	Harrison-Rock'ham CSB/ Slaughbaugh	This definition of the "Target group" needs to be clarified, as, by itself it does not exclude individuals with Intellectual Disabilities. Additionally, if that is intended definition, are we to assume that all sections below 12VAC30-50-490 and up to 12VAC30-122 apply *only* to individuals without a diagnosis of Intellectual Disability? Based on the definition, those under the age of 6 are excluded, does this mean those with DD under six cannot receive Waiver/be on Waitlist?	See Line 12.
40.	Harrison-Rock'ham CSB/ Slaughbaugh	Indicates a Face-to-Face every 3 months; however, 12VAC30-440A.1. indicate Face-to-Face every 90 days. These need use same time frame/language for defining timeframe.	See Line 13.
41.	Harrison-Rock'ham CSB/ Slaughbaugh	States individuals will be placed on waiting list. If the intention is that section 12VAC30-50-490 applies only to Non-ID individuals, then these regulations provide no guidance that individuals with ID can be placed on the waiting list, as there is no corresponding text in 12CAC30-50-440	See Line 14.
42.	Harrison-Rock'ham CSB/ Slaughbaugh	Clarification needing regarding what constitutes a special service need.	See Line 6.
43.	Harrison-Rock'ham CSB/ Slaughbaugh	States CSBs/BHAs *SHALL* contract with private support coordinators/case managers. This needs to be changed to *MAY* contract with private support coordinators/case managers; change to match language in 12VAC30-50-490 E.1. and 12VAC30-50-490 F. 1	See Line 15.

44.	Harrison-Rock'ham CSB/ Slaughbaugh	Definition of Services Inconsistent with 12VAC30-440D. Why are they different?	See Line 10.
45.	Harrison-Rock'ham CSB/ Slaughbaugh	These sections list restrictions on who can provide support coordination, restrictions that do not appear under the qualification in section 12VAC30-50-440. Are we to assume these restrictions apply only to support coordinators providing services to individuals without an Intellectual Disability? What is meant by otherwise related by business or organization to the direct care staff person in E. 2 iii? Seems very broad and concerning with all DD support coordination being under the CSB. Does this mean if a person has a child needing Waiver services, the person will have to quit their job or refuse to get individual services at the CSB.	See Line 17.
46.	Harrison-Rock'ham CSB/ Slaughbaugh	This section states individual providing support coordination needs degree in human services. As this requirement is listed only under 12VAC30-50-490, and not under 12VAC30-50-440, are we to assume this is a requirement only for individuals providing support coordination for clients without an ID diagnosis?	See Line 18.
47.	Harrison-Rock'ham CSB/ Slaughbaugh	Qualifications for support coordinators for individuals with Intellectual disability are inconsistent with qualifications for support coordinators for individuals with a Developmental Disability listed in 12VAC30-50-440. E.3	See Line 4.
48.	Harrison-Rock'ham CSB/ Slaughbaugh	This section describes supervisory requirement, and there is no corresponding text in 12VAC30-50-440. Are we to assume these supervisory requirements apply only to support coordinators providing services to clients without an ID diagnosis? For E.7. a: please define Human Service Degree.	See Line 20.
49.	Harrison-Rock'ham CSB/ Slaughbaugh	There is no corresponding section in 12VAC30-50-440 requiring one hour of documented supervision every 3 months. Are we to assume this requirement applies only to support coordinators providing services to clients without an ID diagnosis?	See Line 21.
50.	Harrison-Rock'ham CSB/ Slaughbaugh	There is no corresponding section in 12 VAC30-50-440 requiring support coordinators to receive 8 hours of training annually. Are we to assume this requirement applies only to support coordinators providing services to clients without an ID diagnosis?	See Line 22.

51.	Henrico Area MHDS	E.3. Leave "The incumbent must have at entry level…." And remove the reference to KSAs must be "documented in the application or supporting documentation or observable and documented during the interview…..". This would require that applicants always come with Virginia Case Management experience and knowledge of resources in the service area. Before assigning a caseload new staff can receive training but this statement requires staff to be already trained prior to hire. F.1. add "available" to "Eligible recipients will have free choice of the (available) providers of support coordination/case management services."	E3. DMAS is not able to make this change at this time. / F1 Edits made.
52.	Henrico Area MHDS	A.1. Why is the face to face requirement changed to every 3 months versus 90 days for people with DD not ID? This also appears to say that there is no basic requirement for significant monthly activity. Does this, then, also apply to people with a DD Waiver? A.4. Clarify what qualifies as an allowable activity. Can on going billing occur if special needs are addressed one by one throughout a year period? D. What is a related condition to a developmental disability? D.7. Why did previous 7 get removed? Is "follow up and monitoring to access ongoing progress and ensure services are delivered" an activity that is not required? E.3. Why limit parents/guardians from providing the service for individuals with DD but not ID. E.5. Why is this also not spelled out in the ID section? 6.a. General comment that KSAs should be the same for ID and DD 7.d. A CM has to have a degree but the person supervising has a lower educational requirement? 8. Why different than ID 9. Why different than ID	A1. See Line 13. / A4. DMAS is not able to make this change at this time. / D.Check SPA. / D7. Edits made. / E3. There are two different State Plan Amendments filed with CMS. / E5. There are two different State Plan Amendments filed with CMS. / 6a There are two different State Plan Amendments filed with CMS. / 7d Educational requirements are balanced with relevant experience.
53.	Blue Ridge Beh Healthcare A. Monti	There is no mention of requiring a degree to provide services. If a degree is required, propose that degree "in human services" be expanded to meet QMHP eligible as defined by the Virginia Board of Counseling (meaning a degree in an unrelated field is acceptable provided there are sufficient human services credits).	Section 6 refers back to Section 5 which requires a degree or RN credentials.
54.	Blue Ridge Beh Healthcare A. Monti	States target group is individuals with Intellectual Disability; however, there is no definition of Intellectual Disability noted in the Regs	See Line 35.
55.	Blue Ridge Beh Healthcare A. Monti	Definition of Services Inconsistent with 12VAC30-490D. Why are they different?	See Line 10.

56.	Blue Ridge Beh Healthcare A. Monti	Qualifications for support coordinators for individuals with Intellectual disability are inconsistent with qualifications for support coordinators for individuals with a Developmental Disability listed in?	See Line 4.
57.	Blue Ridge Beh Healthcare A. Monti	Clarification regarding what the expectation is for #2 Negotiating with individuals and service providers & #6 Coordinating the provision of services by diverse public & private providers.	See Line 8.
58.	Blue Ridge Beh Healthcare A. Monti	This definition of the "Target group" needs to be clarified, as, by itself it does not exclude individuals with Intellectual Disabilities. Additionally, if that is indeed the intended definition, are we to then assume that all sections below 12VAC30-50-490 and up to 12VAC30-122 apply only to individuals without a diagnosis of Intellectual Disability? Based on the definition, those under the age of 6 are excluded, does this mean those with DD under six cannot receive Waiver/be on Waitlist?	See Line 5.
59.	Blue Ridge Beh Healthcare A. Monti	Indicates a Face-to-Face every 3 months; however, 12VAC30-440A.1. indicate Face-to-Face every 90 days. These need use same time frame/language for defining timeframe.	See Line 13.
60.	Blue Ridge Beh Healthcare A. Monti	This section states that individuals will be placed on a waiting list. If the intention is that section 12VAC30-50-490 applies only to Non-ID individuals, then these regulations provide no guidance that individuals with ID can be placed on the waiting list, as there is no corresponding text in 12CAC30-50-440	See Line 14.
61.	Blue Ridge Beh Healthcare A. Monti	Clarification needing regarding what constitutes a special service need.	See Line 6.
62.	Blue Ridge Beh Healthcare A. Monti	States CSBs/BHAs SHALL contract with private support coordinators/case managers. This needs to be changed to MAY contract with private support coordinators/case managers; change to match language in 12VAC30-50-490 E.1. and 12VAC30-50-490 F. 1	See Line 15.
63.	Blue Ridge Beh Healthcare A. Monti	Definition of Services Inconsistent with 12VAC30-440D.	See Line 10.
64.	Blue Ridge Beh Healthcare A. Monti	These sections list restrictions on who can provide support coordination, restrictions that do not appear under the qualification in section 12VAC30-50-440. Are we to assume these restrictions apply only to support coordinators providing services to individuals without an Intellectual Disability? What is meant by otherwise related by business or organization to the direct care staff person in E. 2 iii? This seems very broad and concerning with all DD support coordination being under the CSB. Does this mean if a person has a child	See Line 4. / See Line 3.

		needing Waiver services, the person will have to quite their job or refuse to get individual services at the CSB.	
65.	Blue Ridge Beh Healthcare A. Monti	This section states that an individual providing support coordination needs to have a degree in human services. As this requirement is listed only under 12VAC30-50-490, and not under 12VAC30-50-440, are we to assume this is a requirement only for individuals providing support coordination for clients without an ID diagnosis? Propose that degree "in human services" be expanded to meet QMHP eligible as defined by the Virginia Board of Counseling (meaning a degree in an unrelated field is acceptable provided there are sufficient human services credits).	See Line 18.
66.	Blue Ridge Beh Healthcare A. Monti	Qualifications for support coordinators for individuals with Intellectual disability are inconsistent with qualifications for support coordinators for individuals with a Developmental Disability listed in 12VAC30-50-440. E.3	See Line 4.
67.	Blue Ridge Beh Healthcare A. Monti	This section describes supervisory requirement, and there is no corresponding text in 12VAC30-50-440. Are we to assume these supervisory requirements apply only to support coordinators providing services to clients without an ID diagnosis? For E.7. a: please define Human Service Degree. If a degree is required, propose that degree "in human services" be expanded to meet QMHP eligible as defined by the Virginia Board of Counseling (meaning a degree in an unrelated field is acceptable provided there are sufficient human services credits).	See Line 20.
68.	Blue Ridge Beh Healthcare A. Monti	There is no corresponding section in 12VAC30-50-440 requiring one hour of documented supervision every 3 months. Are we to assume this requirement applies only to support coordinators providing services to clients without an ID diagnosis?	See Line 21.
69.	Blue Ridge Beh Healthcare A. Monti	There is no corresponding section in 12 VAC30-50-440 requiring support coordinators to receive 8 hours of training annually. Are we to assume this requirement applies only to support coordinators providing services to clients without an ID diagnosis? Recommend removing.	See Line 22.
70.	RBHA/M Harrison	Qualifications for support coordinators for individuals with Intellectual disability are inconsistent with qualifications for support coordinators for individuals with a Developmental Disability listed in 12VAC30-50-490. E.6 There is no mention of requiring a degree to provide services.	See Line 4.

71.	RBHA/M Harrison	Clarification regarding what the expectation is for #2 Negotiating with individuals and service providers & #6 Coordinating the provision of services by diverse public & private providers.	See Line 8.
72.	RBHA/M Harrison	This definition of the "Target group" needs to be clarified, as, by itself it does not exclude individuals with Intellectual Disabilities. Additionally, if that is indeed the intended definition, are we to then assume that all sections below 12VAC30-50-490 and up to 12VAC30-122 apply only to individuals without a diagnosis of Intellectual Disability?	See Line 5.
73.	RBHA/M Harrison	Indicates a Face-to-Face every 3 months; however, 12VAC30-440A.1. indicate Face-to-Face every 90 days. These need use same time frame/language for defining timeframe.	See Line 13.
74.	RBHA/M Harrison	This section states that individuals will be placed on a waiting list. If the intention is that section 12VAC30-50-490 applies only to Non-ID individuals, then these regulations provide no guidance that individuals with ID can be placed on the waiting list, as there is no corresponding text in 12CAC30-50-440	See Line 14.
75.	RBHA/M Harrison	States CSBs/BHAs SHALL contract with private support coordinators/case managers. This needs to be changed to MAY contract with private support coordinators/case managers; change to match language in 12VAC30-50-490 E.1. and 12VAC30-50-490 F. 1	See Line 15.
76.	RBHA/M Harrison	Definition of Services Inconsistent with 12VAC30-440D. Why are they different?	See Line 10.
77.	RBHA/M Harrison	These sections list restrictions on who can provide support coordination, restrictions that do not appear under the qualification in section 12VAC30-50-440. Are we to assume these restrictions apply only to support coordinators providing services to individuals without an Intellectual Disability?	See Line 4.
78.	RBHA/M Harrison	This section states that an individual providing support coordination needs to have a degree in human services. As this requirement is listed only under 12VAC30-50-490, and not under 12VAC30-50-440, are we to assume this is a requirement only for individuals providing support coordination for clients without an ID diagnosis?	See Line 18.
79.	RBHA/M Harrison	Qualifications for support coordinators for individuals with Intellectual disability are inconsistent with qualifications for support coordinators for individuals with a Developmental Disability listed in 12VAC30-50-440. E.3	See Line 4.
80.	RBHA/M Harrison	This section describes supervisory requirement, and there is no corresponding text in 12VAC30-50-440. Are we to assume these supervisory requirements apply only to support coordinators providing services to clients without an ID	See Line 20.

		diagnosis? For E.7. a: please define Human Service Degree.	
81.	RBHA/M Harrison	There is no corresponding section in 12VAC30-50-440 requiring one hour of documented supervision every 3 months. Are we to assume this requirement applies only to support coordinators providing services to clients without an ID diagnosis?	See Line 21.
82.	RBHA/M Harrison	There is no corresponding section in 12 VAC30-50-440 requiring support coordinators to receive 8 hours of training annually. Are we to assume this requirement applies only to support coordinators providing services to clients without an ID diagnosis?	See Line 22.
83.	Citizen	Eliminate the term “autism” in the section header. Autism/Autism Spectrum Disorders (ASD) are included in the term developmental disability. A. Eliminate the limitation of case management to individuals who are six years of age and older and who are on the waiting list or receiving services. Since we have moved to a DD Waiver system that does not differentiate based on diagnosis, there should not be an age restriction to the receipt of case management services. This is a remnant from the old IFDDS waiver where children under six were all served through the ID waiver. If individuals under the age of six are not in the target group, then it is unclear how they would gain a slot on the DD Waiver wait list or receive a DD waiver.	Edits made. / See Line 3
84.	VA Board for People with Disabilities	Subsection D: The Board recommends adding a new item at the end of the numbered list that states, “9. Be available to the individual during standard business hours by telephone, and assist the individual upon request.” This language would explicitly state that one of the support coordinator’s responsibilities is to be available to the individual, and is consistent with language used with respect to service facilitators in 12 VAC 30-122-500 B.	DMAS is not able to make this change at this time.
85.	VA Board for People with Disabilities	The Board recommends eliminating the term autism in the section header. Autism/Autism Spectrum Disorders (ASD) are included in the term developmental disability.	See Line 83.
86.	VAIL/G. Brunk	“Target Group. Medicaid eligible individuals who have an intellectual disability as defined in state law.” This should correspond with wording of 12VAC30-50-490 A. “Target Group. Medicaid-eligible individuals with developmental disability or related conditions who are six years of age and older and who are on the waiting list or are receiving services under one of the Developmental Disabilities (DD) Waivers.” Need to include the wording regarding the wait list as	See Line 5.

		well as addressing those age five and younger in 12VAC30-50-440 A	
87.	VAIL/G. Brunk	"at least one face-to-face contact with the individual every 90-days." NOTE: This wording has been removed from 12VAC30-50-490 A.1. but then "Face-to-face contact between the support coordinator/case manager shall occur at least every three months in which there is an activity submitted for billing." The wording and expectations should be the same. NOTE: In 12VAC-30-50-490 A.1., the words "and the individual" need to be added into the sentence so that it reads, "Face-to-face contact between the support/coordinator and the individual shall occur . . . ." Or the sentence should be removed entirely and the section should read exactly as 12VAC-30-50-490 A.1. QUESTIONS: Is the requirement for face-to-face to occur every 90 days or quarterly? Why is the additional wording "in which there is an activity submitted for billing" added to 12VAC30- 50-490 A.1.? - "Billing can be submitted for an active individual only for months in which direct or individualrelated contacts, activity or communications occur." NOTE: This should correspond with the wording of 12VAC30-50-490 A.1. which includes "consistent with the activities in the individual's ISP at the end of that statement	See Line 13.
88.	VAIL/G. Brunk	reads "reimbursement for support coordination/case management shall be limited to thirty days immediately preceding discharge." Where as 12VAC30-50-490 A.3. reads "reimbursement for support coordination/case management services may be billed for no more than two months in a 12-month cycle." These two statements should be the same. Which is correct?	Edits made.
89.	VAIL/G. Brunk	does not include Benefits counseling which is listed under 12VAC30-50-490 D	Benefits counseling removed from 12 VAC 30-50-490.
90.	VAIL/G. Brunk	was removed but is still listed as number 7 under 12VAC30-50-440. – It states "Following up and monitoring to assess ongoing progress and ensure services are delivered;"	This language appears in both 12 VAC 30-50-40 and 30-50-490.
91.	VAIL/G. Brunk	which addresses the waitlist, is not included in 12VAC-30-50-440 and should be included there as well. QUESTIONS: Can individuals be screened for waiver services prior to six years of age and placed on the waitlist? Does an individual have to be re-screened at six years of age to determine which waiver he/she is waiting	See Line 3 and Line 14.

		for and which type of case management he/she is going to receive?	
92.	VAIL/G. Brunk	reads “support coordination” but 12VAC30-50-490 E.3.(2) still reads “service coordination.”	This language appears in both 12 VAC 30-50-40 and 30-50-490.
93.	VAIL/G. Brunk	reads “Different types of assessments and their uses in service planning” but 12VAC30-50-490 E.3.a.(3) reads “Different types of assessments and their uses in determining the specific needs of the individual with respect to his ISP.”	The language is different because there are two different state plan amendments filed with CMS.
94.	VAIL/G. Brunk	reads “Local community resources and service delivery systems, including support services, eligibility criteria and intake process, termination criteria and procedures and generic community resources” but 12VAC30-50-490 E.3.2.(5) reads “Local service delivery systems, including support systems.”	The language is different because there are two different state plan amendments filed with CMS.
95.	VAIL/G. Brunk	“Types of intellectual disability programs and services” but 12VAC30-50-490 E.a.3.(6) reads “Programs and services that support individuals with developmental disabilities.”	One relates to ID case management and the other relates to DD case management.
96.	VAIL/G. Brunk	and 12VAC30-50-490 E. do not correspond. The former does not include the same wording as the latter by not including E.1., E.2., E.5. E.7., E.8., or E.9.	There are two different state plan amendments.
97.	VAIL/G. Brunk	contradicts itself. It states “For these individuals, reimbursement for support coordination/case management shall be limited to thirty days immediately preceding discharge.” But it also states “Support coordination/case management for individuals who reside in an institution may be billed for no more than two predischarge periods within twelve months.” Which statement is accurate? Please clarify.	Edits made.
98.	VAIL/G. Brunk	and 12VAC30-50-490 F. state that individuals are to receive “free choice” of support coordination/case management. - How is choice being ensured and monitored? - 12VAC30-50-490 F.1. allows contracts with private providers but 12VAC-30-50-440 F.1. does not. How is this justified? - If CSBs are contracting with only one private provider and are requiring that individuals must utilize all options of individual case managers within their CSB and then must utilize the other CSB that is contracted before being offered the option of a private provider, how is this considered “free choice”? It is a choice, certainly, but it could be argued that this is not “free choice.” - 12VAC30-50-490 E.1. and	Edits made to reflect that free choice is among available providers.

		12VAC30-50-490 F.1. State that “CSBs/BHAs may contract with private support coordination/case management entities. . . . .” It is our understanding that this is required and should not utilize the word “may” but the word “shall” instead. - 12VAC30-50-490 F.1. also states “If there are no qualified providers in that CSB’s/BHA’s catchment area . . . .” Who determines whether there is a qualified provider?	
99.	VAIL/G. Brunk	states “the provider shall be licensed as a support coordination/case management entity.” Are private support coordination/case management entities to become licensed now? And if so, why are they required to contract with a CSB? Couldn’t they operate independently if licensed?	The provider is the CSB. The CSB has the license. There is no mechanism for private providers to be licensed in this way.
100.	VAIL/G. Brunk	lowers the standard from the current standards, we believe. The current standards require a bachelor’s degree plus two years of experience. Is this intentional? We are in support of this but want to verify that this was the intent. Also, doesn’t E.5. contradict E.6? E.5. spells out a specific education while E.6. simply states that they must have “developmental disability work experience or relevant education”.	E6 states that the requirements of E5 must also be met.
101.	VAIL/G. Brunk	indicates that the supervisor of the support coordinator/case manager can simply have a high school diploma or GED plus experience. Is this accurate? Why are the requirements for supervisors less than support coordinators/case managers?	See Line 20.
102.	VAIL/G. Brunk	says “Individual and Family Developmental Disabilities Support Waiver”. This is not the correct title any longer. And what is it referring to as there is no further text after this title.	This is old regulatory text that is being removed.
103.	VAIL/G. Brunk	When will reserve slots be allotted? What good does having a list of individuals who need to switch waivers if no reserve slots are allotted? Who maintains the list of individuals needing a reserve slot? If reserve slots are not for future planning and only for individuals who currently require a change of waiver, what are these individuals supposed to do to have their needs met in the meantime?	The regulations have a process for the distribution of slots to individuals who need to switch waivers.
104.	Valley CSB T. Martina	states the SC shall not be the direct care staff person. This is in conflict with 12VAC30-122-150 A.2.e. which states the individual SC may also function as the service facilitator. Based on Conflict Free Case Management the SC should not be permitted to serve in this capacity.	A services facilitator is not a DSP.

105.	Valley CSB T. Martina	referencing supervision and training are we to assume that the on hour of documented supervision every 3 months and the 8 hours of annual training only applies to support coordinators providing services to individuals without an ID diagnosis?	See Lines 21 and 22.
106.	Karen Tefelski - vaACCSES	Eliminate the term "autism" in the section header. Autism/Autism Spectrum Disorders (ASD) are included in the term developmental disability. A. Eliminate the limitation of case management to individuals who are six years of age and older and who are on the waiting list or receiving services. Since we have moved to a DD Waiver system that does not differentiate based on diagnosis, there should not be an age restriction to the receipt of case management services. This is a remnant from the old IFDDS waiver where children under six were all served through the ID waiver. If individuals under the age of six are not in the target group, then it is unclear how they would gain a slot on the DD Waiver wait list or receive a DD waiver.	Edits made.
107.	Henrico Area MHDS	E.3. Leave "The incumbent must have at entry level…." And remove the reference to KSAs must be "documented in the application or supporting documentation or observable and documented during the interview…..". This would require that applicants always come with Virginia Case Management experience and knowledge of resources in the service area. Before assigning a caseload new staff can receive training but this statement requires staff to be already trained prior to hire. F.1. add "available" to "Eligible recipients will have free choice of the (available) providers of support coordination/case management services."	E3. DMAS is not able to make this change at this time. / F1 Edits made.
108.	Henrico Area MHDS	A.1. Why is the face to face requirement changed to every 3 months versus 90 days for people with DD not ID? This also appears to say that there is no basic requirement for significant monthly activity. Does this, then, also apply to people with a DD Waiver? A.4. Clarify what qualifies as an allowable activity. Can on going billing occur if special needs are addressed one by one throughout a year period? D. What is a related condition to a developmental disability? D.7. Why did previous 7 get removed? Is "follow up and monitoring to access ongoing progress and ensure services are delivered" an activity that is not required? E.3. Why limit parents/guardians from providing the service for individuals with DD but not ID?	A1. See Line 13. / A4. DMAS is not able to make this change at this time. / D.Check SPA. / D7. Edits made. / E3. There are two different State Plan Amendments filed with CMS. / E5. There are two different State Plan Amendments filed with CMS. / 6a

		E.5. Why is this also not spelled out in the ID section? 6.a. General comment that KSAs should be the same for ID and DD 7.d. A CM has to have a degree but the person supervising has a lower educational requirement? 8. Why different than ID? 9. Why different than ID?	
109.	B Huffman - VersAbility Resources	Eliminate the term "autism" in the section header. Autism/Autism Spectrum Disorders (ASD) are included in the term developmental disability. A. Eliminate the limitation of case management to individuals who are six years of age and older and who are on the waiting list or receiving services. Since we have moved to a DD Waiver system that does not differentiate based on diagnosis, there should not be an age restriction to the receipt of case management services. This is a remnant from the old IFDDS waiver where children under six were all served through the ID waiver. If individuals under the age of six are not in the target group, then it is unclear how they would gain a slot on the DD Waiver wait list or receive a DD waiver.	Edits made.
110.	Elliott/Hanover CSB	Page 1 A Target Group This section relates to individuals with an ID diagnosis and states that services must "include at least one face to face contact with the individual *every 90 days*" This wording is not consistent with Pg 4 Targeted Group – individuals with a DD diagnosis stating a "face to face contact …occurs every three months". This section should state every 90 days with a *10 day grace period.*	See Line 13
111.	Elliott/Hanover CSB	Page 4 Target Group 1 Face to face contacts should state every *90 days with a 10 day grace period.*	See Line 13.
112.	Elliott/Hanover CSB	Page 4 Target Group 2. States that when someone applies for the DD Waiver and there is not slot available he/she will be placed on the waiting list. *There should be a comment that if found eligible or once eligibility is established, will be placed on the waiting list*	Edits made.
113.	Citizen	*C9 Support coordinator shall complete a minimum of 8 hours training annually.* Does this need to be DBHDS training or can it be obtained elsewhere? Needs clarification.	See Line 22.
114.	Citizen	F2 *The individual may have his choice of support coordinator/case manager employed by the CSB or BHA.* This should read that they have their choice of another CM if dissatisfied with services. Being able to hand pick a CM may not be feasible because of caseloads or other circumstances.	See Line 2 and Line 51.

115.	Citizen	C7 *Supervision;* It reads as if the support coordinator needs a degree; however the supervisor is not required to have a degree?	See Line 20.
116.	Citizen	*An active individual….at least one face-to-face contact every 90 days.* Current DMAS regulations allow a 10 day grace period in addition to the 90 days. Suggest continuing with the grace period.	See Line 13.
117.	Citizen	Support Coordination/case management for individuals with developmental disabilities, including autism. • Eliminate the term “autism” in the section header. Autism/Autism Spectrum Disorders (ASD) are included in the term developmental disability. • A. Eliminate the limitation of case management to individuals who are six years of age and older and who are on the waiting list or receiving services. Since we have moved to a DD Waiver system that does not differentiate based on diagnosis, there should not be an age restriction to the receipt of case management services. This is a remnant from the old IFDDS waiver where children under six were all served through the ID waiver. If individuals under the age of six are not in the target group, then it is unclear how they would gain a slot on the DD Waiver wait list or receive a DD waiver.	See Line 83.
118.	Citizen	"These sections list restrictions on who can provide support coordination, restrictions that do not appear under the qualification in section 12VAC30-50-440. Are we to assume these restrictions apply only to support coordinators providing services to individuals without an Intellectual Disability? What is meant by otherwise related by business or organization to the direct care staff person in E. 2 iii? This seems very broad and concerning with all DD support coordination being under the CSB. Does this mean if a person has a child needing Waiver services, the person will have to quit their job or refuse to get individual services at the CSB."	See Line 4. / See Line 17.
119.	H Hines/Reg. 10 CSB	Target Group definition needs to be clarified. DD (no ID Diagnosis) or DD (including ID).	See Line 5.
120.	H Hines/Reg. 10 CSB	Face-to-face every 3 months indicated here; 12 VAC30-50-440 A.1 indicates Face-to-face every 90 days - needs clarification.	See Line 13.
121.	H Hines/Reg. 10 CSB	Qualifications for support coordinators for individuals with Intellectual disability are inconsistent with qualifications for support coordinators for individuals with a Developmental Disability listed in 12VAC30-50-440. E.3 states that an individual providing support coordination needs to have a degree in human services. As this requirement is listed only under 12VAC30-50-490, and not under 12VAC30-50-440, are we to assume this is a requirement only for	See Lines 4 and 18.

		individuals providing support coordination for individuals without an ID diagnosis?	
122.	H Hines/Reg. 10 CSB	This section describes supervisory requirement, and there is no corresponding text in 12VAC30-50-440. Are we to assume these supervisory requirements apply only to support coordinators providing services to clients without an ID diagnosis?	See Line 20.
123.	H Hines/Reg. 10 CSB	There is no corresponding section in 12 VAC30-50-440 requiring support coordinators to receive 8 hours of training annually. Are we to assume this requirement applies only to support coordinators providing services to clients without an ID diagnosis?	See Line 22.
124.	O'Keefe/ESCSB	There are different qualifications for DDCM and IDCM. This needs to be consistent. There is not a difference between DDCM and IDCM - Individuals diagnosed with disabilities are as varied as those without that diagnosis and the supports needed also are varied. Continuing to separate these services is not advantageous to the population we serve. It would make sense for all case management to be considered and named Developmental Services Case Management/Support Coordination with the same rights. Rules and regulations for all individuals under that umbrella.	See Line 4.
125.	Frontier Health K Honeycutt	Eliminate the term “autism” in the section header. Autism/Autism Spectrum Disorders (ASD) are included in the term developmental disability. A. Eliminate the limitation of case management to individuals who are six years of age and older and who are on the waiting list or receiving services. Since we have moved to a DD Waiver system that does not differentiate based on diagnosis, there should not be an age restriction to the receipt of case management services. This is a remnant from the old IFDDS waiver where children under six were all served through the ID waiver. If individuals under the age of six are not in the target group, then it is unclear how they would gain a slot on the DD Waiver wait list or receive a DD waiver.	Edits made.
126.	Wormley, Kerns, Collier, Lester, Hauley - VersAbility Rsc	Eliminate the term “autism” in the section header. Autism/Autism Spectrum Disorders (ASD) are included in the term developmental disability. A. Eliminate the limitation of case management to individuals who are six years of age and older and who are on the waiting list or receiving services. Since we have moved to a DD Waiver system that does not differentiate based on diagnosis, there should not be an age restriction to the receipt of case management services. This is a remnant from the old IFDDS waiver where	Edits made.

		children under six were all served through the ID waiver. If individuals under the age of six are not in the target group, then it is unclear how they would gain a slot on the DD Waiver wait list or receive a DD waiver.	
127.	Johnston/Vector Industries	Eliminate the term "autism" in the section header. Autism/Autism Spectrum Disorders (ASD) are included in the term developmental disability. A. Eliminate the limitation of case management to individuals who are six years of age and older and who are on the waiting list or receiving services. Since we have moved to a DD Waiver system that does not differentiate based on diagnosis, there should not be an age restriction to the receipt of case management services. This is a remnant from the old IFDDS waiver where children under six were all served through the ID waiver. If individuals under the age of six are not in the target group, then it is unclear how they would gain a slot on the DD Waiver wait list or receive a DD waiver.	Edits made.
128.	La Voyce B. Reid/Arlington CSB	Several inconsistencies between Support Coordination requirements and expectations for ID vs. DD with no clear explanation for said differences. We echo the detailed description of the inconsistencies as described by Lisa Snyder (Loudoun County) in an earlier public comment.	There are two different State Plan Amendments.
129.	La Voyce B. Reid/Arlington CSB	An additional discrepancy is added: discharge.	See Line 88.
130.	La Voyce B. Reid/Arlington CSB	For CSBs that hire Master's level Support Coordinators/Case Managers, (to minimize confusion) please clarify that a Master's in a human services field may replace the minimum requirement for a bachelor's degree in a human services field.	This will be clarified in the manual.
131.	La Voyce B. Reid/Arlington CSB	Support clarification that supervision is offered within the employing agency. This is helpful for CSBs that contract with private case management providers.	According to the regulation, supervision is provided within the employing organization.
132.	Fairfax/Falls Ch CSB	12VAC30-50-490 A.I -Indicates a Face-to-Face every 3 months; however, 12VAC30-440A.I. indicate Face-to-Face every 90 days and 12VAC30-122-190 A6 indicates quarterly visit. Please ensure consistency through the document. If a "quarterly" or "3 months" language is used, provide clarification of the term. Early presentation on the new Waiver indicated that a 10 days grace period would be offered for Support Coordinators Face-to-Face visit. The 10 days grace period is crucial in extreme circumstances, e.g. there are times	See Line 13. Edits made on 90 days.

		when a family experience an emergency, or a Support Coordinator must manage a crisis and a planned visit must be rescheduled, illness of the individual etc. The 10 days grace period would allow the face- to -face visit to be rescheduled without the stress on the individuals/families/providers	
133.	Fairfax/Falls Ch CSB	12VAC30-50-490 &12VAC30-50-440. – Inconstancy in qualification and requirements for Support Coordinates for individuals with DD and ID. Clarification is needed whether the same requirements are needed for support coordinators providing services for individuals with ID. The sections differ in the area of supervisory requirement including the frequency of the supervisory, supervisory documentation and training hours.	The differences arose because there are two state plan amendments that were developed at different times. CMS has reviewed and approved these state plan amendments.
134.	Maureen Hollowell, VA Assoc of Centers for Independent Living	12VAC30-50-440. Support coordination/case management for services with intellectual disability; 12VAC30-50-490. Support coordination/case management for individuals with developmental disabilities, including autism - Individuals with developmental disabilities, including individuals with intellectual disabilities, should have access to the same choice of support coordination/case management providers. The historical bifurcation of support coordination/case management is confusing, burdensome and primarily continues because of the significant difference in provider rates between these two services. VACIL recommends that DMAS convene a group of individuals receiving these services, community services boards and providers of private case management organizations to establish a path for combining these services and allow broader choice of case management/support coordination for all individuals with developmental disabilities, including individuals with intellectual disabilities and to resolve existing administrative and fee structure obstacles to permitting choice of providers. 12VAC30-122-10. Purpose: legal authority: covered services: aggregate cost effectiveness: required individual and provider enrollment: individual costs. F. VACIL commends DMAS for establishing regulatory language that clarifies DMAS nor DBHDS may require evaluations that would require a cost to be borne by the individual.	There are two different regulations with different requirements because DMAS has two different state plans filed with CMS. Your suggestion will be taken into consideration.

135.	Virginia Board for People with Disabilities	Subdivision E 3a(1): The Board recommends expanding this item to state, "The definition and causes of intellectual disability (ID), barriers faced by people with intellectual disabilities in community living, and best practices in supporting individuals who have intellectual disability;" Understanding the barriers faced by persons with ID, will help the support coordinator's ability to meet other requirements such as having knowledge of best practices in supporting individuals who have ID, having knowledge of treatment modalities and intervention techniques, having the skills to identify an individual's needs, and having the ability to demonstrate a positive regard for individuals and their families.	This language has been reviewed and approved by CMS in a state plan amendment and cannot be changed at this time.
136.	Virginia Board for People with Disabilities	Subdivision E 3a: The Board recommends adding a new item at the end of this subdivision that states, "(10) Cultural competency." While support coordinators are required in Subdivision E 3c(1) to have the ability to "demonstrate a positive regard for individuals and their families," that requirement does not necessarily encompass all aspects of cultural competency.	DMAS is not able to make this change at this time.
137.	Virginia Board for People with Disabilities	Subdivision E 3b: The Board recommends adding a new item at the end of this subdivision that states, "(11) Evaluating the effectiveness of support plans and the individual's satisfaction with their services and supports, and updating the support plans as necessary." While a key role of the support coordinator is to monitor and update support plans as needed, none of the required knowledge, skills, or abilities specifically speak to this role. Part of monitoring should include assessing an individual's satisfaction level. Because some individuals may not be comfortable expressing dissatisfaction or may have communication or other challenges that create a barrier to participating in a traditional mode of satisfaction inquiry.	DMAS is not able to make this change at this time.
138.	Virginia Board for People with Disabilities	Subsection A: The Board recommends eliminating the limitation of case management to individuals who are six years of age and older and who are on the waiting list or receiving services. Since we have moved to a DD Waiver system that does not differentiate based on diagnosis, there should not be an age restriction to the receipt of case management services. This is a remnant from the old IFDDS waiver where children under six were all served through the ID waiver. If individuals under the age of six are not in the target group, then it is unclear how they would gain a slot on the DD Waiver wait list or receive a DD waiver.	Edits made.

139.	Virginia Board for People with Disabilities	Subdivision A 2: The Board recommends requiring annual contact by telephone between the support coordinator and persons on the Waiver waiting list who are not receiving support coordination because they are not receiving a special service. In addition to verifying waiting list placement, the contact could identify special services that the person may need at that time. 12VAC30-122-79 does requires documentation of annual contact with individuals on waiting list to provide institutional vs. waiver placement choice consistent with 12VAC30-50-440 and 490 (regulatory provisions governing case management).	DMAS is not able to make this change at this time.
140.	Virginia Board for People with Disabilities	The Board recommends consistency between Subsection B, (“Comparability of Services”) and Subsection D (“Definition of Services”): Subsection C states, with respect to support coordination/case management, that “CSBs or BHAs shall contract with private support coordination/case managers for this service.” However Subdivision D 1(“Definition of Services”) states that “CSBs or BHAs may contract with other entities to provide support coordination /case management services.” There should be consistency in these two sections, either shall or may, based on the legal requirement.	Change to “shall” to be consistent throughout.
141.	Virginia Board for People with Disabilities	Subdivision D: The Board recommends adding a new item at the end of the numbered list that states, “9. Be available to the individual during standard business hours by telephone, and assist the individual upon request.” This language would explicitly state that one of the support coordinator’s responsibilities is to be available to the individual, and is consistent with language used with respect to service facilitators in 12 VAC 30-122-500 B.	DMAS is not able to make this change at this time.
142.	Virginia Board for People with Disabilities	Subdivision E 8: The Board recommends increasing the frequency of documented supervision for support coordinators who are in their first year of employment. This subdivision requires that support coordinators obtain at least one hour of documented supervision at least every three months. However, support coordinators who are new to the role should undergo more frequent supervision. The Board recommends at least one hour of documented supervision every month for the first year for these employees.	DMAS is not able to make this change at this time.

Comments related to Section 12 VAC 30-122-20

2.	DDWAC	1. Assistive Technology- add following environment ", actively participate in other waiver services which are part of their plan."; delete "in which they live" 2. Community Coaching – add following participating "or to support an individual when there is an ongoing barrier to participation . . ." [This is a issue of access to the Community Engagement service; individuals with chronic medical, sensory or mobility issues, challenging behavioral issues or a condition which is progressively more debilitating will be barred from Community Engagement as 1:1 staff exceeds the parameters of the service.] 3. Community engagement – delete "one staff person to" or change the last sentence to "Community Engagement Services shall be provided in groups no larger than 3 individuals with a minimum of one staff" [This should be self-evident!] 4. Positive Behavior Supports – use the definition of the American Association for Positive Behavior Supports and delete the language provided [This will bring the service in line with the national standard] 5. Progress Note – We support this definition as written and object to the variations contained in the Provider Requirement sections of the several service descriptions. 6. QDDP – add a reference to all sections in this regulation which permit "QDDP" for the purposes of developing service plans and/or the supervision of staff to be defined in accordance with 12VAC35-105; while it is not necessary for the purposes of the definition, it will add clarity to the regulations. 7. Face-to-face visit- add following support coordinator "or shared living administrative provider" [Face-to-face is the term used for the periodic meetings required in that service] 8. Independent Living – Add a definition 9. Service Authorizations- Strike the word "medically" [While we understand the Medicaid standard of "medical necessity" for payment, it implies that services must have a physician's order and not be developed by the Person-Centered planning process] 10. Supported living residential- delete following a service "taking place in an apartment setting"; add following operated by a DBHDS-licensed provider, "taking place in an individual's own home" [There is no operational reason to limit the choice of the type of living arrangement]	1. Okay to change and match to 270. 2. There is no time limit on the authorization for this service and the service is designed for people to get to communicty engagement. 3. Edits made. 4. Edits made. 5. Edits made. 6.QDDP is defined according to qualifications, not by the functions they perform. 7. Edits made in 12VAC30-122-510. 8. Edits made. 9. Edits made. 10. Edits made.
3.	Loudoun CSB L. Snider	Defines "Support Coordinator" as the person who provides support coordination services to an individual in accordance with 12VAC30-50-455. Section 12VAC30-50-455 is repealed. "Immediate	Edits made.

		family member" definition references (12 VAC 30-50-455), which is no longer in effect	
4.	Dville/Pittvania CSB/S. Craddock	1. Defines "Support Coordinator" as the person who provides support coordination services to an individual in accordance with 12VAC30-50-455. Section 12VAC30-50-455 is repealed. 2. "Immediate family member" definition references (12 VAC 30-50-455), which is no longer in effect	Edits made.
5.	Harrison-Rock'ham CSB/ Slaughbaugh	Defines "Support Coordinator" as the person who provides support coordination services to an individual in accordance with 12VAC30-50-455. Section 12VAC30-50-455 is repealed. "Immediate family member" definition references (12 VAC 30-50-455), which is no longer in effect	See Line 4.
6.	Blue Ridge Beh Healthcare A. Monti	Defines "Support Coordinator" as the person who provides support coordination services to an individual in accordance with 12VAC30-50-455. Section 12VAC30-50-455 is repealed. "Immediate family member" definition references (12 VAC 30-50-455), which is no longer in effect	See Line 4.
7.	Hartwood Foundation, Inc.	1. Challenging Behavior – in the last sentence, after "may include" add "but not be limited to". There are many other types of behaviors that place individuals and others at risk. 2. Family - remove Legal Guardian from list and have a separate and distinct definition for said, including legal guardian's role, responsibilities and limitations as it relates to these regulations. 3. Positive Behavior Supports - use A.A.P.B.S. definition 4. Progress Note - use of this definition should be consistent throughout entirety of the regulations. 5. Supported living residential – remove "in an apartment setting" and replace with "in the individual's home" 6. Add a definition for Independent Living	1. The Code of Virginia states that everywhere "include" is used, it means "includes, but is not limited to." 2. This term only applies in the limited circumstances described in the definition. More detail on legal guardian requirements can be found in the Virginia Code. 3. See Line 2, #4. 4. Edits made. 5. See Line 2, #10. 6. Edits made.
8.	RBHA/M Harrison	Defines "Support Coordinator" as the person who provides support coordination services to an individual in accordance with 12VAC30-50-455. Section 12VAC30-50-455 is repealed. "Immediate family member" definition references (12 VAC 30-50-455), which is no longer in effect	See Line 4.
9.	The Arc of VA T. Milling	Assistive Technology can help a person to be more independent in any setting or environment, including home, work, school, social activities, etc….The Arc of Virginia recommends changing the definition of Assistive Technology to include any place a person may be.	See Line 2, #1.
10.	The Arc of VA T. Milling	Definitions - Positive Behavior Support The Arc of Virginia recommends replacing this definition with the definition by the American Association of Positive Behavior Supports.	See Line 2, #4.

11.	The Arc of VA T. Milling	Definitions - Service Authorizations The term "medical necessity" can be misinterpreted to mean that a service must be ordered by a physician rather than being developed by the person-centered planning process. Medical necessity as required by Medicaid is already established in Medicaid regulations and should not be included in references to service authorization. The Arc of Virginia recommends striking the work "medical".	See Line 2, #9.
12.	The Arc of VA T. Milling	Definitions - Supported Living; This definition refers to services taking place in an apartment setting. There are people living in their own house receiving Supported Living services, this edit would just ensure regulation is not too prescriptive. The Arc of Virginia recommends editing definition to say "a service taking place in a person's own home operated by a DBHDS licensed …."	See Line 2, #10.
13.	Citizen	#3 Support coordination/case management services shall not be provided to the individual by: (i) parents, guardians, spouses, or any family living with the individual, or (ii) parents, guardians, spouses, or any family employed by an organization that provides support coordination/case management for the individual except in cases where the family member was employed by the case management entity prior to implementation of these regulations. - Concern that the final statement in this clause (ii), originally introduced in the emergency regs and redefined here, creates a hardship for the individuals with ID/DD in rural or semi-rural areas with little to no choice of case management providers. In many areas of the state, there may be only one CSB within driving distance. 12VAC30-50-490 also clearly states that individuals with ID/DD have the right to chose their case management provider, but if that individual has a family member who works for the local CSB in any capacity (mental health, early intervention, ID/DD services, etc), the main provider for ID/DD case management is eliminated as a choice for that individual. The initial part of this regulation (i), stating that support coordination should not be provided by family members of an individual, should be sufficient in ensuring authentic and ethical service delivery. - Please consider removing (ii) to ensure that all individuals with ID/DD have sufficient choice in CM regardless of where their family members are employed.	Edits made.

14.	VA Board for People with Disabilities	Assistive Technology. The Board recommends expanding the definition as follows: "'AT means specialized medical equipment and supplies, including those devices, controls, or appliances specified in the individual support plan but not available under the State Plan for Medical Assistance that (1) enable individuals to increase their abilities to perform ADLs, or to (2) enable individuals to perceive, control, or communicate with the environment in which they live, and (3) enable individuals to actively participate in other waiver services which are part of their plan, or (4) that are necessary to the proper functioning of the specialized equipment." The current definition does not account for the new and future uses of technology which are more expansive than those specified in this definition.	See Line 2, #1.
15.	VA Board for People with Disabilities	Community Engagement. The Board recommends deleting the reference to staff in the definition. It is enough to denote that the group of individuals participating in the service can be no larger than three.	See Line 2, #3.
16.	VA Board for People with Disabilities	Independent Living. The Board recommends adding a definition of Independent Living. The phrase "independent living" is used in multiple places throughout the proposed regulations. Proposed 12VAC30-122-90 defines the eligibility criteria for the Priority One waiting list to include young adults who are no longer eligible for IDEA services and who are transitioning to "independent living." The regulations describe the individuals whom the Building Independence Waiver is designed to support as "individuals who reside in an integrated, independent living arrangement...." (proposed 12VAC30-122-240). Additionally, the Independent living support service described in proposed 12VAC30-122-420 is available to adults 18 years of age and older to provide the skill building and supports "necessary to secure and reside in an independent living situation." Nowhere in the regulations, however, is the phrase "independent living" as used in these sections defined.	See Line 2, #8.
17.	VA Board for People with Disabilities	Positive behavior supports. The Board recommends a more user friendly, clear definition of positive behavior supports. One definition that could be considered is from the Association of Positive Behavior Supports: "Positive Behavior Support (PBS) is a set of research-based strategies used to increase quality of life and decrease problem behavior by teaching new skills and making changes in a person's environment." Note that the Board prefers the use of the term "challenging" to "problem" behavior, should this or another definition be adopted.	See Line 2, #4.

18.	VA Board for People with Disabilities	Service Authorization. The Board recommends deleting the word "medically." While DD waiver services are all Medicaid-funded services, not all services authorized or funded under the waiver are medical in nature, e.g., ordered by a physician (e.g., employment, community engagement, etc.). Services are developed in accordance with the person-centered plan.	See Line 2, #9.
19.	VA Board for People with Disabilities	Supported Living Residential. The Board recommends deleting "an apartment setting," and changing to a service "taking place in the individual's 'own home.'" Not all supported living residential settings are apartments.	See Line 2, #10.
20.	Weatherspoon Wall Res, Inc.	1. Community Coaching – add following participating "or to support an individual when there is an ongoing barrier to participation . . ." [This is an issue of access to the Community Engagement service; individuals with chronic medical, sensory or mobility issues, challenging behavioral issues or a condition which is progressively more debilitating will be barred from Community Engagement as 1:1 staff exceeds the parameters of the service.] 2. Progress Note – We support this definition as written and object to the variations contained in the Provider Requirement section as well as the variation written in the Sponsored Residential service description (See Comments for 530 and 120).	See Line 2, # 2 and 5.
21.	J Ciffizari Wall Res, In.	Same as line 20.	See Line 2, #2 and 5.
22.	Citizen	Same as line 20.	See Line 2, #2 and 5.
23.	Citizen	I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20.	See Line 2, #5.
24.	Citizen	1. I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] 2. E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2, #5. Sponsored residential - edits made.
25.	Citizen	I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20.	See Line 2, #5.

26.	Citizen	1. I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] 2. E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2, #5. Sponsored residential - edits made.
27.	J. Healey/Wall Res., Inc.	1. I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] 2. E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2, #5. Sponsored residential - edits made.
28.	Citizen	1. I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] 2. E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2, #5. Sponsored residential - edits made.
29.	M Jennings/Wall Res., Inc.	1. I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] 2. E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2, #5. Sponsored residential - edits made.

30.	Citizen	1. I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] 2. E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2, #5. Sponsored residential - edits made.
31.	Buford/Wall Residence, Inc.	1. I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] 2. E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2, #5. Sponsored residential - edits made.
32.	Citizen	1. I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] 2. E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2, #5. Sponsored residential - edits made.
33.	Citizen	1. I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] 2. E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2, #5. Sponsored residential - edits made.

34.	Citizen	1. I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] 2. E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2, #5. Sponsored residential - edits made.
35.	S. Johnson Wall Res., Inc	1. I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] 2. E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2, #5. Sponsored residential - edits made.
36.	Citizen	1. I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] 2. E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2, #5. Sponsored residential - edits made.
37.	K. Tyree Spons. Res. Prov	1. I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] 2. E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2, #5. Sponsored residential - edits made.

38.	A Layman Wall Res., Prov.	1. I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] 2. E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2, #5. Sponsored residential - edits made.
39.	Karen Tefelski - vaACCSES	1. Definitions for benefits planning, community guide, non-medical transportation/employment and community transportation services should be added to section. Assistive Technology- add following environment ", actively participate in other waiver services which are part of their plan."; delete "in which they live". The current definition does not account for all of the new and possible future expansive use of technology in all available waiver services. Expanding the definition will enable waiver services to adapt to the fast pace of changing technology in all walks of life. 2. Community Coaching – add following participating "or to support an individual when there is an ongoing barrier to participation . . ." [This is an issue of access to the Community Engagement service; individuals with chronic medical, sensory or mobility issues, challenging behavioral issues or a condition which is progressively more debilitating will be barred from Community Engagement as 1:1 staff exceeds the parameters of the service.] 3. Community engagement – delete "one staff person to" or change the last sentence to "Community Engagement Services shall be provided in groups no larger than 3 individuals with a minimum of one staff". Basically, delete the reference to "staff" in the definition. The goal is to limit the size of the group. 4. Independent Living – Add a definition. The term is used throughout the proposed regulations with no definition. Proposed 12VAC30-122-90 defines the eligibility criteria for the Priority One waiting list to include young adults who are no longer eligible for IDEA services and who are transitioning to "independent living." The regulations describe the individuals whom the Building Independence Waiver is designed to support as "individuals who reside in an integrated, independent living arrangement...." (proposed 12VAC30-122-240). Additionally, the Independent living support service described in proposed 12VAC30-122-420 is available to adults	1. Information about these services (including service definitions) has been added. 2. See Line 2, #1. 3. See Line 2, #2. 4. See Line 2, #3. 5. See Line 2, #4. 6. See Line 2, #5. 7. See Line 2, # 6. 8. See Line 2, #7. 9. See Line 2, #8. 10. See Line 2, #9. 11. See Line 2, #10.

		18 years of age and older to provide the skill building and supports "necessary to secure and reside in an independent living situation." Nowhere in the regulations, however, is the phrase "independent living" as used in these sections defined. 5. Positive Behavior Supports – use the definition of the American Association for Positive Behavior Supports and delete the language provided. This will bring the service in line with the national standard. 6. Progress Note – We support this definition as written and object to the variations contained in the Provider Requirement sections of the several service descriptions. See our "General Comments" above. 7. QDDP – add a reference to all sections in this regulation which permit "QDDP" for the purposes of developing service plans and/or the supervision of staff to be defined in accordance with 12VAC35-105; while it is not necessary for the purposes of the definition, it will add clarity to the regulations. 8. Face-to-face visit- add following support coordinator "or shared living administrative provider" [Face-to-face is the term used for the periodic meetings required in that service] 9. Independent Living – Add a definition 10. Service Authorizations- Strike the word "medically". DD waiver services are all Medicaid-funded services. However, not all services authorized or funded under the waiver are medical in nature. (e.g. supported employment, community engagement, etc). While we understand the Medicaid standard of "medical necessity" for payment, it implies that services must have a physician's order and not be developed by the Person-Centered planning process. 11. Supported living residential- delete following a service "taking place in an apartment setting"; add following operated by a DBHDS-licensed provider. Change to "taking place in an individual's own home". There is no operational reason to limit the choice of the type of living arrangement.	
40.	M. Ingram/Wall Res., Inc.	1. Community Coaching – add following participating "or to support an individual when there is an ongoing barrier to participation . . ." [This is an issue of access to the Community Engagement service; individuals with chronic medical, sensory or mobility issues, challenging behavioral issues or a condition which is progressively more debilitating will be barred from Community Engagement as 1:1 staff exceeds the parameters of the service.] 2. Progress Note – We support this definition as written and object to the variations contained in the Provider Requirement section as well as the	See Line 2, #2 and 5.

		variation written in the Sponsored Residential service description (See Comments for 530 and 120).	
41.	M Henley, Wall Res., Inc.	1. I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike “confirming the amount of the individual’s time in service and” [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] 2. E.1.c.- End of second sentence strike “at least a daily note” add “in a progress note” [This makes documentation consistent]	See Line 2, #5. Sponsored residential - edits made.
42.	T. King Wall Res., Inc.	1. I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike “confirming the amount of the individual’s time in service and” [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] 2. E.1.c.- End of second sentence strike “at least a daily note” add “in a progress note” [This makes documentation consistent]	See Line 2, #5. Sponsored residential - edits made.
43.	Henrico Area MHDS	(Definition for Plan for support) DMAS and DBHDS should create the option for a single agency to have one Plan for Supports per individual regardless of the number of services provided to an individual in order to streamline documentation and reduce the number of quarterly reports required. This was a unanimous recommendation of the DBHDS’s own Provider Issues Resolution Workgroup (PIRW) in its report published August 2018. (Definition for progress note) Support the consistent use of “progress notes” as defined in the DD Waiver regulations versus the use of “daily note” references. We support the definition of “progress notes” as defined in 12VAC30-122-20 “Definitions” for consistency. “Progress notes” means individual-specific written documentation that (i) contains unique differences specific to the individual’s circumstances and the supports provided, and the individual’s responses to such supports; (ii) is signed and dated by the person who rendered the supports; and (iii) is written and signed and dated as soon as is practicable but no longer than one week after the referenced service.”	1. DMAS is not able to make this change at this time. 2. Edits made.

44.	R. Ledingham, Wall Res.	Community Coaching – add following participating “or to support an individual when there is an ongoing barrier to participation . . .” [This is an issue of access to the Community Engagement service; individuals with chronic medical, sensory or mobility issues, challenging behavioral issues or a condition which is progressively more debilitating will be barred from Community Engagement as 1:1 staff exceeds the parameters of the service.] Progress Note – We support this definition as written and object to the variations contained in the Provider Requirement section as well as the variation written in the Sponsored Residential service description (See Comments for 530 and 120).	See Line 2.
45.	M. Rosenbaum, Wall Res	Same as Line 20.	See Line 2, #2 and 5.
46.	K. Black-Hope House	Assistive Technology- add following environment “, actively participate in other waiver services which are part of their plan.”; delete “in which they live” Challenging Behavior – change definition to behavior of FID (Frequency, Intensity, and Duration) that limits the person from living a life of their choosing as defined by their ISP. Community Coaching – add following participating “or to support an individual when there is an ongoing barrier to participation . . .” [This is a issue of access to the Community Engagement service; individuals with chronic medical, sensory or mobility issues, challenging behavioral issues or a condition which is progressively more debilitating will be barred from Community Engagement as 1:1 staff exceeds the parameters of the service.] High Intensity/Crisis Behavior - Behavior of FID that places the physical safety of the individual or others serious jeopardy. This may include withdrawal or directed aggression to self, others or property. Positive Behavior Supports – use the definition a data-based system of functional assessment within accepted person-centered practices to design plans that enhance the person’s ability to use positive behavior to communicate and meet their needs in order to enhance their quality of life and enable them to lead a self-directed life in community. Progress Note – We support this definition as written and object to the variations contained in the Provider Requirement sections of the several service descriptions. Service Authorizations- Strike the word “medically” [While we understand the Medicaid standard of “medical necessity” for payment, it implies that services must have a physician’s order and not be developed by the Person-Centered planning process]	See Line 2 and Line 7.

47.	V Frazier-Wall Res.	I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike “confirming the amount of the individual’s time in service and” [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] E.1.c.- End of second sentence strike “at least a daily note” add “in a progress note” [This makes documentation consistent]	See Line 2, #5. Sponsored residential - edits made.
48.	Citizen-Wall Res.	I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20.	See Line 2, #5.
49.	B Martin - CHOICE Group	We support the definition of “progress notes” as defined in “Definitions” for consistency .Progress notes” means individual-specific written documentation that (i) contains unique differences specific to the individual’s circumstances and the supports provided, and the individual’s responses to such supports; (ii) is signed and dated by the person who rendered the supports; and (iii) is written and signed and dated as soon as is practicable but no longer than one week after the referenced service.” Support changing the 10-day requirement to a 15-day requirement for service providers to submit quarterly reports.	See Line 2.
50.	Citizens	I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike “confirming the amount of the individual’s time in service and” [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] E.1.c.- End of second sentence strike “at least a daily note” add “in a progress note” [This makes documentation consistent]	See Line 2, #5. Sponsored residential - edits made.
51.	Citizens	I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike “confirming the amount of the individual’s time in service and” [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] E.1.c.- End of second sentence strike “at least a daily note” add “in a progress note” [This makes documentation consistent]	See Line 2, #5. Sponsored residential - edits made.

52.	B Huffman - VersAbility Resources	Same as Line 39.	1. Information about these services (including service definitions) has been added. 2. See Line 2, #1. 3. See Line 2, #2. 4. See Line 2, #3. 5. See Line 2, #4. 6. See Line 2, #5. 7. See Line 2, # 6. 8. See Line 2, #7. 9. See Line 2, #8. 10. See Line 2, #9. 11. See Line 2, #10.
53.	Citizen	Definitions for benefits planning, community guide, non-medical transportation/employment and community transportation services should be added to the definition section. - Add a definition for Independent Living.	See Line 39.
54.	Citizen	Definitions. General: • Definitions for benefits planning, community guide, non-medical transportation/employment and community transportation services should be added to section. • Assistive Technology- add following environment ", actively participate in other waiver services which are part of their plan."; delete "in which they live". The current definition does not account for all of the new and possible future expansive use of technology in all available waiver services. Expanding the definition will enable waiver services to adapt to the fast pace of changing technology in all walks of life. • Community Coaching – add following participating "or to support an individual when there is an ongoing barrier to participation . . ." [This is an issue of access to the Community Engagement service; individuals with chronic medical, sensory or mobility issues, challenging behavioral issues or a condition which is progressively more debilitating will be barred from Community Engagement as 1:1 staff exceeds the parameters of the service.] • Community engagement – delete "one staff person to" or change the last sentence to "Community Engagement Services shall be provided in groups no larger than 3 individuals with a minimum of one staff". Basically, delete the reference to "staff" in the definition. The goal is to limit the size of the group. • Independent Living – Add a definition. The term is used throughout the proposed regulations with no definition	See Line 2 and Line 39.
55.	Citizen	Positive Behavior Supports – use the definition of the American Association for Positive Behavior Supports and delete the language provided. This will bring the service in line with the national standard. • Progress Note – We support this definition as written and object to the variations contained in the Provider Requirement sections of the several service descriptions. See our "General Comments" above. •	See Line 2 and Line 39.

		QDDP – add a reference to all sections in this regulation which permit "QDDP" for the purposes of developing service plans and/or the supervision of staff to be defined in accordance with 12VAC35-105; while it is not necessary for the purposes of the definition, it will add clarity to the regulations. • Face-to-face visit- add following support coordinator "or shared living administrative provider" [Face-to-face is the term used for the periodic meetings required in that service] • Independent Living – Add a definition • Service Authorizations- Strike the word "medically". DD waiver services are all Medicaid-funded services. However, not all services authorized or funded under the waiver are medical in nature. (e.g. supported employment, community engagement, etc). While we understand the Medicaid standard of "medical necessity" for payment, it implies that services must have a physician's order and not be developed by the Person-Centered planning process. • Supported living residential- delete following a service "taking place in an apartment setting"; add following operated by a DBHDS-licensed provider. Change to "taking place in an individual's own home". • There is no operational reason to limit the choice of the type of living arrangement	
56.	Jan Williams, ServiceSource	1. Assistive Technology – broaden definition beyond "in which they live", to "actively participate in other waiver services which are part of their plan." or to help an individual to be more independent in any setting or any environment including hone, work, school or community social activities." 2. Challenging behavior-in the final sentence, after "may include" add "but not be limited to". 3. Family-remove Legal Guardian from list and have a separate and distinct definition for legal guardian (including role, responsibilities and limitations) 4. Positive Behavior Supports – use the definition of the American Association for Positive Behavior Supports and delete the language provided [This will bring the service in line with the national standard] 5. Progress Note – We support this definition as written in Definitions: "Progress notes" means individual-specific written documentation that - (i) Contains unique differences specific to the individual's circumstances and the supports provided, and the individual's responses to such supports; - (ii) Is signed and dated by the person who rendered the supports; and - (iii) Is written and signed and dated as soon as is practicable but no longer than one week after the referenced service. 6. QDDP - The 2016 (emergency) version of these Waiver regulations included the phrase "or a	See Line 39.

		provider who has documented equivalent experience" to allow providers to substitute experience for a college degree, but this phrase is not included in either the new (2018) Licensing regulations or within the definition of QDDP in these Waiver regulations. We recommend restoring 2016 language to allow for equivalent experience to substitute for education. 7. Service Authorization – The term "medical necessity" can be misinterpreted to mean that a service must be ordered by a physician rather than being developed by the person-centered planning process. Medical necessity as required by Medicaid is already established in Medicaid regulations and should not be included in references to service authorization.	
57.	Citizen	General: • Definitions for benefits planning, community guide, non-medical transportation/employment and community transportation services should be added to section. • Assistive Technology- add following environment ", actively participate in other waiver services which are part of their plan."; delete "in which they live". The current definition does not account for all of the new and possible future expansive use of technology in all available waiver services. Expanding the definition will enable waiver services to adapt to the fast pace of changing technology in all walks of life. • Community Coaching – add following participating "or to support an individual when there is an ongoing barrier to participation . . ." [This is an issue of access to the Community Engagement service; individuals with chronic medical, sensory or mobility issues, challenging behavioral issues or a condition which is progressively more debilitating will be barred from Community Engagement as 1:1 staff exceeds the parameters of the service.] • Community engagement – delete "one staff person to" or change the last sentence to "Community Engagement Services shall be provided in groups no larger than 3 individuals with a minimum of one staff". Basically, delete the reference to "staff" in the definition. The goal is to limit the size of the group. • Independent Living – Add a definition. The term is used throughout the proposed regulations with no definition. Proposed 12VAC30-122-90 defines the eligibility criteria for the Priority One waiting list to include young adults who are no longer eligible for IDEA services and who are transitioning to "independent living." The regulations describe the individuals whom the Building Independence Waiver is designed to support as "individuals who reside in an integrated, independent living arrangement...." (proposed 12VAC30-122-240). Additionally, the	See Line 2 and Line 39.

		Independent living support service described in proposed 12VAC30-122-420 is available to adults 18 years of age and older to provide the skill building and supports "necessary to secure and reside in an independent living situation." Nowhere in the regulations, however, is the phrase "independent living" as used in these sections defined. • Positive Behavior Supports – use the definition of the American Association for Positive Behavior Supports and delete the language provided. This will bring the service in line with the national standard. • Progress Note – We support this definition as written and object to the variations contained in the Provider Requirement sections of the several service descriptions. See our "General Comments" above. • QDDP – add a reference to all sections in this regulation which permit "QDDP" for the purposes of developing service plans and/or the supervision of staff to be defined in accordance with 12VAC35-105; while it is not necessary for the purposes of the definition, it will add clarity to the regulations. • Face-to-face visit- add following support coordinator "or shared living administrative provider" [Face-to-face is the term used for the periodic meetings required in that service] • Independent Living – Add a definition • Service Authorizations- Strike the word "medically". DD waiver services are all Medicaid-funded services. However, not all services authorized or funded under the waiver are medical in nature. (e.g. supported employment, community engagement, etc). While we understand the Medicaid standard of "medical necessity" for payment, it implies that services must have a physician's order and not be developed by the Person-Centered planning process. • Supported living residential- delete following a service "taking place in an apartment setting"; add following operated by a DBHDS-licensed provider. Change to "taking place in an individual's own home". There is no operational reason to limit the choice of the type of living arrangement.	

Comments Related to Section 12 VAC 30-122-30

2.	Loudoun CSB L. Snider	References the Elderly and Disabled Waiver and the Technology Assisted waiver, neither of which exist.	Once the regulations for the EDCD and Tehcnology Assisted waivers are finalized, this text can be updated. (The changes are in process, but have not been finalized yet.)

3.	Dville/Pittvania CSB/S. Craddock	References the Elderly and Disabled Waiver and the Technology Assisted waiver, neither of which exist.	See Line 2.
4.	MPNN CSB L. McCrobie	References the Elderly and Disabled Waiver and the Technology Assisted waiver, neither of which exist.	See Line 2.
5.	Harrison-Rock'ham CSB/ Slaughbaugh	References the Elderly and Disabled Waiver and the Technology Assisted waiver, neither of which exist.	See Line 2.
6.	Henrico Area MHDS	B. EDCD is now CCC Plus	See Line 2.
7.	Blue Ridge Beh Healthcare A. Monti	References the Elderly and Disabled Waiver and the Technology Assisted waiver, neither of which exist.	See Line 2.
8.	RBHA/M Harrison	References the Elderly and Disabled Waiver and the Technology Assisted waiver, neither of which exist.	See Line 2.
9.	VAIL/G. Brunk	contains the wording "Elderly or Disabled with Consumer Direction (EDCD)" which is no longer the name of that waiver.	See Line 2.
10.	VAIL/G. Brunk	where it states "collectively known as the DD Waiver", this should be plural and should read "collectively known as the DD Waivers."	This text could not be found.
11.	Valley CSB T. Martina	references EDCD and Tech Waiver neither of which exists.	See Line 2.
12.	Valley CSB T. Martina	references 5 months to initiate waiver services in which the current requirement is 6 months. The preference is 6 months to allow for adequate time to locate and review service options in order to make an informed decision.	DMAS is not able to make this change at this time.
13.	Henrico Area MHDS	B. EDCD is now CCC Plus	See Line 2.

14.	Elliott/Hanover CSB	Page 19 B - Waiver populations; single waiver enrollment; waiver termination upon loss of eligibility. "An individual who has a diagnosis of DD may be on the waiting list for one of the DD Waivers (FIS, CL, or BI) while simultaneously being enrolled in the Elderly or Disabled with Consumer Direction (EDCD)…." This is confusing due to the new name being the CCC+ Waiver; the name of the EDCD Waiver should be changed to be consistent to what its current title.	See Line 2.
15.	La Voyce B. Reid/Arlington CSB	B. Correct "Elderly or Disabled with Consumer Direction" and "Technology Assisted" Waivers to CCC Plus Waivers. C. Assuming no longer meeting VIDES eligibility is a reason for loss of a DD Waiver, recommend addressing this here. Also, what is the recommended practice for re-doing a VIDES? If someone does not meet, should DMAS and DBHDS be notified immediately (e.g., within 24 hours, three business day, etc.)? Should a supervisor re-do the VIDES and then notify DMAS/DBHDS, if necessary? Shall the CSB seek an independent VIDES completion by another CSB? Improved and consistent guidance in this area would be helpful.	B. See Line 2. C. The regulations describe when a VIDES shall be redone. This is addressed under the functional assessment - it should be redone annually or as needed. Also see the criteria in the regulations for completing the VIDES.
16.	Maureen Hollowell, VA Assoc of Centers for Independent Living	B. Update reference to the Commonwealth Coordinated Care Plus Waiver.	See Line 2.

Comments related to 12VAC30-122-40

1.	Loudoun CSB L. Snider	States individuals with DD who are inpatient may receive Support Coordination as described in 12VAC30-50-440. That section referred to only applies to individuals with ID.	Look at section 440 - the same information applies to DD.
2.	Dville/Pittvania CSB/S. Craddock	States individuals with DD who are inpatient may receive Support Coordination as described in 12VAC30-50-440. That section referred to only applies to individuals with ID.	See Line 2.
3.	Harrison-Rock'ham CSB/ Slaughbaugh	States individuals with DD who are inpatient may receive Support Coordination as described in 12VAC30-50-440. That section referred to only applies to individuals with ID.	See Line 2.

4.	Blue Ridge Beh Healthcare A. Monti	States individuals with DD who are inpatient may receive Support Coordination as described in 12VAC30-50-440. That section referred to only applies to individuals with ID.	See Line 2.
5.	RBHA/M Harrison	States individuals with DD who are inpatient may receive Support Coordination as described in 12VAC30-50-440. That section referred to only applies to individuals with ID.	See Line 2.
6.	VA Board for People with Disabilities	**Subsection B: The Board recommends clarifying that transition services can be provided to individuals who are inpatients at the listed facilities when they are preparing for discharge.** The subsection states that waiver services shall not be furnished to individuals who are inpatients of a hospital, nursing facilities, ICF/IID, or inpatient rehabilitation facility. It goes on to state that waiver services shall not be provided until the individual has exited the institution and has been enrolled in the waiver. However, some of the costs covered by transition services would have to be incurred prior to the individual exiting the institution, in order for the individual to have an alternative place to live. Such expenses include security deposits, set-up fees, or deposits for utilities, etc.	Edits made.
7.	Karen Tefelski - vaACCSES	B. Clarify that transition services can be provided to individuals who are inpatients at the listed facilities when they are preparing for discharge. The subsection states that waiver services shall not be furnished ot individiuals who are inpaients of a hospital, nursing facility, ICF/IID, or inpatient rehab facility. The waiver services shall not be provided until the individual has exited the institution and has been enrolled in the waiver. However, some of the costs covered by transition services would have to be incurred prior to the individual exiting the institution in order for the individual to have an alternative place to live. Such expenses include security deposits, setup fees, or deposits for utilities, etc.	Edits made. See Line 7.
8.	Citizen	*The FIS, CL, and BI Waiver services….shall not be authorized or reimbursed by DMAS for an individual who resides outside of the physical boundaries of the Commonwealth.* **This should apply to those on the waiting list as well.**	Individuals can remain on the waiting list while out of state, but need to be in- state to receive the waiver and must be willing to accept a slot within 30 days.

9.	Citizen	Waiver services; when not authorized. • B. Clarify that transition services can be provided to individuals who are inpatients at the listed facilities when they are preparing for discharge. The subsection states that waiver services shall not be furnished to individuals who are inpatients of a hospital, nursing facilities, ICF/IID, or inpatient rehabilitation facility. It goes on to state that waiver services shall not be provided until the individual has exited the institution and has been enrolled in the waiver. However, some of the costs covered by transition services would have to be incurred prior to the individual exiting the institution, in order for the individual to have an alternative place to live. Such expenses include security deposits, set-up fees, or deposits for utilities, etc.	Edits made. See Line 7.
10.	Jan Williams, ServiceSource	Waiver services: when not authorized - B. We recommend that both assignment of Waiver slots and funding to service providers be available for individuals transitioning out of community ICFs and nursing facilities for up to 60 days prior to discharge to facilitate an efficient and effective transition.	Transition service provides services for individuals transitioning out of an ICF or nursing facility.
11.	Citizen	Waiver services; when not authorized. • B. Clarify that transition services can be provided to individuals who are inpatients at the listed facilities when they are preparing for discharge. The subsection states that waiver services shall not be furnished to individuals who are inpatients of a hospital, nursing facilities, ICF/IID, or inpatient rehabilitation facility. It goes on to state that waiver services shall not be provided until the individual has exited the institution and has been enrolled in the waiver. However, some of the costs covered by transition services would have to be incurred prior to the individual exiting the institution, in order for the individual to have an alternative place to live. Such expenses include security deposits, set-up fees, or deposits for utilities, etc.	Edits made. See Line 7.
12.	Frontier Health K Honeycutt	Waiver service when not authorized. Same as Line 8.	Edits made. See Line 7.
13.	Wormley, Kerns, Collier, Lester, Hauley -VersAbility Rsc	Same as Line 8.	Edits made. See Line 7.
14.	Crum/ServiceSource	Waiver service when not authorized. We recommend that both assignment of waiver slots and funding to service providers be available for individuals transitioning out of community ICFs and nursing	Edits made. See Line 7.

		facilities for up to 60 days prior to discharge to facilitiate an effecient and effective transition.	
15.	Citizen	B. Clarify that transition services can be provided to individuals who are inpatients at the listed facilities when they are preparing for discharge. The subsection states that waiver services shall not be furnished to individuals who are inpatients of a hospital, nursing facilities, ICF/IID, or inpatient rehabilitation facility. It goes on to state that waiver services shall not be provided until the individual has exited the institution and has been enrolled in the waiver. However, some of the costs covered by transition services would have to be incurred prior to the individual exiting the institution, in order for the individual to have an alternative place to live. Such expenses include security deposits, set-up fees, or deposits for utilities, etc.	Edits made. See Line 7.
16.	Virginia Board for People with Disabilities	Subsection B: The Board recommends clarifying that transition services can be provided to individuals who are inpatients at the listed facilities when they are preparing for discharge. The subsection states that waiver services shall not be furnished to individuals who are inpatients of a hospital, nursing facilities, ICF/IID, or inpatient rehabilitation facility. It goes on to state that waiver services shall not be provided until the individual has exited the institution and has been enrolled in the waiver. However, some of the costs covered by transition services would have to be incurred prior to the individual exiting the institution, in order for the individual to have an alternative place to live. Such expenses include security deposits, set-up fees, or deposits for utilities, etc.	Edits made. See Line 7.

Comments related to 12VAC30-122-45

2.	Citizen	Retain slot used to be 180 days now 120 days; Suggest this changes back to 180 day	The slot is retained for 150 days, which is an appropriate length of time.
3.	H Hines/Reg. 10 CSB	Recommend extending retain slot to 180 days due to challenges finding providers.	The slot is retained for 150 days, which is an appropriate length of time.

Comments related to 12VAC30-122-50

2.	Loudoun CSB L. Snider	What is needed to document needing level of care on the annual basis?	DMAS will add text …level of care (as set forth in the VIDES)…"
3.	Harrison-Rock'ham CSB/ Slaughbaugh	What is needed to document needing level of care on the annual basis?	Edits made. See Line 2.
4.	Henrico Area MHDS	A.1. Anything about adaptive functioning? A.2. suggest change "qualify" to "receiving" to clarify that a VIDES for individuals on the DD Waiver WL does not need to be completed annually.	1. Adaptive functioning is addressed in the referenced Code of Virginia citation. Question 2: This will be clarified in the manual.
5.	Blue Ridge Beh Healthcare A. Monti	What is needed to document needing level of care on the annual basis?	Edits made. See Line 2.
6.	RBHA/M Harrison	What is needed to document needing level of care on the annual basis?	Edits made. See Line 2.
7.	VAIL/G. Brunk	Does this refer to a psychological or can the "diagnosed condition" come from any form of medical documentation? Additionally, why is the VIDES assessment listed in numbers one and three? Couldn't number 1 just include the diagnosis, number 2 be the level of care annually, and number 3 indicate the VIDES?	No, it does not have to be a psychological assessment. The diagnosis may come from any appropriate professional. For second question, text changes have been made.
8.	Henrico Area MHDS	A1. Anything about adaptive functioning? A2. Suggest changing "qualify" to "receving" to clarify that a VIDES for individuals on the DD Waiver waitlist don't need to be completed annually.	See Line 4.
9.	Elliott/Hanover CSB	For all those Seeking DD Waiver: A2 Individuals Qualifying for DD Waiver... shall meet level of care provided in an ICF/IID and shall demonstrate this need at least annually….Please clarify if this if for only individuals who have received a DD Waiver or if it includes those on the DD Wait List. It would be very labor intensive to complete a VIDES annually for all individuals on the wait list. The VIDES should only be completed for those receiving the waiver services to demonstrate that he/she meets the level of care of an ICF/IID. For those on the wait list, the VIDES should be completed for eligibility/qualification but then completed again prior to enrolling into the DD Waiver.	Edits made.

10.	Elliott/Hanover CSB	For all those Seeking DD Waiver: 4. Shall meet financial eligibility. This can be interpreted as saying that one must meet Medicaid eligibility to be on the wait list- ***this should be clarified to say "once granted a waiver slot, one must meet financial eligibility….".***	A text change has been made: "Once assigned a waiver slot, the individual shall be determined to meet the financial eligibility criteria for Medicaid."
11.	Citizen	Cites definition of developmental disability 37.2-100. In that section of the Code there are two separate definitions, one for Developmental Disability and one for ID. Is the language in this and following sections now referring to just DD or DD and ID? This section also states individuals must be at risk of institutionalization. This language appears outdated and unrealistic as in present day individuals would find it extremely difficult to be "institutionalized" even if that was their preference.	The language is referring to DD. ID is a subset of DD, so references to DD always include ID. The language about institutionalization is a federal requirement.

Comments related to 12VAC30-122-60

2.	DDWAC	1. B.3.a.(1) and B.3.b.(1) Delete following employed "at least 8 hours but" [Individuals who work fewer than eight hours per week are unnecessarily disadvantaged by the limitation] Recommend Spend-down for all Long-Term Care waiver categories. This language is already in the CCC+ waiver. This language should be moved to all categories. 2. Recommend that Patient Pay be considered an Income Related Work Expense (IRWE). IRWEs are already considered when countable earned income is considered. Reasoning - without waiver services, an individual would not be earning at the level they are earning. But, earning at a higher level is forcing them to incur a Patient Pay. This is a disincentive to earn wages at a higher level. 3. Recommend Special Group Category Consideration – SSI/SSDI waiver recipients increasingly have retired, disabled or deceased parents and the waiver recipient's income increases because their parent's FICA account is opened and a portion of this account is received by the waiver recipient. This amount (now SSDI) often puts the waiver recipient over the 300% gross income limit. The first thing the individual does is quit work if working. These individuals should be put in a "protected category" which will disregard the amount of the new income (SSDI) that will cause them to become ineligible for waiver services. This protection is considered when looking at continued Medicaid eligibility. 4. Recommend Subsidies and Special Conditions as deduction for wages earned (per SSA definitions). If the individual is not fully earning his or her wages because the work is performed under special conditions (e.g. close and continuous supervision, on the job coaching, etc), then we should deduct that part of his or her wages that are not "earned" by the individual from his/her average gross wages.	1. Edits made. Spend-down - DMAS is not able to make this change at this time. 2. Patient pay cannot be an IRWE - IRWEs are work expenses and patient pay is not a work expense. 3. DMAS is not able to make this change at this time. 4. DMAS is not able to make this change at this time.

		This is true whether or not the employer or someone else provides the special on-the-job conditions. Most work supports that an individual receives in order to earn income is provided under LTC (i.e. transportation, personal attendant services, job coaching, etc). However, under current Medicaid LTC regulations, if they earn over 300% of federal benefit rate (FBR), they are penalized. Many individuals do not have the out-of-pocket expenses that are needed to bring down countable earned income due to the LTC supports that they are receiving at no cost to them. However, they would not be earning at the level that they are earning without the waiver provided supports. Subsidies and Special Conditions would give value to the supports that are provided to the individual that enables them to work and earn income.	
3.	Hartwood Foundation, Inc.	Remove "**for an individual employed at least eight**" hours	See Line 2.
4.	Citizen	**Waiver redesign -** I am commenting on Tonya Milling and ARC support of waiver redesign in the following areas: 60- Financial Eligibility Standards: Special Group Category should be created for individuals receiving a portion of parent's FICA account and his/her SSDI puts recipient over 300% of gross income limit. My daughter lost her full Medicaid at that point. Very disturbing. Waiting List C.1.a.: identify age of primary care giver age 70 or greater gives automatic Priority One.	1. See Line 2. There is a shortage resources for waiver services, and this process attempts to allocate those limited services fairly. The waiting list focuses on individual criteria rather than age. 3. That would be an entirely new covered group that would need to approve. DMAS has a protected covered group for individuals who meet the criteria.

5.	Citizen	1. B.3.a.(1) and B.3.b.(1) Delete following *employed* "at least 8 hours but". Individuals who work fewer than eight hours per week are unnecessarily disadvantaged by the limitation. Many individuals may work less than 8 hours per week because of medical or other reasons. Without this disregard, there is no incentive for them to work because their income would go to patient pay. 2. Recommend Spend-down for all Long-Term Care waiver categories. This language is already in the CCC+ waiver. This language should be moved to all categories. 3. B.3. Recommend that Patient Pay be considered an Income Related Work Expense (IRWE). IRWEs are already considered when countable earned income is considered. Reasoning - without waiver services, an individual would not be earning at the level they are earning. But, earning at a higher level is forcing them to incur a Patient Pay. This is a disincentive to earn wages at a higher level. 4. Recommend Special Group Category Consideration – SSI/SSDI waiver recipients increasingly have retired, disabled or deceased parents and the waiver recipient's income increases because their parent's FICA account is opened and a portion of this account is received by the waiver recipient. This amount (now SSDI) often puts the waiver recipient over the 300% gross income limit. The first thing the individual does is quit work if working. These individuals should be put in a "protected category" which will disregard the amount of the new income (SSDI) that will cause them to become ineligible for waiver services. This protection is considered when looking at continued Medicaid eligibility. (https://secure.ssa.gov/poms.nsf/lnx/0501715015) 5. Recommend Subsidies and Special Conditions as deduction for wages earned (per SSA definitions). If the individual is not fully earning his or her wages because the work is performed under special conditions (e.g. close and continuous supervision, on the job coaching, etc), then we should deduct that part of his or her wages that are not "earned" by the individual from his/her average gross wages. This is true whether or not the employer or someone else provides the special on-the-job conditions. Most work supports that an individual receives in order to earn income is provided under LTC (i.e. transportation, personal attendant services, job coaching, etc). However, under current Medicaid LTC regulations, if they earn over 300% of federal benefit rate (FBR), they are penalized. Many individuals do not have the out-of-pocket expenses that are needed to bring down countable earned income due to the LTC supports that they are receiving at no cost to them. However, they would not be earning at the level that they are earning without the waiver provided supports. Subsidies and Special Conditions would give value to the supports that are provided to the individual that enables them to work and earn income. https://www.ssa.gov/disabilityresearch/wi/subsidies.htm	See Line 2.

6.	VA Board for People with Disabilities	**Subdivision B 3a(1): The Board recommends striking "at least eight" as follows:** "For an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200%." Some individuals for medical or other reasons may work less than eight hours a week and without the disregard, there is no incentive for them to work because all of their income would go to cover their patient pay.	See Line 2.
7.	VA Board for People with Disabilities	The Board supports the following recommendations to 12VAC30-122-60 put forth by advocate and provider members of the DD Waiver Advisory Committee, of which the Board is a member.	See Line 2.
8.	Citizen	Please give to Tonia Milling ARC of Virginia 60- Financial Eligibility Standards: Special Group Category should be created for individuals receiving a portion of parent's FICA account and his/her SSDI puts recipient over 300% of gross income limit. My daughter lost her full Medicaid at that point. This reduction should not be allowed.	See Line 4.
9.	Karen Tefelski - vaACCSES	B.3.a.(1) and B.3.b.(1) Delete following employed "at least 8 hours but". Individuals who work fewer than eight hours per week are unnecessarily disadvantaged by the limitation. Many individuals may work less than 8 hours per week because of medical or other reasons. Without this disregard, there is no incentive for them to work because their income would go to patient pay. Recommend Spend-down for all Long-Term Care waiver categories. This language is already in the CCC+ waiver. This language should be moved to all categories. B.3. Recommend that Patient Pay be considered an Income Related Work Expense (IRWE). IRWEs are already considered when countable earned income is considered. Reasoning - without waiver services, an individual would not be earning at the level they are earning. But, earning at a higher level is forcing them to incur a Patient Pay. This is a disincentive to earn wages at a higher level. Recommend Special Group Category Consideration – SSI/SSDI waiver recipients increasingly have retired, disabled or deceased parents and the waiver recipient's income increases because their parent's FICA account is opened and a portion of this account is received by the waiver recipient. This amount (now SSDI) often puts the waiver recipient over the 300% gross income limit. The first thing the individual does is quit work if working. These individuals should be put in a "protected category" which will disregard the amount of the new income (SSDI) that will cause them to become ineligible for waiver services. This protection is considered when looking at continued Medicaid eligibility. (https://secure.ssa.gov/poms.nsf/lnx/0501715015) Recommend Subsidies and Special Conditions as deduction for wages earned (per SSA definitions). If the individual is not fully earning his or her wages because the work is performed under special conditions (e.g. close and continuous supervision, on the job coaching, etc), then we should deduct that part of his or her wages that are not "earned" by the individual from his/her average gross wages. This is true	See Line 2.

		whether or not the employer or someone else provides the special on-the-job conditions. Most work supports that an individual receives in order to earn income is provided under LTC (i.e. transportation, personal attendant services, job coaching, etc). However, under current Medicaid LTC regulations, if they earn over 300% of federal benefit rate (FBR), they are penalized. Many individuals do not have the out-of-pocket expenses that are needed to bring down countable earned income due to the LTC supports that they are receiving at no cost to them. However, they would not be earning at the level that they are earning without the waiver provided supports. Subsidies and Special Conditions would give value to the supports that are provided to the individual that enables them to work and earn income. https://www.ssa.gov/disabilityresearch/wi/subsidies.htm Recommend the addition of the following language - "The support coordinator is responsible for determining which Waiver provider will receive the greater Medicaid reimbursement, and will therefore be responsible for collecting the Medicaid co-payment from the individual. The support coordinator will notify all Waiver providers which provider will collect the monthly co-payment and in what amount. Notification will be in writing from the support coordinator to the individual and to all Waiver providers."	
10.	C Skelly, DD Committee, Arlington CSB	**Medical Spend-Down.** Clients with earned and unearned income that exceeds Medicaid eligibility thresholds should be allowed to spend down against their medical and care expenses in order to retain eligibility for the DD waiver, as they are under the CCC Plus waiver. In addition, waiver eligibility should be protected in cases where mandatory payments from parents' retirement accounts, including SSDI, military, and civil service, cause waiver recipients to exceed the income thresholds (page 3 of the VAA letter).	See Line 2.
11.	Beatty/VA Alliance	People with DD Waivers don't have option to "spend down" income over Waiver income cap on medical expenses to demonstrate eligibility for Waiver. The net result is that people with either high earned or unearned income are ineligible for the DD Waivers. As we see the generation of baby boomers retiring and SSDI payments to adult children reaching and exceeding the limits of financial eligibility, it would be wise to amend the DD Waiver Regulations to allow a "spend down" option similar to that allowed under the CCC Plus Waiver. Additionally, regulations should protect eligibility for anyone who is put over the monthly income cap as a result of SSDI received from parents. This benefit cannot be refused, despite the wishes of the person with a disability, yet it can have the effect of making them ineligible for crucial services they cannot afford.	See Line 2.

12.	Donald Kelly, L'Arche	3. B.3.a.(1) and B.3.b.(1) Delete following employed "at least 8 hours but". Individuals who work fewer than eight hours per week are unnecessarily disadvantaged by the limitation. Many individuals may work less than 8 hours per week because of medical or other reasons. Without this disregard, there is no incentive for them to work because their income would go to patient pay.* Recommend Special Group Category Consideration – SSI/SSDI waiver recipients increasingly have retired, disabled or deceased parents and the waiver recipient's income increases because their parent's FICA account is opened and a portion of this account is received by the waiver recipient. This amount (now SSDI) often puts the waiver recipient over the 300% gross income limit. The first thing the individual does is quit work if working. These individuals should be put in a "protected category" which will disregard the amount of the new income (SSDI) that will cause them to become ineligible for waiver services. This protection is considered when looking at continued Medicaid eligibility. (https://secure.ssa.gov/poms.nsf/lnx/0501715015)	See Line 2.
13.	Citizen	B.3.a.(1) and B.3.b.(1) Delete following employed "at least 8 hours but". Individuals who work fewer than eight hours per week are unnecessarily disadvantaged by the limitation. Many individuals may work less than 8 hours per week because of medical or other reasons. Without this disregard, there is no incentive for them to work because their income would go to patient pay Recommend Spend-down for all Long-Term Care waiver categories. This language is already in the CCC+ waiver. This language should be moved to all categories. B.3. Recommend that Patient Pay be considered an Income Related Work Expense (IRWE). IRWEs are already considered when countable earned income is considered. Reasoning - without waiver services, an individual would not be earning at the level they are earning. But, earning at a higher level is forcing them to incur a Patient Pay. This is a disincentive to earn wages at a higher level. Recommend Special Group Category Consideration – SSI/SSDI waiver recipients increasingly have retired, disabled or deceased parents and the waiver recipient's income increases because their parent's FICA account is opened and a portion of this account is received by the waiver recipient. This amount (now SSDI) often puts the waiver recipient over the 300% gross income limit. The first thing the individual does is quit work if working. These individuals should be put in a "protected category" which will disregard the amount of the new income (SSDI) that will cause them to become ineligible for waiver services. This protection is considered when looking at continued Medicaid eligibility. (https://secure.ssa.gov/poms.nsf/lnx/0501715015) Recommend Subsidies and Special Conditions as deduction for wages earned (per SSA definitions). If the individual is not fully earning his or her wages because the work is performed under special conditions (e.g. close and continuous supervision, on the job coaching, etc), then we should deduct that part of his or her wages that are not "earned" by the	See Line 2.

		individual from his/her average gross wages. This is true whether or not the employer or someone else provides the special on-the-job conditions.	
14.	Citizen	B.3.a.(1) and B.3.b.(1) Delete following employed "at least 8 hours but". Individuals who work fewer than eight hours per week are unnecessarily disadvantaged by the limitation. Many individuals may work less than 8 hours per week because of medical or other reasons. Without this disregard, there is no incentive for them to work because their income would go to patient pay. • Recommend Spend-down for all Long-Term Care waiver categories. This language is already in the CCC+ waiver. This language should be moved to all categories. • B.3. Recommend that Patient Pay be considered an Income Related Work Expense (IRWE). IRWEs are already considered when countable earned income is considered. Reasoning - without waiver services, an individual would not be earning at the level they are earning. But, earning at a higher level is forcing them to incur a Patient Pay. This is a disincentive to earn wages at a higher level. • Recommend Special Group Category Consideration – SSI/SSDI waiver recipients increasingly have retired, disabled or deceased parents and the waiver recipient's income increases because their parent's FICA account is opened and a portion of this account is received by the waiver recipient. This amount (now SSDI) often puts the waiver recipient over the 300% gross income limit. The first thing the individual does is quit work if working. These individuals should be put in a "protected category" which will disregard the amount of the new income (SSDI) that will cause them to become ineligible for waiver services. This protection is considered when looking at continued Medicaid eligibility. (https://secure.ssa.gov/poms.nsf/lnx/0501715015) • Recommend Subsidies and Special Conditions as deduction for wages earned (per SSA definitions). If the individual is not fully earning his or her wages because the work is performed under special conditions (e.g. close and continuous supervision, on the job coaching, etc), then we should deduct that part of his or her wages that are not "earned" by the individual from his/her average gross wages. This is true whether or not the employer or someone else provides the special on-the-job conditions. Most work supports that an individual receives in order to earn income is provided under LTC (i.e. transportation, personal attendant services, job coaching, etc). However, under current Medicaid LTC regulations, if they earn over 300% of federal benefit rate (FBR), they are penalized. Many individuals do not have the out-of-pocket expenses that are needed to bring down countable earned income due to the LTC supports that they are receiving at no cost to them. However, they would not be earning at the level that they are earning without the waiver provided supports. Subsidies and Special Conditions would give value to the supports that are provided to the individual that enables them to work and earn income.	See response to #1. Support coordinators already decide who collects the patient pay.

		https://www.ssa.gov/disabilityresearch/wi/subsidies.htm • Recommend the addition of the following language - "The support coordinator is responsible for determining which Waiver provider will receive the greater Medicaid reimbursement, and will therefore be responsible for collecting the Medicaid co-payment from the individual. The support coordinator will notify all Waiver providers which provider will collect the monthly co-payment and in what amount. Notification will be in writing from the support coordinator to the individual and to all Waiver providers."	
15.	Jan Williams, ServiceSource	The following language is not included; we recommend including this text for accountability and clarity regarding co-payment collection: B. Patient pay methodology. Suggest adding: "The support coordinator is responsible for determining which Waiver provider will receive the greater Medicaid reimbursement, and will therefore be responsible for collecting the Medicaid co-payment from the individual. The support coordinator will notify all Waiver providers which provider will collect the monthly co-payment and in what amount. Notification will be in writing from the support coordinator to the individual and to all Waiver providers." Recommend Spend-down for ALL Long-Term Care Waiver categories. This language already is written in CCC+ Waiver regulations and should be included in ALL Long-Term Care Waivers.	See Line 14.
16.	Citizen	Financial eligibility standards for individuals. • B.3.a.(1) and B.3.b.(1) Delete following employed "at least 8 hours but". Individuals who work fewer than eight hours per week are unnecessarily disadvantaged by the limitation. Many individuals may work less than 8 hours per week because of medical or other reasons. Without this disregard, there is no incentive for them to work because their income would go to patient pay. • Recommend Spend-down for all Long-Term Care waiver categories. This language is already in the CCC+ waiver. This language should be moved to all categories. • B.3. Recommend that Patient Pay be considered an Income Related Work Expense (IRWE). IRWEs are already considered when countable earned income is considered. Reasoning - without waiver services, an individual would not be earning at the level they are earning. But, earning at a higher level is forcing them to incur a Patient Pay. This is a disincentive to earn wages at a higher level. • Recommend Special Group Category Consideration – SSI/SSDI waiver recipients increasingly have retired, disabled or deceased parents and the waiver recipient's income increases because their parent's FICA account is opened and a portion of this account is received by the waiver recipient. This amount (now SSDI) often puts the waiver recipient over the 300% gross income limit. The first thing the individual does is quit work if working. These individuals should be put in a "protected category" which will disregard the amount of the new income (SSDI) that will cause them to become ineligible for waiver services. This protection is considered when looking at continued Medicaid	See Line 2.

		eligibility. (https://secure.ssa.gov/poms.nsf/lnx/0501715015) • Recommend Subsidies and Special Conditions as deduction for wages earned (per SSA definitions). If the individual is not fully earning his or her wages because the work is performed under special conditions (e.g. close and continuous supervision, on the job coaching, etc), then we should deduct that part of his or her wages that are not "earned" by the individual from his/her average gross wages. This is true whether or not the employer or someone else provides the special on-the-job conditions. Most work supports that an individual receives in order to earn income is provided under LTC (i.e. transportation, personal attendant services, job coaching, etc). However, under current Medicaid LTC regulations, if they earn over 300% of federal benefit rate (FBR), they are penalized. Many individuals do not have the out-of-pocket expenses that are needed to bring down countable earned income due to the LTC supports that they are receiving at no cost to them. However, they would not be earning at the level that they are earning without the waiver provided supports. Subsidies and Special Conditions would give value to the supports that are provided to the individual that enables them to work and earn income. https://www.ssa.gov/disabilityresearch/wi/subsidies.htm • Recommend the addition of the following language - "The support coordinator is responsible for determining which Waiver provider will receive the greater Medicaid reimbursement, and will therefore be responsible for collecting the Medicaid co-payment from the individual. The support coordinator will notify all Waiver providers which provider will collect the monthly co-payment and in what amount. Notification will be in writing from the support coordinator to the individual and to all Waiver providers."	
17.	Dominion Waiver/Koke	• B.3. Recommend that Patient Pay be considered an Income Related Work Expense (IRWE). IRWEs are already considered when countable earned income is considered. Reasoning - without waiver services, an individual would not be earning at the level they are earning. But, learning at a higher level is forcing them to incur a Patient Pay. This is a disincentive to earn wages at a higher level. • Recommend Special Group Category Consideration – SSI/SSDI waiver recipients increasingly have retired, disabled or deceased parents and the waiver recipient's income increases because their parent's FICA account is opened and a portion of this account is received by the waiver recipient. This amount (now SSDI) often puts the waiver recipient over the 300% gross income limit. The first thing the individual does is quit work if working. These individuals should be put in a "protected category" which will disregard the amount of the new income (SSDI) that will cause them to become ineligible for waiver services. This protection is considered when looking at continued Medicaid eligibility. (https://secure.ssa.gov/poms.nsf/lnx/0501715015) • Recommend Subsidies and Special Conditions as deduction	See Line 2.

		for wages earned (per SSA definitions). If the individual is not fully earning his or her wages because the work is performed under special conditions (e.g. close and continuous supervision, on the job coaching, etc), then we should deduct that part of his or her wages that are not "earned" by the individual from his/her average gross wages. This is true whether or not the employer or someone else provides the special on-the-job conditions. Most work supports that an individual receives in order to earn income is provided under LTC (i.e. transportation, personal attendant services, job coaching, etc). However, under current Medicaid LTC regulations, if they earn over 300% of federal benefit rate (FBR), they are penalized. Many individuals do not have the out-of-pocket expenses that are needed to bring down countable earned income due to the LTC supports that they are receiving at no cost to them. However, they would not be earning at the level that they are earning without the waiver provided supports. Subsidies and Special Conditions would give value to the supports that are provided to the individual that enables them to work and earn income. https://www.ssa.gov/disabilityresearch/wi/subsidies.htm • Recommend the addition of the following language - "The support coordinator is responsible for determining which Waiver provider will receive the greater Medicaid reimbursement, and will therefore be responsible for collecting the Medicaid co-payment from the individual. The support coordinator will notify all Waiver providers which provider will collect the monthly co-payment and in what amount. Notification will be in writing from the support coordinator to the individual and to all Waiver providers."	
18.	Wormley, Kerns, Collier, Lester, Hauley -VersAbility Rsc	B.3.a.(1) and B.3.b.(1) Delete following employed "at least 8 hours but". Individuals who work fewer than eight hours per week are unnecessarily disadvantaged by the limitation. Many individuals may work less than 8 hours per week because of medical or other reasons. Without this disregard, there is no incentive for them to work because their income would go to patient pay. Recommend Spend-down for all Long-Term Care waiver categories. This language is already in the CCC+ waiver. This language should be moved to allcategories. B.3. Recommend that Patient Pay be considered an Income Related Work Expense (IRWE). IRWEs are already considered when countable earned income is considered. Reasoning - without waiver services, an individual would not be earning at the level they are earning.But, earning at a higher level is forcing them to incur a Patient Pay. This is a disincentive to earn wages at a higherlevel. Recommend Special Group Category Consideration – SSI/SSDI waiver recipients increasingly have retired, disabled or deceased parents and the waiver recipient's income increases because their parent's FICA account is opened and a portion of this account is received by the waiver recipient.	See Line 14.

		This amount (now SSDI) often puts the waiver recipient over the 300% gross income limit. The first thing the individual does is quit work if working. These individuals should be put in a "protected category" which will disregard the amount of the new income (SSDI) that will cause them to become ineligible for waiver services. This protection is considered when looking at continued Medicaid eligibility.(https://secure.ssa.gov/poms.nsf/lnx/0501715015) Recommend Subsidies and Special Conditions as deduction for wages earned (per SSA definitions). If the individual is not fully earning his or her wages because the work is performed under special conditions (e.g. close and continuous supervision, on the job coaching, etc), then we should deduct that part of his or her wages that are not "earned" by the individual from his/her average gross wages. This is true whether or not the employer or someone else provides the special on-the-job conditions. Most work supports that an individual receives in order to earn income is provided under LTC (i.e. transportation, personal attendant services, job coaching, etc). However, under current Medicaid LTC regulations, if they earn over 300% of federal benefit rate (FBR), they are penalized. Many individuals do not have the out-of-pocket expenses that are needed to bring down countable earned income due to the LTC supports that they are receiving at no cost to them. However, they would not be earning at the level that they are earning without the waiver provided supports. Subsidies and Special Conditions would give value to the supports that are provided to the individual that enables them to work and earn income. https://www.ssa.gov/disabilityresearch/wi/subsidies.htm Recommend the addition of the following language - "The support coordinator is responsible for determining which Waiver provider will receive the greater Medicaid reimbursement, and will therefore be responsible for collecting the Medicaid co-payment from the individual. The support coordinator will notify all Waiver providers which provider will collect the monthly co-payment and in what amount. Notification will be in writing from the support coordinator to the individual and to all Waiver providers."	
19.	Wormley, Kerns, Collier, Lester, Hauley -VersAbility Rsc	B.3.a.(1) and B.3.b.(1) Delete following employed "at least 8 hours but". Individuals who work fewer than eight hours per week are unnecessarily disadvantaged by the limitation. Many individuals may work less than 8 hours per week because of medical or other reasons. Without this disregard, there is no incentive for them to work because their income would go to patient pay. Recommend Spend-down for all Long-Term Care waiver categories. This language is already in the CCC+ waiver. This language should be moved to allcategories. B.3. Recommend that Patient Pay be considered an Income Related Work Expense (IRWE). IRWEs are already	See Line 2.

		considered when countable earned income is considered. Reasoning - without waiver services, an individual would not be earning at the level they are earning.But, earning at a higher level is forcing them to incur a Patient Pay. This is a disincentive to earn wages at a higherlevel. Recommend Special Group Category Consideration – SSI/SSDI waiver recipients increasingly have retired, disabled or deceased parents and the waiver recipient's income increases because their parent's FICA account is opened and a portion of this account is received by the waiver recipient. This amount (now SSDI) often puts the waiver recipient over the 300% gross income limit. The first thing the individual does is quit work if working. These individuals should be put in a "protected category" which will disregard the amount of the new income (SSDI) that will cause them to become ineligible for waiver services. This protection is considered when looking at continued Medicaid eligibility.(https://secure.ssa.gov/poms.nsf/lnx/0501715015) Recommend Subsidies and Special Conditions as deduction for wages earned (per SSA definitions). If the individual is not fully earning his or her wages because the work is performed under special conditions (e.g. close and continuous supervision, on the job coaching, etc), then we should deduct that part of his or her wages that are not "earned" by the individual from his/her average gross wages. This is true whether or not the employer or someone else provides the special on-the-job conditions. Most work supports that an individual receives in order to earn income is provided under LTC (i.e. transportation, personal attendant services, job coaching, etc). However, under current Medicaid LTC regulations, if they earn over 300% of federal benefit rate (FBR), they are penalized. Many individuals do not have the out-of-pocket expenses that are needed to bring down countable earned income due to the LTC supports that they are receiving at no cost to them. However, they would not be earning at the level that they are earning without the waiver provided supports. Subsidies and Special Conditions would give value to the supports that are provided to the individual that enables them to work and earn income. https://www.ssa.gov/disabilityresearch/wi/subsidies.htm Recommend the addition of the following language - "The support coordinator is responsible for determining which Waiver provider will receive the greater Medicaid reimbursement, and will therefore be responsible for collecting the Medicaid co-payment from the individual. The support coordinator will notify all Waiver providers which provider will collect the monthly co-payment and in what amount. Notification will be in writing from the support coordinator to the individual and to all Waiverproviders."	
20.	Crum/ServiceSource	Same as Line 15.	

21.	Donald Kelly, L'Arche	3. B.3.a.(1) and B.3.b.(1) Delete following employed "at least 8 hours but". Individuals who work fewer than eight hours per week are unnecessarily disadvantaged by the limitation. Many individuals may work less than 8 hours per week because of medical or other reasons. Without this disregard, there is no incentive for them to work because their income would go to patient pay.* Recommend Special Group Category Consideration – SSI/SSDI waiver recipients increasingly have retired, disabled or deceased parents and the waiver recipient's income increases because their parent's FICA account is opened and a portion of this account is received by the waiver recipient. This amount (now SSDI) often puts the waiver recipient over the 300% gross income limit. The first thing the individual does is quit work if working. These individuals should be put in a "protected category" which will disregard the amount of the new income (SSDI) that will cause them to become ineligible for waiver services. This protection is considered when looking at continued Medicaid eligibility. (https://secure.ssa.gov/poms.nsf/lnx/0501715015)	See Line 2.
22.	Emory, Parent & L'Arche Metro Richmond	1. Patient Pay - Disregard earned income for those who work less than 8 hours 2. Delete the patient pay verbiage that takes earned income from those who work less than 8 hours. Per the regulations, if those affected work 8 - 20, earned income is disregarded. Why less than 8? They have the same work expenses as those who work over 8 hours. 3. See the text below and note that "at least eight but" is crossed out. 4. "For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% of SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI." 5. The 8-hour minimum is arbitrary and unfair. A person who works less than 8 hours per week should not have earned income deducted when they have the same employment expenses as those who work 8-20 hours? In addition, it is likely that those who work less than 8 hours have more intense issues than those who work more hours. These individuals should not be penalized because they are trying to work. Please allow a financial incentive to work for those who work less than 8 hours per week.	See Line 2.
23.	DeAnne Mullins, LCSW	C.4.- Following *initiated within* change "30 days" to "90 days," Taking into account the existing workforce recruitment timeframes, training requirements, etc., services may not realistically be ?initiated in only 30 days. If there are other requirements to notify DSS within that timeframe then the 30-day requirement in line 4 will have to remain. Ensure that references to days (days vs. calendar days) are consistent. There are a variety of reasons that can create a delay of service initiation beyond 30 days. The individual should not be penalized by having to undergo another financial eligibility determination because the provider does not initiate services in a timely manner. It is unlikely that there would be a significant change in financial circumstances within a 30-day period. Furthermore, since the individual/family have up to 30	We were not able to identify the text that this comment relates to.

		days to contact the provider, should this contact be made on day 29, services clearly could not be initiated by day 30.	
24.	Johnston/Vector Industries	B.3.a.(1) and B.3.b.(1) Delete following employed "at least 8 hours but". Individuals who work fewer than eight hours per week are unnecessarily disadvantaged by the limitation. Many individuals may work less than 8 hours per week because of medical or other reasons. Without this disregard, there is no incentive for them to work because their income would go to patient pay. Recommend Spend-down for all Long-Term Care waiver categories. This language is already in the CCC+ waiver. This language should be moved to all categories. B.3. Recommend that Patient Pay be considered an Income Related Work Expense (IRWE). IRWEs are already considered when countable earned income is considered. Reasoning - without waiver services, an individual would not be earning at the level they are earning. But, earning at a higher level is forcing them to incur a Patient Pay. This is a disincentive to earn wages at a higher level. Recommend Special Group Category Consideration – SSI/SSDI waiver recipients increasingly have retired, disabled or deceased parents and the waiver recipient's income increases because their parent's FICA account is opened and a portion of this account is received by the waiver recipient. This amount (now SSDI) often puts the waiver recipient over the 300% gross income limit. The first thing the individual does is quit work if working. These individuals should be put in a "protected category" which will disregard the amount of the new income (SSDI) that will cause them to become ineligible for waiver services. This protection is considered when looking at continued Medicaid eligibility. (https://secure.ssa.gov/poms.nsf/lnx/0501715015) Recommend Subsidies and Special Conditions as deduction for wages earned (per SSA definitions). If the individual is not fully earning his or her wages because the work is performed under special conditions (e.g. close and continuous supervision, on the job coaching, etc), then we should deduct that part of his or her wages that are not "earned" by the individual from his/her average gross wages. This is true whether or not the employer or someone else provides the special on-the-job conditions. Most work supports that an individual receives in order to earn income is provided under LTC (i.e. transportation, personal attendant services, job coaching, etc). However, under current Medicaid LTC regulations, if they earn over 300% of federal benefit rate (FBR), they are penalized. Many individuals do not have the out-of-pocket expenses that are needed to bring down countable earned income due to the LTC supports that they are receiving at no cost to them. However, they would not be earning at the level that they are earning without the waiver provided supports. Subsidies and Special Conditions would give value to the supports that are provided to the individual that enables them to work and earn income. https://www.ssa.gov/disabilityresearch/wi/subsidies.htm	See Line 2.

25.	Virginia Board for People with Disabilities	The Board supports the following recommendations to 12VAC30-122-60 put forth by advocate and provider members of the DD Waiver Advisory Committee, of which the Board is a member.	See Line 2.
26.	Virginia Board for People with Disabilities	Subdivision B 3: The Board recommends that Patient Pay be considered an Income Related Work Expense (IRWE). IRWEs are already considered when countable earned income is considered. Without waiver services, an individual would not be earning at the level they are earning. But, earning at a higher level is forcing them to incur a Patient Pay. This is a disincentive to earn wages at a higher level.	See Line 2.
27.	Virginia Board for People with Disabilities	Recommend Subsidies and Special Conditions as deduction for wages earned (per SSA definitions). If the individual is not fully earning his or her wages because the work is performed under special conditions (e.g. close and continuous supervision, on the job coaching, etc), then we should deduct that part of his or her wages that are not "earned" by the individual from his/her average gross wages.	See Line 2.
28.	Virginia Board for People with Disabilities	Recommend Spend-down for all Long-Term Care waiver categories. This language is already in the CCC+ waiver. This language should be moved to all categories.	See Line 2.
29.	Virginia Board for People with Disabilities	Implement a Special Group Category Consideration. SSI/SSDI waiver recipients increasingly have retired, disabled or deceased parents and the waiver recipient's income increases because their parent's FICA account is opened and a portion of this account is received by the waiver recipient. This amount (now SSDI) often puts the waiver recipient over the 300% gross income limit. The causes the individual to stop working. These individuals should be put in a "protected category" which will disregard the amount of the new income (SSDI) that will cause them to become ineligible for waiver services. This protection is considered when looking at continued Medicaid eligibility.	See Line 2.

Comments related to 12VAC30-122-70

2.	Lucy Beadnell, Virginia Ability Alliance	People with the DD Waivers do not have the option to "spend down" income over the Waiver income cap on medical expenses to demonstrate eligibility for Waiver. Result is people with either high earned or unearned income are ineligible for the DD Waivers. **It would be wise to amend the DD Waiver Regulations to allow a "spend down" option similar to that allowed under the CCC Plus Waiver. Regulations should protect eligibility for anyone who is put over the monthly income cap as a result of SSDI received from parents.** This benefit cannot be refused, despite the wishes of the person with a disability, yet it can have the effect of making them ineligible for crucial services they cannot afford.	See Section 12 VAC 30-122-60, Line 2.

3.	Loudoun CSB L. Snider	Does the DBHDS process of sending letters meet this requirement of annual contact?	Yes.
4.	Dville/Pittvania CSB/S. Craddock	Recent audits by DBHDS have wanted to see that individuals put on the Waitlist agreed to receipt of services within 30 days if awarded the slot. Is this a requirement? If so, where is this to be documented?	This will be added to the DBHDS form.
5.	Dville/Pittvania CSB/S. Craddock	Should reference DBHDS responsibility for collecting the forms and sending to CSBs/BHAs.	The process will be described more fully in the manual.
6.	Dville/Pittvania CSB/S. Craddock	Does the DBHDS process of sending letters meet this requirement of annual contact?	Yes.
7.	Harrison-Rock'ham CSB/ Slaughbaugh	Recent audits by DBHDS have wanted to see that individuals put on the Waitlist agreed to receipt of services within 30 days if awarded the slot. Is this a requirement? If so, where is this to be documented?	This will be added to the DBHDS form.
8.	Harrison-Rock'ham CSB/ Slaughbaugh	Should reference DBHDS responsibility for collecting the forms and sending to CSBs/BHAs.	This will be added to the DBHDS form.
9.	Harrison-Rock'ham CSB/ Slaughbaugh	Does the DBHDS process of sending letters meet this requirement of annual contact?	Yes.
10.	Henrico Area MHDS	F. Clarify the WSAC process so it does not appear that a person can go from the request to a CM assigning any available CSB Waiver slot H. Clarify the state's role in managing the Choice forms.	F. "Consistent with 12VAC122-90 E," was added to the start of first sentence. H. This will be discussed in the Manual.
11.	Blue Ridge Beh Healthcare A. Monti	Recent audits by DBHDS have wanted to see that individuals put on the Waitlist agreed to receipt of services within 30 days if awarded the slot. Is this a requirement? If so, where is this to be documented?	This will be added to the DBHDS form.
12.	Blue Ridge Beh Healthcare A. Monti	Should reference DBHDS responsibility for collecting the forms and sending to CSBs/BHAs.	The process will be described more fully in the manual.
13.	Blue Ridge Beh Healthcare A. Monti	Does the DBHDS process of sending letters meet this requirement of annual contact?	Yes.
14.	RBHA/M Harrison	Recent audits by DBHDS have wanted to see that individuals put on the Waitlist agreed to receipt of services within 30 days if awarded the slot. Is this a requirement? If so, where is this to be documented?	This will be added to the DBHDS form.
15.	RBHA/M Harrison	Should reference DBHDS responsibility for collecting the forms and sending to CSBs/BHAs.	The process will be described more fully in the manual.

16.	RBHA/M Harrison	Does the DBHDS process of sending letters meet this requirement of annual contact?	Yes.
17.	Henrico Area MHDS	F. Clarify the WSAC process so it does not appear that a person can go from the request to a CM assigning any available CSB Waiver slot H. Clarify the state's role in managing the Choice forms.	See Line 10.
18.	Elliott/Hanover CSB	Choice between institutional care and waiver services - Please clarify how often and individual completes this. Currently one must complete this annually while on the wait list, but not once he/she is enrolled in waiver. This question comes up often.	This will be clarified in the manual.
19.	Citizen	I endorse the VAA Comments. The Regulations should reinstate aging parents on the priority 1 list. Although the priority list was developed by a working group, it is obvious that none of these individuals included anyone on the wait list who was previously on the urgent list. Aging parents should not have to be incapacitated or die before their child has an opportunity to wait for services in Priority 1. These parents were on the front lines of deinstitutionalization and were the first ones to decide that their children were better off at home than in the institutions. It is obviously better for people with DD to be a part of the community, however I have heard from a number of aging parents who don't know where to turn. One aging gentleman had obvious disabilities himself, his wife is now deceased, and his aging daughter has nowhere to go except possibly to her sister's home, when he eventually dies. Likewise, if a "transitioning youth" is on the priority 1 list and turns 28 at a time when the General Assembly does not allocate additional waivers, his or her parents will have to wait the rest of their lives for services. There is also a need to define the terms: "immediate jeopardy" and "immediate risk" for the Priority 1 list. The category for "immediate risk: should the unavailability of a caregiver. Here is my suggestion: - "Immediate jeopardy" an urgent threat of harm to self or others. - "immediate risk" a current risk of harm to self or other due to: 1) the person's behavior and/or inability to care for self; 2) the caretaker inability to provide needed care; 3) no caretaker available to provide care (this would also include adults who have aged out of the foster care system, people whose parents are deceased, or individuals who are homeless on the priority 1 list). The VIDES should clearly state to the client and/or caregiver that it assesses level of functioning IN THE ABSENCE OF SUPPORT. At least one person, who was functioning well on the waiver, was terminated because the support he was being provided raised his level of functioning to the point that he was deemed ineligible for the waiver. Clients should be informed of their right to all records, including the care plans, VIDES and SIS assessments (these are all healthcare records). Further, they should have a right to contest or appeal decisions made about their care plans, VIDES or SIS.	1. There is a shortage resources for waiver services, and this process attempts to allocate those limited services fairly. The waiting list focuses on individual criteria rather than age. 2. Transitioning youth: we are attemtping to balance the needs of individuals with a limited number of waiver slots. If additional funding is allocated by the General Assembly, this will be revisited. 3. Immediate jeopardy is related to caregiver's status. Immediate risk is defined more broadly than the commenter has requested. VIDES: Sometimes individuals gain skills and no longer need this set of services. Individuals do have a right to

			request their records, and do have a right to contest decisions made about care plans, VIDES, or SIS.

Changes related to 12VAC30-122-80

2.	DDWAC	1. C.3.- add at the end "and other service plans as applicable." 2. C.4.- Following initiated within change "30 days" to "90 days," [Taking into account the existing workforce recruitment timeframes, training requirements, etc. services can not realistically be initiated in only 30 days. If there are other requirements to notify DSS within that timeframe then the 30 day requirement in line 4 will have to remain] 3. C.6.c.- Following approve change "suspend" to "pend"	1. All plans for support are part of the ISP, so changes will not be made. 2. There is an extension process, so changes will not be made. 3. Suspend and pend have the same meaning.
3.	Loudoun CSB L. Snider	Retain slot used to be 180 days now 120 days; Suggest this changes back to 180 days.	The slot is retained for 150 days, which is an appropriate length of time.
4.	Loudoun CSB L. Snider	The statement "The plan for supports shall also contain the steps for mitigating any identified risks" is a concern. There are times individuals do not want to take steps to mitigate risks. They have the right to refuse, with choice and dignity of risk. This statement should be revised to indicate "The plan for supports shall also contain the steps for mitigating	The text in the regulation already addresses this issue.

		any identified risks or document the person's refusal of mitigating actions."	
5.	Dville/Pittvania CSB/S. Craddock	Retain slot used to be 180 days now 120 days; Suggest this changes back to 180 days.	The slot is retained for 150 days, which is an appropriate length of time.
6.	Citizen	change 30 days to 90 days. It is an unrealistic expectation to have all of the required components competed in 30 days regarding the application/interview/training process and the case management requirements. 90 days is more realistic and supports individuals to have time to make fully informed decisions and not feel pressured or rushed.	There is an extension process, so changes will not be made.
7.	Harrison-Rock'ham CSB/ Slaughbaugh	Retain slot used to be 180 days now 120 days; Suggest this changes back to 180 days.	The slot is retained for 150 days, which is an appropriate length of time.
8.	Harrison-Rock'ham CSB/ Slaughbaugh	The statement "The plan for supports shall also contain the steps for mitigating any identified risks" is a concern. There are times individuals do not want to take steps to mitigate risks. They have the right to refuse, with choice and dignity of risk. This statement should be revised to indicate "The plan for supports shall also contain the steps for mitigating any identified risks or document the person's refusal of mitigating actions."	The text in the regulation already addresses this issue.
9.	VNPP/J Fidura	Add new language - see below: 12VAC30-122-80. Waiver approval process; authorizing and accessing services. C.6. The providers, in conjunction with the individual and the individual's family/caregiver, as appropriate, and the support coordinator shall develop a plan for supports for each service. a. Each provider shall submit a copy of his plan for supports to the support coordinator. The plan for supports from each provider shall be incorporated into the ISP. The ISP shall also contain the steps for mitigating any identified risks. b. The support coordinator shall review and ensure the provider-specific plan for supports meets the established service criteria for the identified needs prior to electronically submitting the plan for supports along with the results of the comprehensive assessment and a recommendation for the final determination of the need for ICF/IID level of care to DMAS or its designee for service authorization. "Comprehensive assessment" means the gathering of relevant social, psychological, medical, and level of care information by the support coordinator that are used as bases for the development of the individual support plan. c. DMAS or its designee shall, within 10 working days of receiving all supporting documentation, review and approve, suspend for more information, or deny the individual service requests. DMAS or its designee shall communicate	There are appeal rights in place that allow for continuation of benefits during the appeal period. However, if the individual loses the appeal, they may be liable for the cost of the services provided during that period.

		electronically to the support coordinator whether the recommended services have been approved and the amounts and types of services authorized or if any services have been denied. If the service request is to be denied for a service that in both type and amount is currently authorized, DMAS or it's designee shall communicate electronically to the support coordinator that the recommended services have been approved for a period of ninety (90). In advance of resubmitting the service request, the team shall consider if there are other alternatives and/or provide additional justification for the request. DMAS or it's designee shall make a final determination upon receipt of a revised service request and if the service is denied instruct the support coordinator to provide appeal rights to the individual, or family/caregiver as appropriate.	
10.	Henrico Area MHDS	C.6.a. Clarify that submission is through WaMS or call it electronic system	This will be discussed in the manual.
11.	Blue Ridge Beh Healthcare A. Monti	Retain slot used to be 180 days now 120 days; Suggest this changes back to 180 days.	The slot is retained for 150 days, which is an appropriate length of time.
12.	Blue Ridge Beh Healthcare A. Monti	The statement "The plan for supports shall also contain the steps for mitigating any identified risks" is a concern. There are times individuals do not want to take steps to mitigate risks. They have the right to refuse, with choice and dignity of risk. This statement should be revised to indicate "The plan for supports shall also contain the steps for mitigating any identified risks or document the person's refusal of mitigating actions."	The text in the regulation already addresses this issue.
13.	Hartwood Foundation, Inc.	C4 - Extend timeframe for initiating service from 30 days to **60 or 90 days.** It takes more than a few weeks to provide and obtain completed service applications (and related materials), arrange for tours, schedule and conduct intake meetings and hire/train/assign staff, etc.	There is an extension process, so changes will not be made.
14.	RBHA/M Harrison	Retain slot used to be 180 days now 120 days; Suggest this changes back to 180 days.	The slot is retained for 150 days, which is an appropriate length of time.
15.	RBHA/M Harrison	The statement "The plan for supports shall also contain the steps for mitigating any identified risks" is a concern. There are times individuals do not want to take steps to mitigate risks. They have the right to refuse, with choice and dignity of risk. This statement should be revised to indicate "The plan for supports shall also contain the steps for mitigating any identified risks or document the person's refusal of mitigating actions."	The text in the regulation already addresses this issue.
16.	VA Board for People with Disabilities	**Subdivision C 3: The Board recommends adding "and other service plans, as applicable" at the end of this subdivision.** This subdivision relates to signature on the individual service plan by the individual, family member and	All plans for support are part of the ISP, so

		support coordinator. In addition to the ISP, there may be other provider service plans that are agreed to and should be signed (e.g., an employment plan).	changes will not be made.
17.	Karen Tefelski - vaACCSES	C.3. - add at the end "and other service plans as applicable." C.4.- Following initiated within change "30 days" to "90 days," Taking into account the existing workforce recuitment timeframes, training requirements, etc. services may not realistically be initiated in only 30 days. If there are other requirements to notify DSS within that timeframe then the 30-day requirement in line 4 will have to remain. Ensure that references to day (days vs. calendar days) are consistent. There are a variety of reasons that can create a delay of service initiation beyond 30 days. The individual shouldn't be penalized by having to undergo another financial eligibility determination because the provider does not initiate services in a timely manner. It is unlikely that there would be a significant change in financial circumstances within the 30 day period. Since the individual/family have up to 30 days to contact the provider, should this contact be made on day 29. Services clearly could not be initiated on day 30. C.6.c.- Following approve change "suspend" to "pend"	See Line 2.
18.	Henrico Area MHDS	C.6.a. Clarify that submission is through WaMS or call it electronic system	See Line 10.
19.	K. Black-Hope House	C.3. - add at the end "and other service plans as applicable." C.4.- Following *initiated within* change "30 days" to "90 days," C.6.c.- Following *approve* change "suspend" to "pend"	1. All plans for support are part of the ISP, so changes will not be made. 2. There is an extension process, so changes will not be made. 3. Suspend and pend have the same meaning.
20.	B Huffman - VersAbility Resources	C.3.- add at the end "and other service plans as applicable." C.4.- Following initiated within change "30 days" to "90 days," Taking into account the existing workforce recruitment timeframes, training requirements, etc., services may not realistically be initiated in only 30 days. If there are other requirements to notify DSS within that timeframe then the 30-day requirement in line 4 will have to remain. Ensure that references to days (days vs. calendar days) are consistent. There are a variety of reasons that can create a delay of service initiation beyond 30 days. The individual should not be penalized by having to undergo another financial eligibility determination because the provider does not initiate services in a timely manner. It is unlikely that there would be a significant change in financial circumstances within a 30-day period. Furthermore, since the individual/family have up to 30 days to contact the provider, should this contact be made on day 29, services clearly could not be initiated by day 30. C.6.c.- Following approve change "suspend" to "pend" which	See Line 2.

		is the terminology currently utilized when seeking more information.	
21.	Elliott/Hanover CSB	Page 24 C1 Waiver approval process; authorizing and accessing services - “The individual and the individual's family/caregiver, as appropriate, shall meet with the support coordinator within 30 calendar days of the waiver enrollment date…” Please clarify if this is the Projected Enrollment Date or the Active Enrollment Date.	More information will be included in the manual.
22.	Elliott/Hanover CSB	Page 24 C4 –Initiating services in 30 days - There is a shortage in providers for many of the waiver services and we are finding that once a provider is secured, it can take months to get a staff hired to provide the service. Giving 30 days doesn’t appear to be realistic, 60-90 days would be better.	There is an extension process, so changes will not be made.
23.	Citizen	*DBHDS and slot retention;* **Need clarification if eligibility is defined by the VIDES or if it is a financial issue (Medicaid).**	Eligibility includes both VIDES determination and financial determination.
24.	Citizen	Waiver approval process; authorizing and accessing services. • C.3.- add at the end “and other service plans as applicable.” • C.4.- Following initiated within change “30 days” to “90 days,” Taking into account the existing workforce recruitment timeframes, training requirements, etc., services may not realistically be initiated in only 30 days. If there are other requirements to notify DSS within that timeframe then the 30-day requirement in line 4 will have to remain. Ensure that references to days (days vs. calendar days) are consistent. There are a variety of reasons that can create a delay of service initiation beyond 30 days. The individual should not be penalized by having to undergo another financial eligibility determination because the provider does not initiate services in a timely manner. It is unlikely that there would be a significant change in financial circumstances within a 30-day period. Furthermore, since the individual/family have up to 30 days to contact the provider, should this contact be made on day 29, services clearly could not be initiated by day 30. • C.6.c.- Following approve change “suspend” to “pend” whh is the terminology currently utilized when seeking more information.	1. All plans for support are part of the ISP, so changes will not be made. 2. There is an extension process, so changes will not be made. 3. Suspend and pend have the same meaning.

25.	Jan Williams, ServiceSource	C.4. Following *initiated within* change "30 days" to "90 days," Taking into account the existing workforce recruitment timeframes, training requirements, etc. services cannot realistically be initiated in only 30 days. If there are other requirements to notify DSS within that timeframe then the 30-day requirement in line 4 will have to remain. Ensure that references to days (days vs. calendar days) are consistent. There are a variety of reasons that can create a delay of service initiation beyond 30 days. The individual should not be penalized by having to undergo another financial eligibility determination because the provider does not initiate services in a timely manner.	1. All plans for support are part of the ISP, so changes will not be made. 2. There is an extension process, so changes will not be made. 3. Suspend and pend have the same meaning.
26.	Citizen	Waiver approval process; authorizing and accessing services. • C.3.- add at the end "and other service plans as applicable." • C.4.- Following initiated within change "30 days" to "90 days," Taking into account the existing workforce recruitment timeframes, training requirements, etc., services may not realistically be initiated in only 30 days. If there are other requirements to notify DSS within that timeframe then the 30-day requirement in line 4 will have to remain. Ensure that references to days (days vs. calendar days) are consistent. There are a variety of reasons that can create a delay of service initiation beyond 30 days. The individual should not be penalized by having to undergo another financial eligibility determination because the provider does not initiate services in a timely manner. It is unlikely that there would be a significant change in financial circumstances within a 30-day period. Furthermore, since the individual/family have up to 30 days to contact the provider, should this contact be made on day 29, services clearly could not be initiated by day 30. • C.6.c.- Following approve change "suspend" to "pend" whh is the terminology currently utilized when seeking more information.	1. All plans for support are part of the ISP, so changes will not be made. 2. There is an extension process, so changes will not be made. 3. Suspend and pend have the same meaning.
27.	Dominion Waiver/Koke	• C.3.- add at the end "and other service plans as applicable." • C.4.- Following initiated within change "30 days" to "90 days," Taking into account the existing workforce recruitment timeframes, training requirements, etc., services may not realistically be initiated in only 30 days. If there are other requirements to notify DSS within that timeframe then the 30-day requirement in line 4 will have to remain. Ensure that references to days (days vs. calendar days) are consistent. There are a variety of reasons that can create a delay of service initiation beyond 30 days. The individual should not be penalized by having to undergo another financial eligibility determination because the provider does not initiate services in a timely manner. It is unlikely that there would be a significant change in financial circumstances within a 30-day period. Furthermore, since the individual/family have up to 30 days to contact the provider, should this contact be made on day 29, services clearly could not be initiated by day 30. C.6.c.- Following approve change "suspend" to "pend" whh is the terminology currently utilized when seeking more information.	1. All plans for support are part of the ISP, so changes will not be made. 2. There is an extension process, so changes will not be made. 3. Suspend and pend have the same meaning.

28.	Wormley, Kerns, Collier, Lester, Hauley -VersAbility Rsc	C.3.- add at the end “and other service plans as applicable.” C.4.- Following initiated within change “30 days” to “90 days,” Taking into account the existing workforce recruitment timeframes, training requirements, etc., services may not realistically be initiated in only 30 days. If there are other requirements to notify DSS within that timeframe then the 30-day requirement in line 4 will have to remain. Ensure that references to days (days vs. calendar days) are consistent. There are a variety of reasons that can create a delay of service initiation beyond 30 days. The individual should not be penalized by having to undergo another financial eligibility determination because the provider does not initiate services in a timely manner. It is unlikely that there would be a significant change in financial circumstances within a 30-day period. Furthermore, since the individual/family have up to 30 days to contact the provider, should this contact be made on day 29, services clearly could not be initiated by day 30. C.6.c.- Following approve change “suspend” to “pend” whh is the terminology currently utilized when seeking more information.	See Line 2.
29.	Wormley, Kerns, Collier, Lester, Hauley -VersAbility Rsc	C.3.- add at the end “and other service plans as applicable.” C.4.- Following initiated within change “30 days” to “90 days,” Taking into account the existing workforce recruitment timeframes, training requirements, etc., services may not realistically be initiated in only 30 days. If there are other requirements to notify DSS within that timeframe then the 30-day requirement in line 4 will have to remain. Ensure that references to days (days vs. calendar days) are consistent. There are a variety of reasons that can create a delay of service initiation beyond 30 days. The individual should not be penalized by having to undergo another financial eligibility determination because the provider does not initiate services in a timely manner. It is unlikely that there would be a significant change in financial circumstances within a 30-day period. Furthermore, since the individual/family have up to 30 days to contact the provider, should this contact be made on day 29, services clearly could not be initiated by day 30. C.6.c.- Following approve change “suspend” to “pend” which is the terminology currently utilized when seeking more information.	See Line 2.
30.	Citizen	H. Providing choice of institutional vs. community placement is currently performed by DBHDS staff, not the CSB/BHA. 12VAC50-122-80.C7b. Does developmental disability refer to DD or ID or both as the code referenced differentiates.	1. This is described more fully in the manual. 2. ID is a subset of DD, so references to DD always include ID. The language about institutionalization is a federal requirement.
31.	Crum/ServiceSource	Same as Line 25.	See Line 25.

32.	Fairfax/Falls Ch CSB	Requesting change the time to 180 days for retain slot	The slot is retained for 150 days, which is an appropriate length of time.
33.	La Voyce B. Reid/Arlington CSB	C.3 – second to last sentence, recommend clarifying family/caregiver if not the guardian. Currently reads, ". . .the individual enrolled in the waiver, or the family caregiver as appropriate, and support coordinator shall sign and date the ISP." My understanding has always been that the individual always signs his or her ISP unless he or she has an Authorized Rep, legal guardian, or someone appointed with Power of Attorney. The wording in the proposed waiver regulations suggest that the individual "OR" the family/caregiver may sign the ISP whether or not the family caregiver is a legal guardian or Authorized Rep. 5.b – Recommend increasing up to a maximum of five or six consecutive extensions for a maximum of 150 – 180 days. This allows the Department greater flexibility for special, extenuating circumstances. The extension to 180 days in no ways suggests that the Department has to always approve extensions up to 180 days.	C3. Edits made. 5b - The slot is retained for 150 days, which is an appropriate length of time.
34.	La Voyce B. Reid/Arlington CSB	Waiver approval process: authorized and accessing services	Comment is not clear; no response can be provided.
35.	Virginia Board for People with Disabilities	Subdivision C 3: The Board recommends adding "and other service plans, as applicable" at the end of this subdivision. This subdivision relates to signature on the individual service plan by the individual, family member and support coordinator. In addition to the ISP, there may be other provider service plans that are agreed to and should be signed (e.g., an employment plan).	All plans for support are part of the ISP.
36.	Virginia Board for People with Disabilities	Subdivision C 4: The Board recommends changing 30 days to 90 days and to ensure that references to days (days vs. calendar days) are consistent. There are a variety of reasons that can create a delay of service initiation beyond 30 days. The individual should not be penalized by having to undergo another financial eligibility determination because the provider does not initiate services in a timely manner. It is unlikely that there would be a significant change in financial circumstances within a 30-day period. Furthermore, since the individual/family have up to 30 days to contact the provider, should this contact be made on day 29, services clearly could not be initiated by day 30.	See Line 2.
37.	Virginia Board for People with Disabilities	Subdivision C 6c: The Board recommends that the term "suspend" should be changed to "pend," which is the terminology currently utilized when seeking more information.	See Line 2.

Changes made to 12VAC30-122-90

2.	Lucy Beadnell, Virginia Ability Alliance	1. The growing waiting list to access the DD Waiver is concern. Support any consideration of a contract that would not allow a waiting list for basic care services. For individuals on the waiting list, concerns re: age of the primary caregiver(s) not being considered in assessing waiting list priority. Aging caregivers who no longer qualify for the Priority One waiting list due to age. Removal of this eligibility for Priority One reduces odds that the person with a disability will be able to access services before their caregiver dies. Sets up the person with disability for series of rapid crises, as they lose parents, navigate the service system, and, in many cases, move to access services they need. Propose caregiver age be considered as factor in determining eligibility for Priority One of the waiting list. 2. Terminology used in association with the Priority tiers is confusing and misleading. To explain categories in terms of years someone could be expected to wait for services furthers the notion that our system will always have multiple years of wait time for assistance. Additionally, the usage of years of wait time confuses families who often feel it is a guaranteed maximum waiting time. For individuals transferring from one Waiver to another with higher service levels, urgency of need should be taken into account. There are people on list with emergency needs (e.g., death of all caregivers or behavioral crises) and people who need higher level of service but may be able to wait a short period of time (e.g., parent who is struggling to lift them and perform needed personal care at home). A system to assess that urgency and award reserve Waiver slots accordingly would be a better solution. If no one is currently on the reserve list at a given CSB when a slot becomes available, that slot should be made available to the person highest on the Priority One waiting list.	There is a shortage resources for waiver services, and this process attempts to allocate those limited services fairly. The waiting list focuses on individual criteria rather than age. 2. Urgency is addressed in the criteria. We will provide additional language in the manual in an attempt to clarify. Reserve slot - This is the current process.
3.	Lucy Beadnell, Virginia Ability Alliance	Current rules/regs prohibit Virginia residents from accessing DD Waiver svs while living outside of Virginia, as is the case for Foreign Service families, military families, and students with disabilities attending school in another state. These families have option to stay on waiting list while out of the area, but do not have the ability to accept services if offered as they do not have the option to choose where they are stationed (and in the case of college students, often do not have the option of attending simply any college or university). We support an adjustment to the regulations to allow people to use consumer directed personal care services when living outside of Virginia as long as they maintain Virginia residence, while using technology-based options for "face to face visits." They would allow Service Facilitators and Support Coordinators to have visits and inspect the home environment.	Edits made.
4.	DDWAC	1. C.1.a. – Following care for the individual add "a primary care giver who is 70 years of age or greater" [While we recognize that the age criterion was removed	1. There is a shortage resources for

		during the "redesign," we feel that the impact has been significant on older families; it also limits the families ability to assist their adult children to make life decisions before it is an emergency] C.1.a- Following there are no strike "other" 2. C.1.b.(1)- Following effectively managed strike "by the primary caregiver or unpaid provider" [Not everyone has a primary caregiver] 3. C.1.b.(2)- Following managed strike "by the primary caregiver" 4. C.1.d- Following IDEA services and strike "is transitioning to independent living" and add "has expressed a desire to live independently" 5. E.3- Strike "A regional WSAC session will then be held for the remainder of available slots, reviewing those individuals meeting criteria for the Priority Two and then Priority Three." [We feel strongly that all slots should be for the Priority 1 list – if the service array in the BI Waiver is not attractive to those on Priority 1 then either the slots should be repurposed or the service array should be changed!]	waiver services, and this process attempts to allocate those limited services fairly. The waiting list focuses on individual criteria rather than age. 2, 3, and 4. - Edits made. 5. This process has been reviewed and approved by CMS.
5.	Loudoun CSB L. Snider	Emergency Slot Clarification on number of emergency slots, what is 10% based upon?	This amount is ten percent of the total emergency slots funded for each fiscal year.
6.	Citizen	Strike - "by the primary caregiver or unpaid provider" - not everyone has a primary caregiver and there is no operational reason to specify that in the regulations.	Edits made.
7.	Harrison-Rock'ham CSB/ Slaughbaugh	Clarification that regional WSAC is for BI only (not for other Waivers) and clarification on why indicates regional WSAC?	There are fewer people who request the BI waiver, so CSBs were grouped together to give a larger pool for the WSCAC to review.
8.	Harrison-Rock'ham CSB/ Slaughbaugh	Emergency Slot Clarification on number of emergency slots, what is 10% based upon?	This amount is ten percent of the total emergency slots funded for each fiscal year.
9.	Henrico Area MHDS	E.3. BI slots have not been allocated using this process	For further discussion of this issue, please contact your Regional Support Specialist.

10	Blue Ridge Beh Healthcare A. Monti	Clarification that regional WSAC is for BI only (not for other Waivers) and clarification on why indicates regional WSAC?	See Line 7.
11.	Blue Ridge Beh Healthcare A. Monti	Emergency Slot Clarification on number of emergency slots, what is 10% based upon?	See Line 5.
12.	Hartwood Foundation, Inc.	C1a – Add (reinstitute) age (**65 or 70**) of primary care giver as criteria for Priority One eligibility in an effort to allow for a modicum of individual and family service planning before the individual is in crisis, dealing with the death or serious health issue of a aging parent and potential life-changing move to an unfamiliar setting. E3 – All waiver slots should be for Priority One individuals. Further, if there is a lack of interest in the BI waiver, the slots should be reassigned to Priority One CL and FIS waivers with no need for WSAC session to review re-assignment to Priority Two and Three.	C1a - Same as age of caregiver. E3 - same as line 4, 5th item.
13.	RBHA/M Harrison	Clarification that regional WSAC is for BI only (not for other Waivers) and clarification on why indicates regional WSAC?	See Line 7.
14.	RBHA/M Harrison	Emergency Slot Clarification on number of emergency slots, what is 10% based upon?	See Line 5.
15.	Virginia Ability Alliance - Citizen	Our daughter is 29 years old and has intellectual disabilities. She has been on the (DD) waiver waiting list for over 14 years. We have not received an indication of when she might receive a slot and the unknown future weighs heavy on our minds. I fully support the comments provided by the Virginia Ability Alliance. The line that hit me the most is this one "… reduces the odds that the person with a disability will be able to access services notably before, or at all before, their caregiver dies". I know the DBHDS is not in control of the funding, but it is very important to know that many parents and caregivers of people with intellectual disabilities are exhausted and overwhelmed. Many of us have put our own lives and plans on hold to care for our adult children. Our over functioning, year after year, is one of the main reasons more people who have disabilities are not in extreme crisis situations. We all know this arrangement cannot last forever and help will be needed sooner or later. Much more importantly, in many ways this does a great disservice to our adult children. As a result of our young adult and not so young adult children not receiving waivers, it is very difficult for the person with a disability to move out and develop the natural supports and establish the planned supports that will allow them to grow in their independence in the community. Ideally,	We empathize with your situation, and we are grateful to you for expressing it to us. Unfortunately, we have a limited amount of funding allocated by the General Assembly for waiver slots.

		parents and caregivers, the people who know the person with the disabilities the very best, need to be a part of this transition to independence and be able to monitor how things are going and make necessary changes for the first couple years (or longer) as our young adults move out into the community.	
16.	The Arc of VA T. Milling	**Waiting List Criteria - 12VAC30-122-**90 We understand that the age of the caregiver was removed during waiver redesign, and we agreed that the age was too low. However, many individuals/families know that the only way their adult child will get a waiver is when they die. Parents and individuals on the waiting list should not have to face this reality, they should be able to plan with for the future. At some age, regardless of health, end of life becomes a reality, and families need to be able to prepare. Doing so saves the family in human costs, and saves the Commonwealth in financial cost by avoiding crisis scenarios. **The Arc of Virginia recommends that having a caregiver that is 70 or older, meets criteria for Priority One.**	There is a shortage resources for waiver services, and this process attempts to allocate those limited services fairly. The waiting list focuses on individual criteria rather than age.
17.	VA Board for People with Disabilities	**Subdivision C 1a: The Board recommends striking "there are no other unpaid caregivers" and changing it to "or there are no unpaid caregivers" to read as follows: "**An immediate jeopardy exists to the health and safety of the individual due to the unpaid primary caregiver having a chronic, long term physical or psychiatric condition that currently significantly limits the ability of the primary caregiver to care for the individual; or there are no other unpaid caregivers available to provide services."	Edits made.
18.	VAIL/G. Brunk	is very confusing. Why are only 10% of the allotted emergency slots allowed to be utilized? If they are needed, all emergency slots should be utilized by individuals in emergency situations. Or is this trying to say that up to 10% of allotted emergency slots may be utilized by individuals who are not in emergency situations?	Once 90% of the emergency slots are in use, the remaining 10% of the emergency slots go on a "lend" basis to CSBs, which are required to return the next available slot in that waiver to the state for use in another emergency.
19.	VAIL/G. Brunk	indicates that "the waiting list shall be created and maintained by DBHDS which shall update it no less than annually." We do not believe this is an efficient and effective way to maintain the waitlist. It is our understanding that DBHDS is maintaining the list by sending out letters annually to verify that individuals want to remain on the waitlist. If individuals have moved, simply do not receive this letter, or does not respond appropriately, is there follow up? It seems it would be more effective to allow the local CSBs to maintain contact with the local individuals on the waitlist	These regulations attempt to allocate limited resources fairly. Three communications are sent in an attempt to notify individuals. If an individual does not receive the communications,

			they can request to be added back to the waiting list.
20.	Citizen	90 - Waiting List C.1.a.: identify age of primary care giver age 70 or greater gives automatic Priority One, some parents die before their adult children with disabilities every reach Priority One.	There is a shortage resources for waiver services, and this process attempts to allocate those limited services fairly. The waiting list focuses on individual criteria rather than age.
21.	Karen Tefelski - vaACCSES	C.1.a. – Following care for the individual add "a primary care giver who is 70 years of age or greater". While we recognize that the age criterion was removed during the "redesign," we feel that the impact has been significant on older families. It also limits the family's ability to assist their adult children to make life decisions before it is an emergency. C.1.a- Following there are no strike "other" C.1.b.(1)- Following effectively managed strike "by the primary caregiver or unpaid provider". Not everyone has a primary caregiver. C.1.b.(2)- Following managed strike "by the primary caregiver" C.1.d- Following IDEA services and strike "is transitioning to independent living" and add "has expressed a desire to live independently" E.3- Strike "A regional WSAC session will then be held for the remainder of available slots, reviewing those individuals meeting criteria for the Priority Two and then Priority Three." We feel strongly that all slots should be for the Priority 1 list – if the service array in the BI Waiver is not attractive to those on Priority 1 then either the slots should be re-purposed or the service array should be changed.	See Line 4.
22.	Henrico Area MHDS	E.3. BI slots have not been allocated using this process	See Line 9.
23.	Citizen	I am a 67 year old mom of a 36 year old woman on the Waiver Wait List. Before the redesign, she was deemed "urgent" because I was over 55. While I agree that 55 is low, when the redesign blanketly removed this criteria for Priority 1, I was aghast. Caring for my daughter is getting harder and harder each year. I live in fear that I may die not knowing my daughter's fate, or that she will face a frightening change or questionable care at a time of grief or trauma. **Please reinstate a parent age criteria for Priority 1. I suggest 65 years old**	We empathize with your situation, and we are grateful to you for expressing it to us. Unfortunately, we have a limited amount of funding allocated by the General Assembly for waiver slots. With a shortage of resources for waiver services,

			this process attempts to allocate those limited services fairly. The waiting list focuses on individual criteria rather than age. If the caregiver develops a serious illness or upon their death, the individual may be considered for an emergency slot.
24.	B Huffman - VersAbility Resources	C.1.a. – Following care for the individual add "a primary care giver who is 70 years of age or greater". While we recognize that the age criterion was removed during the "redesign," we feel that the impact has been significant on older families. It also limits the family's ability to assist their adult children to make life decisions before it is an emergency. C.1.a- Following there are no strike "other" C.1.b.(1)- Following effectively managed strike "by the primary caregiver or unpaid provider". Not everyone has a primary caregiver. C.1.b.(2)- Following managed strike "by the primary caregiver" C.1.d- Following IDEA services and strike "is transitioning to independent living" and add "has expressed a desire to live independently" E.3- Strike "A regional WSAC session will then be held for the remainder of available slots, reviewing those individuals meeting criteria for the Priority Two and then Priority Three." We feel strongly that all slots should be for the Priority 1 list – if the service array in the BI Waiver is not attractive to those on Priority 1 then either the slots should be re-purposed or the service array should be changed.	See Line 4.
25.	C Skelly, DD Committee, Arlington CSB	**Criteria for Priority 1 on the Waitlist.** We strongly recommend reinstating caregiver age as a criterion on the Priority 1 waitlist. The elimination of age as a qualifying factor has put the current generation of aging parents in the alarming position of waiting for a health crisis, incapacitation, or even sudden death, before their adult children can transition to waiver services. We were informed that the priority list was developed by a working group of stakeholders. However, it clearly was not developed by a group that included the aging parents who were removed from the former urgent needs list, after years of waiting under the previous rules. These aging parents were on the front lines of deinstitutionalization and were the first ones to decide	There is a shortage resources for waiver services, and this process attempts to allocate those limited services fairly. The waiting list focuses on individual criteria rather than age.

		that their children were better off at home than in the institutions (see pages 1-2 of the VAA comment letter).	
26.	C Skelly, DD Committee, Arlington CSB	**Reserve Waiver Slots.** We endorse the VAA's recommendation that reserve waiver slots be allocated on the basis of the most urgent needs, instead of time on the waitlist. In addition, we ask that DBHDS establish an appeal or recourse process for individuals whose requests to move from a lower-service to a higher-service waiver are denied (page 2 of the VAA letter).	There is a shortage resources for waiver services, and this process attempts to allocate those limited services fairly. The waiting list focuses on individual criteria rather than time on the waitlist. There are appeal rights for denied requests.
27.	Citizen	I fully support the comments made by the Virginia Ability Alliance. I am a parent of two children on the autism spectrum and have been on the waitlist for services for over 10 years. My son has been a priority one for 2 years and is still waiting. I am hoping these changes will shorten the waitlist for all.	We empathize with your situation, and we are grateful to you for expressing it to us. Unfortunately, we have a limited amount of funding allocated by the General Assembly for waiver slots.
28.	Citizen	I support the comments made by Virginia Ability Alliance. There should be more aide made available and families should not have to be put on multiple year long waitlists to receive help. There are so many families effected by disability and there needs to be adequate state support.	Unfortunately, we have a limited amount of funding allocated by the General Assembly for waiver slots.
29.	Elliott/Hanover CSB	DD Waiting List - Has the criteria that to be on the waiver waiting list one must indicate that he/she would use a waiver if offered within 30 days still a requirement? I did not see this in these proposed regs.	Edits were made to regulatory text in Section 30-122-50 -- a new #5 - Individuals shall indicate willingness to accept waiver services within 30 days of slot assignment.

30.	Beatty/VA Alliance	1) Though the funding for DD Waivers is beyond the control of DBHDS, the long and continuously growing waiting list to access the DD Waiver is a foremost concern of our organizations. We support any consideration of a contract that would not allow a waiting list for basic care services. 2) For individuals on the waiting list, we have growing concerns about the age of the primary caregiver(s) not being considered in assessing waiting list priority. Since the new regulations have been in effect, we have seen rapidly growing panic from aging caregivers who no longer qualify for the Priority One waiting list due to age. It creates tremendous stress for the caregivers and loved ones. We have done ourselves a disservice in planning as it is obvious that caregivers in advanced age, no matter how healthy, are going to reach a point in the near future when help is critical. The removal of this eligibility for Priority One reduces the odds that the person with a disability will be able to access services before their caregiver dies. This is setting up the person with a disability for a series of rapid crises, as they lose parents, navigate the service system, and, in many cases, move to access services they need. We propose that the age of the caregiver again be considered as a factor in determining eligibility for Priority One of the waiting list. 3) The terminology used in association with the Priority tiers is confusing and misleading. To explain these categories in terms of years someone could be expected to wait for services furthers notion our system will always have multiple years of wait time for assistance. It frames our future in a negative light and is disrespectful to people who are eligible for assistance immediately, but who have been failed by our state's continuous failure to budget appropriately. Additionally, usage of years of wait time confuses families - feel it is a guaranteed maximum waiting time. 4) For individuals who need to transfer from one Waiver to another Waiver offering a higher level of services, urgency of need should be taken into account. Though anyone in this situation is in need, there are people on that list who have emergency needs (e.g., death of all caregivers or behavioral crises) and people who need a higher level of service but may be able to wait a short period of time (e.g., parent who is struggling to lift them and perform needed personal care at home). A system to assess that urgency and award reserve Waiver slots accordingly would be a better solution. If no one is currently on the reserve list at a given CSB when a slot becomes available, that slot should be made available to the person highest on the Priority One waiting list.	With a shortage of resources for waiver services, the waitlist process attempts to allocate limited services fairly. The waiting list focuses on individual criteria rather than age. If the caregiver develops a serious illness or upon their death, the individual may be considered for an emergency slot.

31.	Citizen	C.1.a. – Following care for the individual add "a primary care giver who is 70 years of age or greater". While I recognize that the age criterion was removed during the "redesign," I feel that the impact has been significant on older families. It also limits the family's ability to assist their adult children to make life decisions before it is an emergency. C.1.d- Following IDEA services and strike "is transitioning to independent living" and add "has expressed a desire to live independently" E.3- Strike "A regional WSAC session will then be held for the remainder of available slots, reviewing those individuals meeting criteria for the Priority Two and then Priority Three." I feel strongly that all slots should be for the Priority 1 list – if the service array in the BI Waiver is not attractive to those on Priority 1 then either the slots should be re-purposed or the service array should be changed.	See Line 4.
32.	Citizen	*CSB's or BHA's shall document and notify DBHDS…..The Assignment of reserve slots shall be managed by DBHDS, which will maintain a chronological list of individuals in need of a reserve slot in the event that the reserve slot supply is exhausted.* **Individuals requesting a reserve slot should be included in the pool being considered for vacated slots and that the WSAC should be the only entity that awards waiver slots.**	WSAC does not make an award; they make recommendations. Reserve slots are for individuals who are in a waiver, but whose needs have changed and need to move to a different waiver.
33.	Citizen	*Wait list* - **Request that age of care giver continue to be a factor.**	There is a shortage resources for waiver services, and the waitlist process attempts to allocate those limited services fairly. The waiting list focuses on individual criteria rather than age.
34.	Citizen	1. For individuals on the waiting list like my daughter, I am extremely concerned about the age of the primary caregiver(s) not being considered in assessing waiting list priority. My wife and I are in our late 50's and wonder how long we will be physically able to care for our daughter. However, our relatively good health disqualifies my daughter from receive the waiver she needs. Do we need to be near death or dead and buried for our daughter to receive a waiver? Since the new regulations have been in effect, I believe aging caregivers, such as myself, feel it is criminal to downgrade my daughter on the waiting list because we are able to provide limited care. This situation creates a great deal of stress for us and how will care be provide	With a shortage of resources for waiver services, the waitlist process attempts to allocate limited services fairly. The waiting list focuses on individual criteria rather than age. If the caregiver develops a serious illness or

		for our daughter in the future. No matter how healthy we are, we are going to reach a point in the near future where care must be provided by someone else. Additionally, the removal of this eligibility for Priority One reduces the odds that my daughter will be able to access services notably before, or at all before, one of us dies. This is setting up my daughter for a series of rapid crises, as she loses her parents, must navigate the service system without a support system. I strongly propose that the age of the caregiver again be considered as a factor in determining eligibility for Priority One of the waiting list. Parents 55 and older should be considered, with higher priority. 2. The terminology used in association with the Priority One, Two, and Three tiers is confusing and misleading. To explain these categories in terms of years someone could be expected to wait for services furthers the notion that our system will always have multiple years of wait time for people determined eligible. My daughter has been on the Waiting List for well over 10 years, this is outrageous and provides no hope that she will ever receive the services she deserves. It frames our future in an incredibly negative light and is disrespectful to people who are eligible for assistance immediately, but who have been failed by our state's continuous failure to budget for Waivers. Additionally, the usage of years of wait time to explain the Priority Tiers creates confusion to my family as we navigate the system and there is no guarantee of a timeline for when services will be made available. 3. Our daughter's future looks questionable at best. She is unable to provide care for herself and relies on others for the most basic of assistance. With continued therapy, Sabrina can learn to provide care for herself and to be somewhat independent. Without, Sabrina will need intense care for the rest of her life and will need to rely on others for all areas of support. Providing waiver supports now, will save the State of Virginia over her lifetime as she can learn to do more for herself with lower levels of support. The current system is just a disaster and will cost every taxpayer much more in the long run as Virginia makes the poor choice not to provide the services these individuals desperately need.	upon their death, the individual may be considered for an emergency slot.
35.	Citizen	Proposed 12VAC30-122-90 defines the eligibility criteria for the Priority One waiting list to include young adults who are no longer eligible for IDEA services and who are transitioning to "independent living." The regulations describe the individuals whom the Building Independence Waiver is designed to support as "individuals who reside in an integrated, independent living arrangement...."	DMAS is not able to make this change at this time.

36.	Citizen	Waiting list; criteria; slot assignment; emergency access; reserve slots. • C.1.a. – Following care for the individual add "a primary care giver who is 70 years of age or greater". While we recognize that the age criterion was removed during the "redesign," we feel that the impact has been significant on older families. It also limits the family's ability to assist their adult children to make life decisions before it is an emergency. • C.1.a- Following there are no strike "other" • C.1.b.(1)- Following effectively managed strike "by the primary caregiver or unpaid provider". Not everyone has a primary caregiver. • C.1.b.(2)- Following managed strike "by the primary caregiver" • C.1.d- Following IDEA services and strike "is transitioning to independent living" and add "has expressed a desire to live independently" • E.3- Strike "A regional WSAC session will then be held for the remainder of available slots, reviewing those individuals meeting criteria for the Priority Two and then Priority Three." We feel strongly that all slots should be for the Priority 1 list – if the service array in the BI Waiver is not attractive to those on Priority 1 then either the slots should be re-purposed or the service array should be changed.	See Line 4.
37.	Jan Williams, ServiceSource	C.1.a. – Following care for the individual add "a primary care giver who is 70 years of age or greater". While we recognize that the age criterion was removed during the "redesign," we feel that the impact has been significant on older families. It also limits the family's ability to assist their adult children to make life decisions before it is an emergency.	With a shortage of resources for waiver services, the waitlist process attempts to allocate limited services fairly. The waiting list focuses on individual criteria rather than age. If the caregiver develops a serious illness or upon their death, the individual may be considered for an emergency slot.
38.	Dennis Brown, Consultant	C.1.a. – Following *care for the individual* add "**a primary care giver who is 70 years of age or older**". The age criterion of caregivers was removed during the "redesign". The impact of thiis change was significant. ?In 2016, preceding redesign, the number assigned to urgent status was 4,943 and after redesign in 2017, the number assigned to priority one decreased by nearly half to 2,749. In addition, I am personally very troubled by the significant number of individuals who remain on the Wait List and who themselves are over age 70. Based on DBHDS data as of 2/1/19, there were 43 individuals over age 70 ON THE WAIT LIST. Of these, 7 were priority one. I recommend adjusting the	With a shortage of resources for waiver services, the waitlist process attempts to allocate limited services fairly. The waiting list focuses on individual criteria rather than age. If the caregiver develops a

		definitions of priority status to **ALSO address the age of the individuals waiting for a Waiver**. A measure of the age of the individual should assign these older individuals to a more urgent status for slot assignment.	serious illness or upon their death, the individual may be considered for an emergency slot.
39.	Citizen	Waiting list; criteria; slot assignment; emergency access; reserve slots. • C.1.a. – Following care for the individual add "a primary care giver who is 70 years of age or greater". While we recognize that the age criterion was removed during the "redesign," we feel that the impact has been significant on older families. It also limits the family's ability to assist their adult children to make life decisions before it is an emergency. • C.1.a- Following there are no strike "other" • C.1.b.(1)- Following effectively managed strike "by the primary caregiver or unpaid provider". Not everyone has a primary caregiver. • C.1.b.(2)- Following managed strike "by the primary caregiver" • C.1.d- Following IDEA services and strike "is transitioning to independent living" and add "has expressed a desire to live independently" • E.3- Strike "A regional WSAC session will then be held for the remainder of available slots, reviewing those individuals meeting criteria for the Priority Two and then Priority Three." We feel strongly that all slots should be for the Priority 1 list – if the service array in the BI Waiver is not attractive to those on Priority 1 then either the slots should be re-purposed or the service array should be changed.	See Line 36.
40.	Dominion Waiver/Koke	• C.1.a. – Following care for the individual add "a primary care giver who is 70 years of age or greater". While we recognize that the age criterion was removed during the "redesign," we feel that the impact has been significant on older families. It also limits the family's ability to assist their adult children to make life decisions before it is an emergency. C.1.a- Following there are no strike "other" • C.1.b.(1)- Following effectively managed strike "by the primary caregiver or unpaid provider". Not everyone has a primary caregiver. • C.1.b.(2)- Following managed strike "by the primary caregiver" • C.1.d- Following IDEA services and strike "is transitioning to independent living" and add "has expressed a desire to live independently" • E.3- Strike "A regional WSAC session will then be held for the remainder of available slots, reviewing those individuals meeting criteria for the Priority Two and then Priority Three." We feel strongly that all slots should be for the Priority 1 list – if the service array in the BI Waiver is not attractive to those on Priority 1 then either the slots should be re-purposed or the service array should be changed.	See Line 36.

41.	Wormley, Kerns, Collier, Lester, Hauley -VersAbility Rsc	C.1.a. – Following care for the individual add "a primary care giver who is 70 years of age or greater". While we recognize that the age criterion was removed during the "redesign," we feel that the impact has been significant on older families. It also limits the family's ability to assist their adult children to make life decisions before it is an emergency. C.1.a- Following there are no strike "other" C.1.b.(1)- Following effectively managed strike "by the primary caregiver or unpaid provider". Not everyone has a primary caregiver. C.1.b.(2)- Following managed strike "by the primary caregiver" C.1.d- Following IDEA services and strike "is transitioning to independent living" and add "has expressed a desire to live independently" E.3- Strike "A regional WSAC session will then be held for the remainder of available slots, reviewing those individuals meeting criteria for the Priority Two and then Priority Three." We feel strongly that all slots should be for the Priority 1 list – if the service array in the BI Waiver is not attractive to those on Priority 1 then either the slots should be re-purposed or the service array should be changed.	See Line 4.
42.	Citizen	1. 12VAC30-50-440 and 12VAC30-50-490 outline expectations and requirements for Support Coordination differently for those with a diagnosed Intellectual Disability (440) and those with a diagnosed Developmental Disability (490) despite the merger of the ID and DD Waivers. It would seem that the requirements for Support Coordination providers, definitions of the service and knowledge, skills and abilities would be the same. These sections of the regulations do not align and show there is a disparity in the service and expectations depending on the individuals diagnosis. 2. 12VAC30-50-490 A2. Discusses placement on wait list for individuals with DD diagnosis whereas this is not referenced for individuals with ID diagnosis in 12VA30-50-440. Individuals are placed on the waitlist regardless of diagnosis when slots are not available. These sections also allow for individuals with ID and DD diagnosis to receive Support Coordination services while on the Waiver wait list but makes it time limited and more restrictive for individuals with DD diagnosis. With DD and ID systems merged there is nothing of which I am aware that would show that individuals with DD diagnoses would not have the same need for SPO Support Coordination as those with ID diagnoses. Support Coordinator qualifications should allow an option for entry level Support Coordinators who possess a Human Services degree but lack the experience to provide services under a QDDP to gain the required experience similar to QMHP-Eligible.	1. There are two different state plan amendments that describe these services. 2. CMS hs reviewed and approved the different state plan amendments for ID and DD Case Management. Support coordinator qualifications are determined by DBHDS Office of Licensing.
43.	Citizen	Same as Line 42	See Line 42.

44.	Crum/ServiceSource	Same as Line 37.	See Line 37.
45.	Donald Kelly, L'Arche	Waiting list; criteria; slot assignment; emergency access; reserve slots.* C.1.a. – Following care for the individual add “a primary care giver who is 70 years of age or greater”. While we recognize that the age criterion was removed during the “redesign,” we feel that the impact has been significant on older families. It also limits the family’s ability to assist their adult children to make life decisions before it is an emergency.* C.1.a- Following there are no strike “other”* C.1.b.(2)- Following managed strike “by the primary caregiver”	See Line 36.
46.	La Voyce B. Reid/Arlington CSB	F. “If the individual determines at any time he no longer wishes to be on the DD Waiver waiting list, he may contact his support coordinator to request removal from the waiting list. The SC shall notify DBHDS so that the individual’s name can be removed from the waiting list.” Shall the SC provide the appeals notice giving the individual time to change his or her mind? Or, would the person be re-screened or simply added back in the event that he or she changes his or her mind? And, if so, is there a minimum or maximum amount of time that should pass to determine the manner by which the individual should be added back to the waitlist if he changes his mind? G.2.a – comment pertains to the “the next non-emergency waiver slot that becomes available at the CSB or BHA in receipt of an emergency slot shall be re-assigned to the emergency slot pool to ensure emergency slots remain to be assigned to future emergencies within the Commonwealth’s fiscal year.” Is there a process wherein a slot made available by a CSB for emergency purposes is returned to that CSB once more slots/emergency slots are made available to DBHDS? Or, is the slot not returned to the CSB? Can this point be clarified? H.1.c – Recommend adding in timeframe by which DBHDS notifies the Support Coordinator (from date request is submitted) of decision to add or not add the individual to the reserve waitlist. Recommend ten days. 4. “When a slot is vacated in one of the DD Waivers (e.g., due to death of an individual) the slot shall be assigned to the next individual in that CSB’s chronological queue for a reserve slot in accordance with the procedures outlined in subdivision 3 of this section. My only concern about this is that in subdivision 3, “if there is not an individual in that CSB’s chronological queue for a reserve slot, the vacated slot will be assigned to an individual on the statewide waiting list who resides in the CSB’s or BHA’s catchment area.” So, under this, the waiver for a deceased person could be used by a CSB or BHA in the “catchment area” as opposed to convening a WSAC and assigning that same waiver to someone on the originating CSB’s Priority lists. Is it really intended that all of subdivision 3 is applicable	F. Yes, an appeals notice should be provided. The individual should always be rescreened to make sure that any changes are reviewed. G2a - the process is descibed in regulations. H1c - Timeframe is 3 days once decision is made - this is in regulations. DMAS is not able to add the ten day timeframe for making the decision. H4 - CSB would follow the process for allocating slots, and this goes through the WSAC.

		to subdivision 4? If not, please clarify (or better yet, state in subdivision 4 what is applicable without reference to subdivision 3).	
47.	Maureen Hollowell, VA Assoc of Centers for Independent Living	1) C.1.d. Reference to the individual no longer being eligible for IDEA services should be expanded to include individuals who are no longer eligible for 504 plan services; 2) H. Include a statement that the individual has the right to appeal a decision of the community services board or DBHDS to not place the individual on the reserve slot waiting list. Individuals have the right to appeal a denial of services. If an individual is requesting transition to a different waiver in order to receive a specific service not available in the waiver they are currently using, then denying them placement on the reserve slot waiting list is a denial of the service they are seeking.	C1d. See Line 36. H. There is no appeal right because these individuals are not being denied a service - they already have a waiver and due to a change in needs, are moving to a different waiver.
48.	Virginia Board for People with Disabilities	Subdivision C 1a: The Board recommends striking "there are no other unpaid caregivers" and changing it to "or there are no unpaid caregivers" to read as follows: "An immediate jeopardy exists to the health and safety of the individual due to the unpaid primary caregiver having a chronic, long term physical or psychiatric condition that currently significantly limits the ability of the primary caregiver to care for the individual; or there are no other unpaid caregivers available to provide services."	Edits made.
49.	Virginia Board for People with Disabilities	The way this provision is currently written, the portion of the sentence is inter-related to the first sentence, which could be interpreted as there are no unpaid caregivers in the event of the primary caregiver having a chronic condition. An individual should be on Priority 1 if there are no unpaid caregivers available, without qualification.	Edits made.
50.	Virginia Board for People with Disabilities	Subdivision C 1b: The Board recommends adding a new criterion as follows: "or (3) the age of the primary caregiver is 70 or greater." The Board supported the removal of age 55 as a criteria for Priority 1. However, there are growing numbers of aging parents, well beyond age 55, who need to be able to plan for their child's future. The Board agrees with the recommendation from the DD Waiver Advisory Council participants that 70 is a reasonable age to add as a criterion.	See Line 4.
51.	Virginia Board for People with Disabilities	Subdivision C 1b(1): The Board recommends striking "by the primary caregiver or unpaid provider" as follows: "The individual's behavior, presenting a risk to himself or others, cannot be effectively managed ~~by the primary caregiver or unpaid provider~~ even with support coordinator arranged generic or specialized supports…." It is possible that an individual may not have a primary caregiver. They may be living independently and experience a crisis. The focus should be on the inability to manage the behavior even with additional supports.	Edits made.
52.	Virginia Board for People with Disabilities	Subdivision C 1b(2): The Board recommends striking "by the primary caregiver." The reason mirrors Comment #29 above.	Edits made.

53.	Virginia Board for People with Disabilities	Subdivision C 1d: The Board recommends the following addition: "The individual is a young adult who is no longer eligible for IDEA services and is transitioning or has expressed a desire to transition to independent living. After individuals attain 27 years of age, this criterion shall no longer apply." As written, the regulation implies that the transition is underway; however, the individual may need the waiver slot in order to begin the transition.	Edits made.
54.	Virginia Board for People with Disabilities	Subdivision E 3: The Board recommends striking the last sentence of this subdivision which states, "A regional WSAC session will then be held for the remainder of available slots, reviewing those individuals meeting criteria for Priority Two and then Priority Three." The purpose of having a priority system is that individuals in Priority 1 be served prior to anyone in other priorities who, by the nature of being placed in a lower priority, have indicated they don't need services for at least a year (or in the case of Priority 3, more than five years). We recognize this may be a controversial recommendation; however, if Building Independence waiver slots are going to individuals on Priority 2 and 3 because individuals on Priority 1 are unable or unwilling to benefit from the BI waiver, this implies that these slots are not needed and that slot requests should be geared to the FIS and CL waivers which are more appropriate to Priority 1. In other sections, the Board is recommending that certain key services be added to the BI waiver. This may make that waiver more likely to provide services from which individuals on Priority 1 can benefit.	See Line 4.

Comments related to 12VAC30-122-100

2.	Loudoun CSB L. Snider	An amendment is needed for statement "When an individual is transitioning to a different provider, the former provider that served said individual shall, at the request of the provider, provide all medical records and documentation of services to the new provider to ensure high quality continuity of care and service provision." This statement must include caveat as permitted by confidentiality regulations including HIPAA, 42 CFR and Human Rights.	Edits made.
3.	Dville/Pittvania CSB/S. Craddock	An amendment is needed for statement "When an individual is transitioning to a different provider, the former provider that served said individual shall, at the request of the provider, provide all medical records and documentation of services to the new provider to ensure high quality continuity of care and service provision." This statement must include caveat as permitted by confidentiality regulations including HIPAA, 42 CFR and Human Rights	Edits made.
4.	Harrison-Rock'ham CSB/ Slaughbaugh	An amendment is needed for statement "When an individual is transitioning to a different provider, the former provider that served said individual shall, at the request of the provider, provide all medical records and documentation of services to the new provider to ensure high quality continuity of care and service provision." This statement must include	Edits made.

		caveat as permitted by confidentiality regulations including HIPAA, 42 CFR and Human Rights.	
5.	Blue Ridge Beh Healthcare A. Monti	An amendment is needed for statement "When an individual is transitioning to a different provider, the former provider that served said individual shall, at the request of the provider, provide all medical records and documentation of services to the new provider to ensure high quality continuity of care and service provision." This statement must include caveat as permitted by confidentiality regulations including HIPAA, 42 CFR and Human Rights.	Edits made.
6.	RBHA/M Harrison	An amendment is needed for statement "When an individual is transitioning to a different provider, the former provider that served said individual shall, at the request of the provider, provide all medical records and documentation of services to the new provider to ensure high quality continuity of care and service provision." This statement must include caveat as permitted by confidentiality regulations including HIPAA, 42 CFR and Human Rights.	Edits made.
7.	Elliott/Hanover CSB	Page 29 3F Modifications to or Termination of Services - In nonemergency situations, I would like to see that providers are required to give at least 30 day notice if they decide to discontinue services. This would decrease the possibility that an individual may go without needed supports which may impact health and safety. This gives the individual and his support team time to transition to another provider without a lapse of services.	DMAS is not able to make this change at this time.
8.	Elliott/Hanover CSB	Page 29 3F Modifications to or termination of service - "The support coordinator shall have the responsibility to identify those individuals who no longer meet the ***level of functioning criteria*** or…." Please update this to say "…no longer meet the ***VIDES*** criteria…."	Edits made -- added "(VIDES)" after "no longer meet level of functioning criteria"
9.	Citizen	*Termination in a non-emergency situation;* **Request that 30 day notice is given instead of 10.**	DMAS is not able to make this change at this time.

Comments related to 12VAC30-122-120

2.	DDWAC	1. A.4.- Change "30 calendar days" to "90 calendar days" [See comment above in Section 80] 2. A.5.- Strike "medically necessary services and supplies" and add "services and supports" 3. A.6.- Strike "supplies" and add "supports" 4. A.10.d- Strike "Such documentation shall be written on the date of service delivery." [This is not in keeping with the definition of Progress Note] 5. A.10.d- Strike "medical" in the first sentence 6. A.10.f- Add "if applicable" within the parenthetical phrase "including specific timeframe" 7. A.13- Change 37.2-600 to 37.2-607 8. A.14- Strike "-s of Licensing and" [Abuse and neglect are reported to the Office of Human Rights not the Office of Licensing]	A4 DMAS considered this but believes that 30 calendar days is the appropriate timeframe. A.5 - Edits made - "services and supports" in lieu of "medically necessary" A.6 - Edits made A10.d - Edits made.

		9. D- Strike “may” add “shall” in last sentence [If the purpose is to improve or remove poor providers then this should not be an option]	A.10 Edits made A10f Edits made A13 - Edits made. A14 - Edits made. D - DMAS is not able to make this change at this time.
3.	MPNN CSB L. McCrobie	Why do you report APS issues to DARS? This is a potential HIPAA concern.	APS is under DARS as its authority.
4.	Loudoun CSB L. Snider	Concern with implications of Standardized or Formulaic notes being considered unacceptable. Clarification that templates are acceptable to ensure notes contain appropriate information.	DMAS considered this but believes that templates are different than a 'form'. The content needs to be specific to the service, and service date for that individual.
5.	Loudoun CSB L. Snider	Why do you report APS issues to DARS? This is a potential HIPAA concern.	APS in under DARS as its authority.
6.	Loudoun CSB L. Snider	Is requirement that providers "must read and write in English" related to literacy or meant to mean must read and write in English?	QMR needs to be able to read a service plan in English which is why this is required.
7.	Loudoun CSB L. Snider	Clarification on where the objective documentation must be maintained. Is this in the provider record and/or Support Coordination record?	Ideally, should be in both provider and support Coordinator's record. Will clarify in the manual.
8.	Dville/Pittvania CSB/S. Craddock	Concern regarding matching language of support plan needs with licensing regulations. Clarification regarding services rendered schedule and timetable	DMAS is not able to make this change at this time.
9.	Dville/Pittvania CSB/S. Craddock	Why do you report APS issues to DARS? This is a potential HIPAA concern.	APS in under DARS as its authority.
10.	Dville/Pittvania CSB/S. Craddock	Clarification on where the objective documentation must be maintained. Is this in the provider record and/or Support Coordination record?	Ideally, should be in both provider and support Coordinator's

			record. Will clarify in the manual.
11.	Citizen	1. A.4. change 30 calendar days to 90 calendar days 2. A.5. - strike "medically necessary services and supplies" and replace with "services and supports" 3. A.6. - strike "supplies" and replace with "supports" 4. A.10.3. - strike "such documentation shall be written on the date of service delivery" as this is not consistent with the definition of progress note 5. A.13 - change 37.2-600 to 37.2-607 6. D. strike "may" and replace with "shall"	See Line 2
12.	Harrison-Rock'ham CSB/ Slaughbaugh	Concern with implications of Standardized or Formulaic notes being considered unacceptable. Clarification that templates are acceptable to ensure notes contain appropriate information.	DMAS considered this but believes that templates are different than a 'form'. The content needs to be specific to the service, and include the service date for that individual.
13.	Harrison-Rock'ham CSB/ Slaughbaugh	Concern regarding matching language of support plan needs with licensing regulations - Clarification regarding services rendered schedule and timetable	See Line 8.
14.	Harrison-Rock'ham CSB/ Slaughbaugh	Why do you report APS issues to DARS? This is a potential HIPAA concern.	APS in under DARS as its authority.
15.	Harrison-Rock'ham CSB/ Slaughbaugh	Is requirement that providers "must read and write in English" related to literacy or meant to mean must read and write in English?	See Line 6
16.	Harrison-Rock'ham CSB/ Slaughbaugh	Clarification on where the objective documentation must be maintained. Is this in the provider record and/or Support Coordination record?	Ideally, should be in both provider and support Coordinator's record. Will clarify in the manual.
17.	Family Sharing/Farrell	1. A.5.- Strike "medically necessary services and supplies" and add "services and supports" 2. A.10.d- Strike "medical" in the first sentence 3. A-10-d ...Such documentation shall be written on the date of service delivery. 4. Strike or change to as soon as practicable but no longer than one week after the service. This keeps with the definition of Progress Note from this chapter.	See Line 2

		5. A.10.f- Add “if applicable” within the parenthetical phrase “including specific timeframe”	
18.	Henrico Area MHDS	A.4. Clarify “accept referrals”. Does this mean that providers should not maintain a WL? A.10.d This states that there should be a “progress note written documentation”. It further states “ shall be written on the date of service delivery”.The definition of the progress note states “it is written, signed and dated as soon as is practical but no longer than one week after the referenced service”. This section should be amended to be consistent with the progress note, as it is NOT practical to requirement a note written the same day, when circumstances may occur where this is not able to be completed.	A4 - no mentinon waitlist in the reg. If you tell someone YES, if the provider has a slot, they need to be able to serve within 30 days. A10.d. Edits made.
19.	Family Sharing/Engleman	120-A-10-d ...Such documentation shall be written on the date of service delivery. Strike or change to as soon as practicable but no longer than one week after the service. This is in keeping with the definition of Progress Note from this chapter.	Edits made.
20.	Citizen	A.5.- Strike “medically necessary services and supplies” and add “services and supports” A.10.d- Strike “medical” in the first sentence A-10-d ...*Such documentation shall be written on the date of service delivery.* Strike or change to as soon as practicable but no longer than one week after the service. This is in keeping with the definition of Progress Note from this chapter. A.10.f- Add “if applicable” within the parenthetical phrase “including specific timeframe”	See Line 2
21.	Blue Ridge Beh Healthcare A. Monti	Concern with implications of Standardized or Formulaic notes being considered unacceptable. Clarification that templates are acceptable to ensure notes contain appropriate information.	See Line 12
22.	Blue Ridge Beh Healthcare A. Monti	Concern regarding matching language of support plan needs with licensing regulations Clarification regarding services rendered schedule and timetable	See Line 13
23.	Blue Ridge Beh Healthcare A. Monti	Why do you report APS issues to DARS? This is a potential HIPAA concern.	APS in under DARS as its authority.
24.	Blue Ridge Beh Healthcare A. Monti	Is requirement that providers "must read and write in English" related to literacy or meant to mean must read and write in English?	See Line 6
25.	Blue Ridge Beh Healthcare A. Monti	Clarification on where the objective documentation must be maintained. Is this in the provider record and/or Support Coordination record?	Ideally, should be in both provider and support Coordinator's record. Will clarify in the manual.

26.	Hartwood Foundation, Inc.	A4 – Extend timeframe for initiating service from 30 days to **60 or 90 days** *(see note in section 80 above)* *A6 – Remove "supplies" and replace with "supports"*	see Line #2 above for A4; A6 - edits made
27.	RBHA/M Harrison	Concern with implications of Standardized or Formulaic notes being considered unacceptable. Clarification that templates are acceptable to ensure notes contain appropriate information.	See Line 4
28.	RBHA/M Harrison	Concern regarding matching language of support plan needs with licensing regulations	See Line 8.
29.	RBHA/M Harrison	Why do you report APS issues to DARS? This is a potential HIPAA concern.	See Line 6
30.	RBHA/M Harrison	Is requirement that providers "must read and write in English" related to literacy or meant to mean must read and write in English?	See Line 6
31.	RBHA/M Harrison	Clarification on where the objective documentation must be maintained. Is this in the provider record and/or Support Coordination record?	Ideally, should be in both provider and support Coordinator's record. Will clarify in the manual.
32.	Citizen	1. A.4.- Change "30 calendar days" to "90 calendar days" (See comment above in Section 80) 2. A.5.- Strike "medically necessary services and supplies" and add "services and supports" 3. A.6.- Strike "supplies" and add "supports" 4. A.10.d- Strike "Such documentation shall be written on the date of service delivery." This is not in keeping with the definition of Progress Note in 122-20 and as referenced earlier in comments. 5. A.10.d- Strike "medical" in the first sentence 6. A.10.f- Add "if applicable" within the parenthetical phrase "including specific timeframe" 7. A.13- Change 37.2-600 to 37.2-607 8. A.14- Strike "-s of Licensing and". Abuse and neglect are reported to the Office of Human Rights not the Office of Licensing. 9. D- Strike "may" add "shall" in last sentence. If the purpose is to improve or remove poor providers - then this should not be an option.	See Line 2.
33.	VA Board for People with Disabilities	**Subdivision A 4: The Board recommends changing 30 days to 90 days.** There may be unforeseen barriers, including bureaucratic hurdles, which prevent the initiation of services within 30 days.	See Line 2, A4.
34.	VAIL/G. Brunk	states "documentation shall be written on the date of service delivery." This is not always possible. Additionally, it contradicts other documentation requirements throughout the proposed regulations. 12VAC30-122-1300 E.2.b. states that "CD services facilitator's notes recorded and dated at the time of service delivery."	Edits made.

35.	VAIL/G. Brunk	states "Providers shall not be reimbursed while the individual enrolled in a waiver is receiving inpatient services in either an acute care hospital, nursing facility, rehabilitation facility, ICF/IID, or any other type of facility." Individuals who are receiving care in a hospital or rehabilitation facility need ongoing support coordination/case management so that they have services arranged and prepared for their discharge. Additionally, individuals in a hospital or rehabilitation facility are not receiving case management services through those entities so it would not be a duplication of services. Support coordination/case management should be allowed for individuals in a hospital or rehabilitation facility.	This comment is not applicable to this section.
36.	Weatherspoon Wall Res, Inc.	1. A.5.- Strike "medically necessary services and supplies" and add "services and supports" 2. A.6.- Strike "supplies" and add "supports" 3. A.10.d- Strike "Such documentation shall be written on the date of service delivery." [This is not in keeping with the definition of Progress Note]	See Line 2 and Line 19
37.	J Ciffizari Wall Res, In.	A.5.- Strike "medically necessary services and supplies" and add "services and supports" A.6.- Strike "supplies" and add "supports" A.10.d- Strike "Such documentation shall be written on the date of service delivery." [This is not in keeping with the definition of Progress Note]	See Line 2 and Line 19.
38.	Citizen	Same as Line 37.	See Line 37.
39.	A. May/Spons. Res GH Provider	Under 120 Provider Requirements in A.5.- Strike "medically necessary services and supplies" and add "services and supports" in A.6.- Strike "supplies" and add "supports" and in A.10.d- Strike "Such documentation shall be written on the date of service delivery." [This is not in keeping with the definition of Progress Note]	See Line 2 and Line 19
40.	Citizen	Under 120 Provider Requirements in A.5.- Strike "medically necessary services and supplies" and add "services and supports" in A.6.- Strike "supplies" and add "supports" and in A.10.d- Strike "Such documentation shall be written on the date of service delivery." [This is not in keeping with the definition of Progress Note	See Line 2 and Line 19
41.	Citizen	1. Under 120 Provider Requirements in A.5.- Strike "medically necessary services and supplies" and add "services and supports" in A.6.- Strike "supplies" and add "supports" and in A.10.d- Strike "Such documentation shall be written on the date of service delivery." [This is not in keeping with the definition of Progress Note] 2. Under 120 Provider Requirements in A.5.- Strike "medically necessary services and supplies" and add "services and supports" in A.6.- Strike "supplies" and add "supports" and in A.10.d- Strike "Such documentation shall be written on the date of service delivery." [This is not in keeping with the definition of Progress Note]	See Line 2 and Line 19

42.	Citizen	1. Under 120 Provider Requirements in A.5.- Strike "medically necessary services and supplies" and add "services and supports" in A.6.- Strike "supplies" and add "supports" and in A.10.d- Strike "Such documentation shall be written on the date of service delivery." [This is not in keeping with the definition of Progress Note] 2. Under 120 Provider Requirements in A.5.- Strike "medically necessary services and supplies" and add "services and supports" in A.6.- Strike "supplies" and add "supports" and in A.10.d- Strike "Such documentation shall be written on the date of service delivery." [This is not in keeping with the definition of Progress Note]	See Line 2 and Line 19
43.	Citizen	1. Under 120 Provider Requirements in A.5.- Strike "medically necessary services and supplies" and add "services and supports" in A.6.- Strike "supplies" and add "supports" and in A.10.d- Strike "Such documentation shall be written on the date of service delivery." [This is not in keeping with the definition of Progress Note] 2. Under 120 Provider Requirements in A.5.- Strike "medically necessary services and supplies" and add "services and supports" in A.6.- Strike "supplies" and add "supports" and in A.10.d- Strike "Such documentation shall be written on the date of service delivery." [This is not in keeping with the definition of Progress Note]	See Line 2 and Line 19
44.	M Jennings/Wall Res., Inc.	1. Under 120 Provider Requirements in A.5.- Strike "medically necessary services and supplies" and add "services and supports" in A.6.- Strike "supplies" and add "supports" and in A.10.d- Strike "Such documentation shall be written on the date of service delivery." [This is not in keeping with the definition of Progress Note] 2. Under 120 Provider Requirements in A.5.- Strike "medically necessary services and supplies" and add "services and supports" in A.6.- Strike "supplies" and add "supports" and in A.10.d- Strike "Such documentation shall be written on the date of service delivery." [This is not in keeping with the definition of Progress Note]	See Line 2 and Line 19
45.	Karen Tefelski - vaACCSES	A.4.- Change "30 calendar days" to "90 calendar days" (See comment above in Section 80) A.5.- Strike "medically necessary services and supplies" and add "services and supports" A.6.- Strike "supplies" and add "supports" A.10.d- Strike "Such documentation shall be written on the date of service delivery." This is not in keeping with the definition of Progress Note in 122-20 and as referenced earlier in comments. A.10.d- Strike "medical" in the first sentence A.10.f- Add "if applicable" within the parenthetical phrase "including specific timeframe" A.13- Change 37.2-600 to 37.2-607 A.14- Strike "-s of Licensing and". Abuse and neglect are reported to the Office of Human Rights not the Office of Licensing. D- Strike "may" add "shall" in last sentence. If the purpose is to improve or remove poor providers - then this should not be an option.	See Line 2.

46.	M. Ingram/Wall Res., Inc.	1. A.5.- Strike "medically necessary services and supplies" and add "services and supports" 2. A.6.- Strike "supplies" and add "supports" 3. A.10.d- Strike "Such documentation shall be written on the date of service delivery." [This is not in keeping with the definition of Progress Note]	See Line 2 and Line 19
47.	M Henley, Wall Res., Inc.	1. Under 120 Provider Requirements in A.5.- Strike "medically necessary services and supplies" and add "services and supports" in A.6.- Strike "supplies" and add "supports" and in A.10.d- Strike "Such documentation shall be written on the date of service delivery." [This is not in keeping with the definition of Progress Note] 2. Under 120 Provider Requirements in A.5.- Strike "medically necessary services and supplies" and add "services and supports" in A.6.- Strike "supplies" and add "supports" and in A.10.d- Strike "Such documentation shall be written on the date of service delivery." [This is not in keeping with the definition of Progress Note]	See Line 2 and Line 19
48.	T. King Wall Res., Inc.	1. Under 120 Provider Requirements in A.5.- Strike "medically necessary services and supplies" and add "services and supports" in A.6.- Strike "supplies" and add "supports" and in A.10.d- Strike "Such documentation shall be written on the date of service delivery." [This is not in keeping with the definition of Progress Note] 2. Under 120 Provider Requirements in A.5.- Strike "medically necessary services and supplies" and add "services and supports" in A.6.- Strike "supplies" and add "supports" and in A.10.d- Strike "Such documentation shall be written on the date of service delivery." [This is not in keeping with the definition of Progress Note]	See Line 2 and Line 19
49.	Henrico Area MHDS	A.4. Clarify "accept referrals". Does this mean that providers should not maintain a WL? A.10.d This states that there should be a "progress note written documentation". It further states " shall be written on the date of service delivery". The definition of the progress note states "it is written, signed and dated as soon as is practical but no longer than one week after the referenced service". This section should be amended to be consistent with the progress note, as it is not practical to require a note written the same day, when circumstances may occur where this is not able to be completed.	See Line 2.
50.	R. Ledingham, Wall Res.	A.5.- Strike "medically necessary services and supplies" and add "services and supports" A.6.- Strike "supplies" and add "supports" A.10.d- Strike "Such documentation shall be written on the date of service delivery." [This is not in keeping with the definition of Progress Note]	See Line 2 and Line 19
51.	M. Rosenbaum, Wall Res	Same as Line 48.	See Line 48.

52.	K. Black-Hope House	A.4.- Change “30 calendar days” to “90 calendar days” [See comment above in Section 80] A.4. - Clarify this section. Providers should be prepared to provide services at the agreed upon date indicated on the service authorization A.5.- Strike “medically necessary services and supplies” and add “services and supports” A.6.- Strike “supplies” and add “supports” A.10.d- Strike “Such documentation shall be written on the date of service delivery.” in the 3rd sentence and the last sentence. [This is not in keeping with the definition of Progress Note] A.10.d- Strike “medical” in the first sentence A.10.f- Add “if applicable” within the parenthetical phrase “including specific timeframe” A.13- Change 37.2-600 to 37.2-607 A.14- Strike “-s of Licensing and” [Abuse and neglect are reported to the Office of Human Rights not the Office of Licensing] B.-Strike ‘may’ D- Strike “may” add “shall” in last sentence [If the purpose is to improve or remove poor providers then this should not be an option]. D - Include a specific timeframe or frequency that the Department will use to determine a history of noncompliance such as “during the current license period	See Line 2 and Line 19
53.	J Orchant Aceto/MVLE	4. Accept referrals for services only when staff is available to initiate services within 30 calendar days of the referral and perform such services on an ongoing basis. RESPONSE/ CONCERNS: What happens/ how does the provider document that the services cannot be started within the 30 calendar days? It is possible a staff person unexpectedly resigns and the individual or their family wants to wait for the provider to get a staff person and NOT to start the process with another provider. How can this be properly documented it’s the individual’s preference to wait? 9.d Providers shall prepare and maintain unique person-centered progress notes…. Such documentation shall be written on the date of service delivery, in instances when the individual does not communicate through words the provider shall note his observations about the individual’s condition and observable responses, if any, at the time of the service delivery. RESPONSE/ CONCERNS: There are occurrences whereby staff do not have access to computers/ tablets to write daily notes ‘that day’ depending on the service and where they are providing the service. Internet / computers can break down. Emergencies can arise whereby staff would have to write the note within a few days.	See Line 2. Edits made to progress note definition.
54.	V Frazier-Wall Res.	Under 120 Provider Requirements in A.5.- Strike “medically necessary services and supplies” and add “services and supports” in A.6.- Strike “supplies” and add “supports” and in A.10.d- Strike “Such documentation shall be written on the date of service delivery.” [This is not in keeping with the definition of Progress Note]	See Line 2 and Line 19
55.	Citizen-Wall Res.	Under 120 Provider Requirements in A.5.- Strike “medically necessary services and supplies” and add “services and supports” in A.6.- Strike “supplies” and add “supports” and in A.10.d- Strike “Such documentation	See Line 2 and Line 19

		shall be written on the date of service delivery.” [This is not in keeping with the definition of Progress Note]	
56.	B Martin - CHOICE Group	A.(10) d.. Providers shall prepare and maintain unique person-centered progress note written documentation in each individual's medical record about the individual's responses to services and rendered supports. Such documentation shall be provided to DMAS or its designee upon request. Such documentation shall be written on the date of service delivery. In instances when the individual does not communicate through words, the provider shall note his observations about the individual's condition and observable responses, if any, at the time of service delivery. Recommendation – documentation written within a reasonable time (48 hours)	Edits made.
57.	Citizens	Under 120 Provider Requirements in A.5.- Strike “medically necessary services and supplies” and add “services and supports” in A.6.- Strike “supplies” and add “supports” and in A.10.d**-** Strike “Such documentation shall be written on the date of service delivery.” [This is not in keeping with the definition of Progress Note]	See Line 2 and Line 19
58.	Citizens	Under 120 Provider Requirements in A.5.- Strike “medically necessary services and supplies” and add “services and supports” in A.6.- Strike “supplies” and add “supports” and in A.10.d**-** Strike “Such documentation shall be written on the date of service delivery.” [This is not in keeping with the definition of Progress Note]	See Line 2 and Line 19
59.	T Goodman/Hanover CSB	**A.10.d** This states that there should be a “progress note written documentation”. It further states “shall be written on the date of service delivery”. The definition of the progress note states “it is written, signed and dated as soon as is practical but no longer than one week after the referenced service”. This section should be amended to be consistent with the progress note, as it is NOT practical to requirement a note written the same day, when circumstances may occur where this is not able to be completed. The use of “daily note” references. We support the definition of “progress notes” as defined in 12VAC30-122-20 “Definitions” for consistency. “Progress notes” means individual-specific written documentation that (i) contains unique differences specific to the individual’s circumstances and the supports provided, and the individual’s responses to such supports; (ii) is signed and dated by the person who rendered the supports; and (iii) is written and signed and dated as soon as is practicable but no longer than one week after the referenced service.”	Edits made.

60.	B Huffman - VersAbility Resources	A.4.- Change “30 calendar days” to “90 calendar days” (See comment above in Section 80) A.5.- Strike “medically necessary services and supplies” and add “services and supports” A.6.- Strike “supplies” and add “supports” A.10.d- Strike “Such documentation shall be written on the date of service delivery.” This is not in keeping with the definition of Progress Note in 122-20 and as referenced earlier in comments. A.10.d- Strike “medical” in the first sentence A.10.f- Add “if applicable” within the parenthetical phrase “including specific timeframe” A.13- Change 37.2-600 to 37.2-607 A.14- Strike “-s of Licensing and”. Abuse and neglect are reported to the Office of Human Rights not the Office of Licensing. D- Strike “may” add “shall” in last sentence. If the purpose is to improve or remove poor providers - then this should not be an option.	See Line 2.
61.	D Reynolds, Fair Haven Residential Services	In response to Carla Groff’s suggestion for the criteria for substitution of provider staffing to be amended to “registered nurse” VS “experience” for the education requirement: Though some Individuals served in both group home and sponsored-placement residential homes now do require support for complex medical needs, the majority do not. I agree that in situations where an Individual is in need of daily supervision to address the complex health concerns she identified, the agency that has committed to their support should be required to be staffed with licensed medical professionals. I also question her inclusion of colonoscopies as a “complex medical need”. The QDDP functional equivalent has earned, with years of demonstrated knowledge, skills and abilities, an essential role for the majority who do not present with these needs.	Thank you for your comment.
62.	Elliott/Hanover CSB	Page 30 A 4 Provider requirements. - “Accept referrals for services only when staff is available to initiate services within 30 calendar days of the referral and perform such services on an ongoing basis.” There are several individuals currently waiting for over 30 days for staff to be hired after a provider accepts the referral. There needs to be a rate change or incentives given to providers that can be passed on to potential staff. The rates that DSPs make is way too low for the quality of care we are asking. DBHDS, DMAS and Licensure needs to hold providers accountable in actively looking for staff as well as provide assistance to providers in recruiting and securing staff.	See Line 2
63.	Citizen	*Providers shall prepare and maintain unique person-centered progress note written documentation…..Such documentation shall be written on the date of service delivery.* **Suggesting a longer grace period for progress note writing.**	Edits made.

64.	Citizen	Provide for the opportunity for deemed provider status for providers that hold a national accreditation (CARF) or specific certification to reduce the frequency of reviews. This would reduce both state government and provider time and money.	DMAS is not able to make this change at this time.
65.	Citizen	Provider requirements. • A.4.- Change “30 calendar days” to “90 calendar days” (See comment above in Section 80) • A.5.- Strike “medically necessary services and supplies” and add “services and supports” • A.6.- Strike “supplies” and add “supports” • A.10.d- Strike “Such documentation shall be written on the date of service delivery.” This is not in keeping with the definition of Progress Note in 122-20 and as referenced earlier in comments. • A.10.d- Strike “medical” in the first sentence • A.10.f- Add “if applicable” within the parenthetical phrase “including specific timeframe” • A.13- Change 37.2-600 to 37.2-607 • A.14- Strike “-s of Licensing and”. Abuse and neglect are reported to the Office of Human Rights not the Office of Licensing. • D- Strike “may” add “shall” in last sentence. If the purpose is to improve or remove poor providers - then this should not be an option.	See Line 2 and Line 19
66.	Jan Williams, ServiceSource	A.10.d states “Such documentation shall be written on the date of service delivery”. We suggest instead that this language be consistent with the definition of Progress Note referenced in Section 20 (definitions): "Progress notes" means individual-specific written documentation that - (iv) Contains unique differences specific to the individual's circumstances and the supports provided, and the individual's responses to such supports; (v) Is signed and dated by the person who rendered the supports; and (vi) Is written and signed and dated as soon as is practicable but no longer than one week after the referenced service. In addition, we request that DMAS and DBHDS actively work with CMS to develop and seek approval of a checklist to replace the narrative portion of progress notes - the demands of which detract from providers’ resources to effectively support individuals. We recommend that this checklist includes all required information and is displayed as a checklist. We recommend that whenever the term “written” is used, it is inclusive of electronic documentation, such as but not limited to dictation, voice to text or audio files. A.4.- Change “30 calendar days” to “90 calendar days” [See comment above in Section 80]; A.5.- Strike “medically necessary services and supplies” and add “services and supports” A.6.- Strike “supplies” and add “supports”; A.10.d- Strike “medical” in the first sentence; A.10.f- Add “if applicable” within the parenthetical phrase “including specific timeframe”; A.13- Change 37.2-600 to 37.2-607; A.14- Strike “-s of Licensing and” [Abuse and neglect are reported to the Office of Human Rights not the Office of Licensing]; D- Strike “may” add “shall” in last sentence [If the purpose is to improve or remove poor providers then this should not be an option]	Edits have been made to progress note definition. See Line 2 and Line 19. Checklists are permitted. Electronic documentation is permitted.

67.	Citizen	Provider requirements. • A.4.- Change “30 calendar days” to “90 calendar days” (See comment above in Section 80) • A.5.- Strike “medically necessary services and supplies” and add “services and supports” • A.6.- Strike “supplies” and add “supports” • A.10.d- Strike “Such documentation shall be written on the date of service delivery.” This is not in keeping with the definition of Progress Note in 122-20 and as referenced earlier in comments. • A.10.d- Strike “medical” in the first sentence • A.10.f- Add “if applicable” within the parenthetical phrase “including specific timeframe” • A.13- Change 37.2-600 to 37.2-607 • A.14- Strike “-s of Licensing and”. Abuse and neglect are reported to the Office of Human Rights not the Office of Licensing. • D- Strike “may” add “shall” in last sentence. If the purpose is to improve or remove poor providers - then this should not be an option.	See Line 2 and Line 19
68.	Dominion Waiver/Koke	• A.4.- Change “30 calendar days” to “90 calendar days” (See comment above in Section 80)• A.5.- Strike “medically necessary services and supplies” and add “services and supports”• A.6.- Strike “supplies” and add “supports” • A.10.d- Strike “Such documentation shall be written on the date of service delivery.” This is not in keeping with the definition of Progress Note in 122-20 and as referenced earlier in comments. • A.10.d- Strike “medical” in the first sentence • A.10.f- Add “if applicable” within the parenthetical phrase “including specific timeframe” • A.13- Change 37.2-600 to 37.2-607 • A.14- Strike “-s of Licensing and”. Abuse and neglect are reported to the Office of Human Rights not the Office of Licensing. • D- Strike “may” add “shall” in last sentence. If the purpose is to improve or remove poor providers - then this should not be an option.	See Line 2 and Line 19
69.	Cheryl Emory, Parent & L'Arche Metro Richmond	**"Medically" is problematic in "Medically Necessary"** The term, "Medically Necessary" is a long-standing criteria for health insurance coverage, yet it is not appropriate for disabilities related services such as community engagement, companion care, and supported employment. While managed care is a viable route for cost containment and to promote appropriate services, existing health insurance definitions and methods do not always fit. It seems that we're trying to fit a square peg into a round hole. "Medical necessity” for payment implies that services must have a physician’s order and not be developed by the Person-Centered planning process. Please strike the word, "medically" from the term "medically necessary" in the following sections. 12VAC30-122 B 1. - Legal Authority 12VAC30-122-20. Definitions. The term and definition: " 'Medically necessary' means an item or service provided for the diagnosis or treatment of an individual's condition consistent with community standards of medical practice as determined by DMAS" don't fit with some waiver services that are not medical (e.g. community engagement, companion care, and supported employment). Perhaps there is a need to add a definition for necessity that is not medical.	Edits made.

		12VAC30-122-120. Provider requirements. A. 5. 12VAC30-122-410. In-home support service. C. 2. Note: The term "medically necessary" does seem appropriate for private duty nursing and skilled nursing.	
70.	Wormley, Kerns, Collier, Lester, Hauley -VersAbility Rsc	12VAC30-122-120. Provider requirements. A.4.- Change “30 calendar days” to “90 calendar days” (See comment above in Section 80) A.5.- Strike “medically necessary services and supplies” and add “services and supports” A.6.- Strike “supplies” and add “supports” A.10.d- Strike “Such documentation shall be written on the date of service delivery.” This is not in keeping with the definition of Progress Note in 122-20 and as referenced earlier in comments. A.10.d- Strike “medical” in the first sentence A.10.f- Add “if applicable” within the parenthetical phrase “including specific timeframe” A.13- Change 37.2-600 to 37.2-607 A.14- Strike “-s of Licensing and”. Abuse and neglect are reported to the Office of Human Rights not the Office of Licensing. D- Strike “may” add “shall” in last sentence. If the purpose is to improve or remove poor providers - then this should not be an option.	See Line 2.
71.	Renon/Wall Res.	Same as Line 36.	See Line 36.
72.	Crum/ServiceSource	Same as Line 66.	See Line 36.
73.	Donald Kelly, L'Arche	* A.10.d- Strike “Such documentation shall be written on the date of service delivery.” This is not in keeping with the definition of Progress Note in 122-20 and as referenced earlier in comments.	Edits made.
74.	La Voyce B. Reid/Arlington CSB	Consider adding, “and, if applicable, to the local police” (in reference to reporting suspicions of abuse and neglect).	Edits made.
75.	Maureen Hollowell, VA Assoc of Centers for Independent Living	A.13.a. The first sentence states that the criminal history records check is “conducted” by the FEA. Clarify this sentence to show that the FEA submits the information to the State Police, but does not actually conduct or perform the check. The second sentence states that the CD employee must submit to a CPS check, but does not include the statement that the FEA actually conducts the CPS check, similar to the responsibility the FEA has for the criminal history check.	FEA does submit to SP. Edits made - "Obtained by Fiscal Employer Agent".

76.	Citizen	Semi-Annual Supervisory Notes for DSPs including "individual's satisfaction with service provision" Req. should be eliminated or changed per comments below: Community Coaching (122-310.E.2), Community Engagement (122-320.E.2), Group Day (122-380.D.5.), Group Residential (122-390.D.5), Crisis Support Services (122-350.E.2) and Center-Based Crisis Support Services (122-300.E.2) all have additional burdensome requirements under Service Documentation or Provider requirements that state that there must be written supervision notes for each DSP, signed by the supervisor and included semi-annual documentation of individual's satisfaction by the supervisor. (Center-based Crisis Supports does not include the semi-annual requirement.) Semi-Annual supervisory documentation of an individual's "Satisfaction with service provision" or "observation of satisfaction" is also required. - This is duplicative of the initial and annual thereafter required documentation of proficiency of staff competencies included under 122-180. Not to mention, much more stringent. Why some services and not others? Consistency between the services does not exist. Group Day requires documentation of "observation of satisfaction". The requirement of semi-annual notes in the DSP supervision note regarding "satisfaction of the individual" or "observation of satisfaction of the individual" is not consistent with the already required individualized documentation. If anyone should be documenting an "individual's satisfaction with service provision" or "observation of satisfaction" – it should be the support coordinator/case manager during their regular visits. Someone other than the provider should be evaluating whether an individual is satisfied with the service they are receiving from the provider. It's like the proverbial "rooster guarding the hen house". The support coordinator/case manager is the more appropriate person and, if required, it should be required for all waiver services and not just some services. The requirement of proscribed supervisory notes on a regular semi-annual basis is another added administrative burden layered on top of the annual DSP staff competency requirement which was added after the waiver rates were set. Both cumbersome doc requirements are not included in any rate.	Edits made to 12 VAC 30-122-120 to include these requirements for all services.
77.	Citizen	Same as Line 76.	See Line 76.
78.	Virginia Board for People with Disabilities	Subdivision A 4: The Board recommends changing 30 days to 90 days. There may be unforeseen barriers, including bureaucratic hurdles, which prevent the initiation of services within 30 days.	See Line 2.
79.	Virginia Board for People with Disabilities	Subdivision A 5: The Board recommends removing the term "medically necessary" since the key to the plan is to provide person-centered services. The provision would begin as follows: "Provide medically necessary services and supplies for individuals in accordance with the ISP…."	See Line 2.

80.	Virginia Board for People with Disabilities	Subsection D: The Board recommends changing may to shall with respect to the referral to program integrity for providers who demonstrate a history of non-compliance. The sentence would read, "Failure to complete the mandatory training or identified technical assistance ~~may~~ shall result in referral to DMAS Program Integrity or termination of the provider Medicaid participation agreement."	Edits made.
81.	Virginia Board for People with Disabilities	Subdivision A 10d: The Board recommends striking the word "medical" to read as follows: "Providers shall prepare and maintain unique person centered progress note written documentation in each individual's medical record regarding their response to services and rendered supports." Not all records are medical.	See Line 2.
82.	Virginia Board for People with Disabilities	Subdivision A 10d: the Board recommends adding, if applicable within the parenthetical: "Providers shall maintain an attendance log or similar document that indicates the date services were rendered, type of services rendered, and number of hours or units provided (including specific timeframe, if applicable)…." Not all services are delivered in hourly units and the day the service is provided is already required.	Edits made.
83.	Virginia Board for People with Disabilities	Subdivision A 13: The Board recommends changing the code citation from 37.2-600 to 37.2-607.	See Line 2.
84.	Virginia Board for People with Disabilities	Subdivision A 14: The Board recommends removing the DBHDS Office of Licensure from the list of entities to whom abuse or neglect should be reported. These are required to be reported to the DBHDS Office of Human Rights.	See Line 2.
85.	Virginia Board for People with Disabilities	Subsection D: The Board recommends that the regulations discuss what additional remedial actions for providers, beyond mandatory training or technical assistance, can be taken and the circumstances in which each of these actions will be taken. The regulations state that providers with a history of noncompliance will be required to undergo mandatory training and technical assistance. However, it is unclear what steps would be taken if a provider continues to be out of compliance following participation in the mandatory training or technical assistance. Would additional training or technical assistance be required? Would other remedial actions such as fines or provider enrollment freezes be implemented? At what point will providers' Medicaid participation agreements be terminated?	This will be discussed in the manual.

Comments related to 12VAC30-122-150

2.	Loudoun CSB L. Snider	Concern regarding ensuring Conflict Free Case Management with statement "The individual's support coordinator/case manager may also function as the service facilitator." Suggest adding, if the support coordination/case manager agency has a provider agreement with DMAS to provide such service.	DMAS cannot make this change at this time.

3.	Dville/Pittvania CSB/S. Craddock	Concern regarding ensuring Conflict Free Case Management with statement "The individual's support coordinator/case manager may also function as the service facilitator." Suggest adding, if the support coordination/case manager agency has a provider agreement with DMAS to provide such service.	DMAS cannot make this change at this time.
4.	Harrison-Rock'ham CSB/ Slaughbaugh	Concern regarding ensuring Conflict Free Case Management with statement "The individual's support coordinator/case manager may also function as the service facilitator." Suggest adding, if the support coordination/case manager agency has a provider agreement with DMAS to provide such service.	DMAS cannot make this change at this time.
5.	Blue Ridge Beh Healthcare A. Monti	Concern regarding ensuring Conflict Free Case Management with statement "The individual's support coordinator/case manager may also function as the service facilitator." Suggest adding, if the support coordination/case manager agency has a provider agreement with DMAS to provide such service.	DMAS cannot make this change at this time.
6.	RBHA/M Harrison	Concern regarding ensuring Conflict Free Case Management with statement "The individual's support coordinator/case manager may also function as the service facilitator." Suggest adding, if the support coordination/case manager agency has a provider agreement with DMAS to provide such service.	DMAS cannot make this change at this time.
7.	VA Board for People with Disabilities	Subdivision A 2a: The Board recommends modifying the second sentence of this subdivision to state, "If an individual is unable <u>or unwilling</u> to direct his own care or is younger than 18 years of age, he may designate another person older than 18 years of age to serve as the employer of record (EOR) on his behalf." Individuals who are capable of, but unwilling to, direct their own care should also be allowed to designate an EOR if desired.	Edits made.
8.	VAIL/G. Brunk	indicates that an individual can choose not to utilize a service facilitator and instead utilize the EOR in this capacity. It states that "the EOR shall perform all of the duties and meet all of the requirements of a CD services facilitator" Does this mean that the EOR also must have the same educational and experience requirements as a service facilitation provider? Additionally, if so, who is conducting the criminal background check? And who is conducting the two references from prior job experiences from human services work referenced in 12VAC30-122-1300 D.c.(1)?	DMAS does not require these steps, as the EOR is not getting paid.
9.	Elliott/Hanover CSB	Support Coordinators can act as Service Facilitators - A Support Coordinator who provides Service Facilitation Services cannot guarantee conflict free case management services. I would like to see this not be an option for Support Coordination.	DMAS will not make changes at this time. CMS has reviewed and approved this.
10.	Citizen	Concern that a non-sponsor family member living in the same home cannot provide CD services. There may be limited circumstances where this may be the only option. Recommend this must be done with Objective Documentation this is the option.	Another family member living in the home can provide CD services if there is 'objective documentation' Reference 12VAC30-122-120-B
11.	Fairfax/Falls Ch CSB	12-VAC30-122-150 A. 2.e-the language indicates a Support Coordinator may also function as a Service Facilitator, which will not ensure conflict free case management, requesting clarification.	DMAS will not make changes at this time. CMS has reviewed and approved this.

12.	Maureen Hollowell, VA Assoc of Centers for Independent Living	1) Change "DD Waivers" to the FIS and CL Waivers. The BI Waiver does not offer a CD model of services; 2) 2.e. The regulation should provide additional information about the duties of the person who will perform the duties of the services facilitator, if the individual or EOR elects not to use services facilitation.	1. Edits made. 2. This will be discussed more fully in the manual.
13.	Virginia Board for People with Disabilities	Subdivision A 2a: The Board recommends modifying the second sentence of this subdivision to state, "If an individual is unable or unwilling to direct his own care or is younger than 18 years of age, he may designate another person older than 18 years of age to serve as the employer of record (EOR) on his behalf." Individuals who are capable of, but unwilling to, direct their own care should also be allowed to designate an EOR if desired.	Edits made.

Comments related to 12VAC30-122-160

VA Board for People with Disabilities	**Subdivision 3: The Board recommends adding a new item to the lettered list that states that the service facilitator or care coordinator shall "Take intermediate steps to address emerging issues – such as alerting the individual of the challenges, facilitating the appointment of an employer of record, providing additional training and assistance, and collaborating with the member or representative, service facilitator, and the Department – and document the intermediate steps taken**." At a minimum, additional safeguards should be implemented prior to involuntary disenrollment, as suggested in the Joint Legislative Audit and Review Commission's December 2016 report, Managing Spending in Virginia's Medicaid Program (see pages 74-5). Intermediate steps should be taken as soon as emerging issues become apparent.	There are steps that must be followed before disenrolling. DMAS believess all suggestions have been addressed in regulation section 160. The process outlined in this regulation section addresses intermediate steps providing adequate time prior to disenrollment.

Comments related to 12VAC30-122-180

2.	DDWAC	1. C.1.- The reference should to the "personnel file" not the "provider record" 2. D.1- The reference should to the "personnel file" not the "provider record" 3. D.2- Change sentence to "Completed documentation from the online certificate shall be maintained in the Personnel File." 4. E.7- Add "only" before specific to the needs; and following specific to the needs strike "and level" 5. E.8- add "only" before "specific to the needs"; strike "and service levels" [These changes clarify the intent to have the advanced competencies applicable as the needs of the individual requires.]	1. Edits made. 2. Edits made. 3. Edits made. 4. Edits made. 5. Edits made.
3.	MPNN CSB L. McCrobie	The regulations state that new hires have to complete competencies in 180 days. **Is this the same requirement for supporting individual with a Leve 6 or 7?**	Edits made.
4.	Loudoun CSB L. Snider	The regulations state that new hires have to complete competencies in 180 days. Is this the same requirement for supporting individual with a Leve 6 or 7?	See Line 3.
5.	Dville/Pittvania CSB/S. Craddock	The regulations state that new hires have to complete competencies in 180 days. Is this the same requirement for supporting individual with a Level 6 or 7?	See Line 3.

6.	Harrison-Rock'ham CSB/ Slaughbaugh	The regulations state that new hires have to complete competencies in 180 days. Is this the same requirement for supporting individual with a Level 6 or 7?	See Line 3.
7.	Henrico Area MHDS	ADD language to incorporate new Legislation re SE competencies.	Edits made.
8.	Blue Ridge Beh Healthcare A. Monti	The regulations state that new hires have to complete competencies in 180 days. Is this the same requirement for supporting individual with a Leve 6 or 7?	See Line 3.
9.	RBHA/M Harrison	The regulations state that new hires have to complete competencies in 180 days. Is this the same requirement for supporting individual with a Leve 6 or 7?	See Line 3.
10.	Citizen	D.1- The reference should to the "personnel file" not the "provider record" 2. D.2- Change sentence to "Completed documentation from the online certificate shall be maintained in the Personnel File." 3. E.7- Add "only" before specific to the needs; and following specific to the needs strike "and level" 4. E.8- add "only" before "specific to the needs"; strike "and service levels" [These changes clarify the intent have the advanced competencies applicable as the needs of the individual requires.]	See Line 2.
11.	Diana Wilson, WorkSource Enterprises	1. C5. If upon review a DSP or DSP supervisor **does not demonstrate proficiency in one or more competency areas, then within 180 days of this review the DSP or DSP supervisor shall review the training information, and orientation retesting shall be completed achieving a score of at least 80% documenting proficiency in the identified area or areas.** 2. The orientation is a knowledge based assessment, while the competencies are both knowledge and action based. On many of the competencies, you are required to assess action and knowledge. Where I have found the deficiencies to be is in the action part of the competencies. Therefore, retaking the orientation test is not a valid way of training for action. Having state wide readily available online training tools for the competencies from department would be helpful. 3. DMAS shall not reimburse for those services provided by DSPs or DSP supervisors who have failed to pass the orientation test or demonstrate competencies as required. 4. So if I am reading this correctly, if someone is not proficient on the competencies after the 180 days, I either have to fire them or they cannot work with individuals until they are considered proficient. Is this a correct understanding?	2. DMAS will take this into consideration as a possible future change. 4. DMAS has stated that a provider can consider additional training for the staff not meeting standards within 180 days (programatic decision based on the DSP and situation), but it is correct that the person cannot work indpendently until they pass the test. Edits made.

12.	VA Board for People with Disabilities	**Subdivision A 1e: The Board recommends adding a new item at the end of this subdivision that states, "(e) Cultural competence."** It is important that direct support professionals understand how to respect cultural differences of the individuals they serve.	In order to add this as a separate item, DMAS would need to determine the degree to which training is required. In the DSP Orientation training materials culture is referrenced under Section I: The Value of Respect. DBHDS will work to develop or obtain resources on cultural competence that can be made available to providers.
13.	Karen Tefelski - vaACCSES	12VAC30-122-180. Orientation testing; professional competency requirements; advanced competency requirements. A.2. refers to the standardized test as "DMAS approved" while the 2016 version of the regulations refers to the test as "DBHDS" approved. Please clarify which agency must approve the test, describe the process of approval, and include a list of approved standardized tests and resources for providers. C5. The orientation is a knowledge-based assessment, while the competencies are both knowledge and action based. On many of the competencies, you are required to assess action and knowledge. Where I have found the deficiencies to be is in the action part of the competencies. Therefore, retaking the orientation test is not a valid way of training for action. Having statewide readily available online training tools for the competencies from department would be helpful. D.1- The reference should to the "personnel file" not the "provider record" D.2- Change sentence to "Completed documentation from the online certificate shall be maintained in the Personnel File." E.7- Add "only" before specific to the needs; and following specific to the needs strike "and level" E.8- add "only" before "specific to the needs"; strike "and service levels". These changes clarify the intent have the advanced competencies applicable as the needs of the individual requires.	A.2 - DMAS approves the test and materials provided by DBHDS. C5. DMAS will take this into consideration as a possible future change. D/E: See Line 2.
14.	Henrico Area MHDS	Add language to incorporate new legislation re: SE competencies.	DMAS is not able to make this change at this time.

15.	K. Black-Hope House	Strike “most intensive need” from this section. Stating level 6 or 7 is suffice. C.1., 3. 4.- Include that DMAS forms may be adapted to increase ease of completion for providers as long as all elements of original form are present. D.1- The reference should to the “personnel file” not the “provider record”. D.2- Change sentence to “Completed documentation from the online certificate shall be maintained in the Personnel File.” E.7.,8.- Include that DMAS forms may be adapted to increase ease of completion for providers as long as all elements of original form are present. E.5.- Should be in the customized rate section and not here. E.7- Add “only” before *specific to the needs*; and following *specific to the needs* strike “and level”. E.8- add “only” before “specific to the needs”; strike “and service levels” [These changes clarify the intent to have the advanced competencies applicable as the needs of the individual requires.]	1. Edits made. C1, 3, 4: DMAS is not able to make this change at this time. D1, D2, E7, E8: Edits made. E5. DMAS is not able to make this change at this time. E8. Edits made.
16.	B Huffman - VersAbility Resources	12VAC30-122-180. Orientation testing; professional competency requirements; advanced competency requirements. A.2. refers to the standardized test as “DMAS approved” while the 2016 version of the regulations refers to the test as “DBHDS” approved. Please clarify which agency must approve the test, describe the process of approval, and include a list of approved standardized tests and resources for providers. C5. The orientation is a knowledge-based assessment, while the competencies are both knowledge and action based. On many of the competencies, you are required to assess action and knowledge. Where I have found the deficiencies to be is in the action part of the competencies. Therefore, retaking the orientation test is not a valid way of training for action. Having statewide readily available online training tools for the competencies from department would be helpful. D.1- The reference should to the “personnel file” not the “provider record” D.2- Change sentence to “Completed documentation from the online certificate shall be maintained in the Personnel File.” E.7- Add “only” before specific to the needs; and following specific to the needs strike “and level” E.8- add “only” before “specific to the needs”; strike “and service levels”. These changes clarify the intent have the advanced competencies applicable as the needs of the individual requires.	See Line 13.
17.	Jan Williams, ServiceSource	A.2. refers to the standardized test as “DMAS approved” while the 2016 version of the regulations refers to the test as “DBHDS” approved. Please clarify which agency must approve the test, and also describe the process of approval, and finally include a list of approved standardized tests and resources for providers. A provider often needs to have all staff certified for advanced competencies, not just those directly assigned to specific individuals with SIS scores at levels 6 or 7. For instance, if the regularly assigned “advanced trained” staff are absent, other staff must be deployed to serve those individuals. Also, staff may request transfers or accept promotions. Providers need staff to be “advanced trained” to move between sites and assignments. Therefore, the impact of compliance cannot be measured only by the number of individuals assessed at level 6 or	DMAS approves the test and materials provided by DBHDS. Edits made in regard to personnel file.

		7. A provider may need to have all staff trained in advanced competencies. In consideration of this logistical reality, we recommend a substitution for the core and advanced competency checklists whenever a staff has completed the State mandated trainings and met the minimum requirements of acquiring these core competencies. We further recommend that Staff with one year of experience can substitute this experience for the advanced competency checklists associated with levels 6 and 7. C.1.- The reference should to the "personnel file" not the "provider record" D.1- The reference should to the "personnel file" not the "provider record"	
18.	Citizen	• A.2. refers to the standardized test as "DMAS approved" while the 2016 version of the regulations refers to the test as "DBHDS" approved. Please clarify which agency must approve the test, describe the process of approval, and include a list of approved standardized tests and resources for providers. • C5. The orientation is a knowledge-based assessment, while the competencies are both knowledge and action based. On many of the competencies, you are required to assess action and knowledge. Where I have found the deficiencies to be is in the action part of the competencies. Therefore, retaking the orientation test is not a valid way of training for action. Having statewide readily available online training tools for the competencies from department would be helpful. • D.1- The reference should to the "personnel file" not the "provider record" • D.2- Change sentence to "Completed documentation from the online certificate shall be maintained in the Personnel File." • E.7- Add "only" before specific to the needs; and following specific to the needs strike "and level" • E.8- add "only" before "specific to the needs"; strike "and service levels". These changes clarify the intent have the advanced competencies applicable as the needs of the individual requires.	See Line 2.
19.	Dominion Waiver/Koke	• A.2. refers to the standardized test as "DMAS approved" while the 2016 version of the regulations refers to the test as "DBHDS" approved. Please clarify which agency must approve the test, describe the process of approval, and include a list of approved standardized tests and resources for providers. • C5. The orientation is a knowledge-based assessment, while the competencies are both knowledge and action based. On many of the competencies, you are required to assess action and knowledge. Where I have found the deficiencies to be is in the action part of the competencies. Therefore, retaking the orientation test is not a valid way of training for action. Having statewide readily available online training tools for the competencies from department would be helpful. • D.1- The reference should to the "personnel file" not the "provider record" • D.2- Change sentence to "Completed documentation from the online certificate shall be maintained in the Personnel File." • E.7- Add "only" before specific to the needs; and following specific to the needs strike "and level" • E.8- add "only" before "specific to the needs"; strike "and service levels". These changes clarify the intent have the advanced competencies applicable as the needs of the individual requires.	See Line 2.

20.	Wormley, Kerns, Collier, Lester, Hauley - VersAbility Rsc	12VAC30-122-180. Orientation testing; professional competency requirements; advanced competency requirements. A.2. refers to the standardized test as "DMAS approved" while the 2016 version of the regulations refers to the test as "DBHDS" approved. Please clarify which agency must approve the test, describe the process of approval, and include a list of approved standardized tests and resources for providers. C5. The orientation is a knowledge-based assessment, while the competencies are both knowledge and action based. On many of the competencies, you are required to assess action and knowledge. Where I have found the deficiencies to be is in the action part of the competencies. Therefore, retaking the orientation test is not a valid way of training for action. Having statewide readily available online training tools for the competencies from department would be helpful. D.1- The reference should to the "personnel file" not the "provider record" D.2- Change sentence to "Completed documentation from the online certificate shall be maintained in the Personnel File." E.7- Add "only" before specific to the needs; and following specific to the needs strike "and level" E.8- add "only" before "specific to the needs"; strike "and service levels". These changes clarify the intent have the advanced competencies applicable as the needs of the individual requires.	See Line 2, Line 11, and Line 13.
21.	Johnston/Vector Industries	CommunityCoaching(122-310.E.2),CommunityEngagement(122-320.E.2),GroupDay (122-380.D.5.), Group Residential (122-390.D.5), Crisis Support Services (122-350.E.2) and Center-Based Crisis Support Services (122-300.E.2) all have additional burdensome requirements under Service Documentation or Provider requirements that state that there must be written supervision notes for each DSP, signed by the supervisor and included semi-annual documentation of individual's satisfaction by the supervisor. (Center-based Crisis Supports does not include the semi-annual requirement.) Semi-Annual supervisory documentation of an individual's "Satisfaction with service provision" or "observation of satisfaction" is also required. ? This is duplicative of the initial and annual thereafter required documentation of proficiency of staff competencies included under 122-180. Not to mention, much more stringent. ? Why some services and not others? ? Consistency between the services does not exist. Group Day requires documentation of "observation of satisfaction". ? The requirement of semi-annual notes in the DSP supervision note regarding "satisfaction of the individual" or "observation of satisfaction of the individual" is not consistent with the already required individualized documentation.	See Line 20.

22.	Susan Keenan, Community Living Alternatives	In general, Community Living Alternatives supports and endorses the comments of vaACCSES with emphasis placed on the following points: Such documentation shall be written on the date of service delivery. Strike or change to as soon as practicable but no longer than one week after the service. This is in keeping with the definition of Progress Note from this chapter. Support changing the 10-day requirement to a 15-day requirement for service providers to submit quarterly reports. C5. The orientation is a knowledge-based assessment, while the competencies are both knowledge and action based. On many of the competencies, you are required to assess action and knowledge. Where I have found the deficiencies to be is in the action part of the competencies. Therefore, retaking the orientation test is not a valid way of training for action. Having statewide readily available online training tools for the competencies from department would be helpful. A.1- Delete "to 72" and add "or older" after "years of age." If the SIS is only validated to age 72 then language should be added to automatically assign all individuals age 72 or older to Level 5, Tier 4. Level 5 is the highest level denoting significant need in general but not specifying it to medical or behavioral. Tier 4 is mid-range denoting significant need, which is appropriate for an aging population. However, there should be a statement that these individuals shall not be excluded from consideration of an individualize rate because of medical or behavioral needs. Add a new E.- "An automatic, independent review of the SIS administration process and results when an individual's SIS Score changes despite a lack of change in their health or other circumstances, upon request."	DMAS will take this into consideration as a possible future change.
23	Virginia Board for People with Disabilities	Subsections C and D: The Board recommends that all core competency training and professional assurances be completed prior to working with an individual, including specialized services needed by the individual. Advanced competencies not directly related to working with the individual can have a longer timeframe for completion as the list is extremely lengthy. The Board understands the need to have an observation period for completing the competency checklist. However, the Board is concerned that new direct support professionals (DSPs) and DSP supervisors have 180 days from date of hire to complete competency training, in the case of licensed providers, and 180 days to complete professional assurances in the case of non-licensed providers. Requiring completion of competency training and professional assurances prior to working with the individual would be feasible and consistent with requirements for service facilitators in 12 VAC 30-122-500 D 2e.	This would create greater workforce shortages, and DMAS is unable to make this change at this time.
24.	Virginia Board for People with Disabilities	Subdivision D 1: The Board recommends changing "provider record" to "personnel file or record" with respect to the documentation of assurances required to be maintained regarding DSP training. Records relate to individual personnel.	Edits made

Comments related to 12VAC30-122-190

2.	D. Meadows/ Chesterfield MHSS	Comment on proposed reg indicating the quarterly reviews must be in the individual's record no later than 15 calendar days from date review was due to be completed. Concern for CMs/SCs who must receive/review providers' quarterly reviews incorporating the info in their review. At times provider is late or does not submit quarterly documentation at all, even with numerous follow up by the CM/SC. This reg will prevent the CM/SC opportunity to review the provider quarterlies and synthesize the info. Also create potential citation for not meeting regulation when it is not within their control. **Can the regulation be edited to offer a period of time for the CM/SC to review provider quarterlies and then complete the Case Management quarterly?**	No reference to a 15 day criteria in this section of regulation.
3.	DDWAC	A.8- Add "by the support coordinator" before *with a copy of the*	Edits made.
4.	MPNN CSB L. McCrobie	1. Support Coordinators shall conduct and document a minimum of quarterly visits to all other individuals at least one annually occurring in the home. It used to be that we alternate visits occurring in the home. 2. Also asking for consistency between 90 day visit, 3 month visit and quarterly visit	This is a basic waiver requirement that is not related to alternate visits. (Is the commenter thinking of ECM requirements?) Edits made to "90 days".
5.	Loudoun CSB L. Snider	Support Coordinators shall conduct and document a minimum of quarterly visits to all other individuals at least one annually occurring in the home. It used to be that we alternate visits occurring in the home. Also asking for consistency between 90 day visit, 3 month visit and quarterly visit	This is a basic waiver requirement that is not related to alternate visits. (Is the commenter thinking of ECM requirements?) The term "quarterly" is used throughout.
6.	Harrison-Rock'ham CSB/ Slaughbaugh	Support Coordinators shall conduct and document a minimum of quarterly visits to all other individuals at least one annually occurring in the home. It used to be that we alternate visits occurring in the home. Also asking for consistency between 90 day visit, 3 month visit and quarterly visit	This is a basic waiver requirement that is not related to alternate visits. (Is the commenter thinking of ECM requirements?) The term "quarterly" is used throughout.

7.	Henrico Area MHDS	A. 6. Is it quarterly face to face or every 90 days? A.8. Specify providers of each service furnish individuals with a copy of their part of the ISP C.2.d. Is a new evaluation required (psychological or otherwise) whenever an individual with dementia experiences a loss of cognitive ability?	A6 - Edits made to "90 days." A8 - Additional clarification was provided that the SC should provide family with ISP. C2d - new assessments are required when substantial change occurs.
8.	Blue Ridge Beh Healthcare A. Monti	Support Coordinators shall conduct and document a minimum of quarterly visits to all other individuals at least one annually occurring in the home. It used to be that we alternate visits occurring in the home. Also asking for consistency between 90 day visit, 3 month visit and quarterly visit	This is a basic waiver requirement that is not related to alternate visits. (Is the commenter thinking of ECM requirements?) The term "quarterly" is used throughout.
9.	Hartwood Foundation, Inc.	A8 – Specify that the ISP is to be provided **by the Support Coordinator**	Edits made.
10.	RBHA/M Harrison	Support Coordinators shall conduct and document a minimum of quarterly visits to all other individuals at least one annually occurring in the home. It used to be that we alternate visits occurring in the home. Also asking for consistency between 90 day visit, 3 month visit and quarterly visit	This is a basic waiver requirement that is not related to alternate visits. (Is the commenter thinking of ECM requirements?) The term "quarterly" is used throughout.
11.	The Arc of VA T. Milling	Part 5 of Individual Service Plans; Currently in the Individual Service Plan, there are separate part 5 sections for each service a person receives. This is cumbersome for the person using services and time consuming for the provider of multiple services. As people begin to live more included and more self-directed lives with supports following them as needed, they will likely weave together a combination of support services in order to live the life that they choose. The need for multiple plans takes away from the purpose of person centeredness. The Arc of Virginia recommends one Plan for one person, including one Part 5 for that plan.	Thank you for your comment. DMAS will continue to review opportunities to streamline documentation.

12.	Region 10	**ISP;** We want one simplified ISP to allow more time towards direct services. We are tired of being burdened by duplicative paperwork.	Thank you for your comment. We will continue to review opportunities to streamline documentation.
13.	Citizen	A.8- Add “by the support coordinator” before *with a copy of the.* This clarifies that the support coordinator is responsible for providing a copy of the ISP to the individual family.	Edits made.
14.	VA Board for People with Disabilities	**Subdivision A 8: The Board recommends adding the word, “by the support coordinator” at the end of the sentence.** This clarifies that support coordinator is responsible for providing a copy of the ISP to individual-family	Edits made.
15.	VAIL/G. Brunk	indicates “support coordinators shall conduct and document a minimum of quarterly visits”. 12VAC30-122-1300 B.2.d. states “the services facilitator shall continue to monitor the individual’s plan for supports quarterly (i.e., every 90 days)”. 12VAC30-122-1300 B.4. alludes to routine quarterly visits. 12VAC30-122-1300 B.8. states “at a minimum quarterly routine visits”. We recommend making all regulations, across all waivers, across all services, consistent and utilizing the phrasing “every three months” or “every third month” to allow some flexibility in scheduling as needed. Ninety days is not equal to three months and becomes very challenging, and often requires a fifth visit during the year, which costs DMAS additional funds that are an unintended consequence of this level of specificity in the regulations.	Edits made.
16.	Karen Tefelski - vaACCSES	A.8 Add "by the support coordinator" before with a copy of the This clarifies that the support coordinator is responsible for providing a copy of the ISP to the individual family.	See Line 13.
17.	Henrico Area MHDS	A.6 Is it quarterly face-to-face or every 90 days. A.8 Specify providers of each service furnished individuals with a copy of their part of the ISP. C.2.d Is a new evaluation required (pyschological or otherwise) whenever an individual with dementia experiences a loss of cognitive ability?	See Line 7.
18.	K. Black-Hope House	A.8- Add “by the support coordinator” before *with a copy of the*	Edits made.
19.	H Denman/Arc of Harrisonburg	<u>One Plan</u>: It is imperative that there be one plan: ISP, one semi-annual, one quarterly and one progress note per individual. Under the current waiver system, as the current provider of In-home, Respite, Group Day and Community Engagement services, we write two to four daily progress notes, quarterlies etc. per individual. This reporting places an undue and costly administrative burden on the agency and requires the individual..........	A single plan for supports of like services is being reviewed. Combined progress notes and quarterlies are not under consideration.
20.	H Denman/Arc of Harrisonburg	Currently in the Individual Service Plan, there are separate part 5 sections for each service a person receives. This is cumbersome for the person using services and time consuming for the provider of multiple services. As people begin to live more included and more self-directed lives with supports following them as needed, they will likely weave together a combination of support services in order to live the life that they choose. The need for multiple plans	A single plan for supports of like services is being reviewed. Combined progress notes and quarterlies

		takes away from the purpose of person centeredness. The Arc of Harrisonburg and Rockingham recommends one Plan for one person, including one Part 5 for that plan. ?	are not under consideration.
21.	B Huffman - VersAbility Resources	Same as Line 16.	See Line 16.
22.	Elliott/Hanover CSB	Support coordinators shall conduct and document a minimum of quarterly visits to all other individuals with at least one visit annually occurring in the home - Quarterly visits ***should be clarified to state "a minimum of face to face visits every 90 days with a 10 day grace period*** " This statement should further ***describe visits as being in a variety of settings with every other visit being in the home*** to be consistent with the Enhanced Case Management Criteria set for by the DOJ Settlement.	Edits made. ECM comment - these regulations do not address ECM.
23.	Elliott/Hanover CSB	The reassessment shall be signed and dated by the support coordinator and shall include an update of the level of care….Please clarify that the "level of care" is actually the VIDES..	Edits made.
24.	Jan Williams, ServiceSource	Individual support plan; plans for supports; reevaluation of service need. A.8 states a requirement that "individuals and the family/caregiver shall be provided with a copy of the individual's ISP". We suggest the following clarifying language, "The support coordinator shall provide the individual and the family/caregiver with a copy of the individual's full Person Centered ISP including all Part Vs." We recommend the following additional text here OR in the appropriate section of 12VAC30-50: "The support coordinator shall conduct capacity screenings as a preliminary assessment of significant change. When the results of the capacity screening indicate the need for a full capacity assessment, the support coordinator shall coordinate a full capacity evaluation. If a qualified examiner evaluates the individual and indicates that the individual is unable to give informed consent, the support coordinator shall provide the individual and family with a list of local attorneys known to assist in pursuing legal guardianship. If the individual and family cannot afford the services of an attorney or decline to pursue guardianship, the support coordinator will follow the Code of Virginia, all regulations, and CSB procedures for appointing an authorized representative. The support coordinator will inform all providers about the appointment of an authorized representative. The support coordinator shall convey to DBHDS and to DMAS the names of all individuals who need public guardianship."	A8 - Additional clarification was added that the SC should provide family with ISP. Regarding capacity screening - this is in a Human Rights regulation, and not in this section.
25.	Citizen	The provider shall update the ISP at least annually. For all services except Case Management, the provider shall complete a quarterly review of the ISP at least every three months from the date of the implementation of the ISP or whenever there is a revised assessment based upon the individual's changing needs or goals. These reviews shall evaluate the individual's progress toward meeting the plan's goals and objectives and the continued relevance of the ISP's objectives and strategies. The provider shall update the goals, objectives, and strategies contained in the ISP, if indicated, and implement any updates made. Documentation of each review shall be added to the individual's record no later than	DMAS does not reference 15 calendar days in this regulation. If the recommendation is to add the 15 days - this will be clarified in the manual.

		<u>15 calendar days from the date the review was due to be completed.</u> <u>**Case Management services must complete a review and document it in the individual's record no later than 30 calendar days from the date the review period ended.**</u>	
26.	Citizen	Individual support plan; plans for supports; reevaluation of service need. • A.8- Add "by the support coordinator" before with a copy of the. This clarifies that the support coordinator is responsible for providing a copy of the ISP to the individual family.	A8 - Additional clarification was provided that the SC should provide family with ISP.
27.	O'Keefe/ESCSB	Re: quarterly reviews by CM's - There needs to be consistency with this process in order to allow the CM's opportunity to review providers quarterlies. Allowing CM's till the end of the month, or 30 days if the due date is toward the end of the month, to complete the quarterly takes into account the late quarterlies from providers. 15 days from the due date of the quarterly is not enough time to complete documentation. There needs to be consistency between 90 day visit, 3 month visit and quarterly visit or clarification. Producing more documentation does not make sense when it is redundant.	There is no reference to 15 days that could be found. This will be addressed in the manual
28.	Dominion Waiver/Koke	• A.8- Add "by the support coordinator" before with a copy of the. This clarifies that the support coordinator is responsible for providing a copy of the ISP to the individual family.	Additional clarification was provided that the SC should provide family with ISP.
29.	Wormley, Kerns, Collier, Lester, Hauley - VersAbility Rsc	Same as Line 16.	See Line 16.
30.	Yaun/RACSB	1. Ask for reconsideration of the grace period of 15 days to submit quarterly review to support coordinator. Support Coordinators will not have enough time to process the information submitted and be in compliance with their requirements should this grace period stand 2. Ask for reconsideration around the language that "3. Support coordination/case management services shall not be provided to the individual by: (i) parents, guardians, spouses, or any family living with the individual, or (ii) parents, guardians, spouses, or any family employed by an organization that provides support coordination/case management for the individual except in cases where the family member was employed by the case management entity prior to implementation of these regulations. 3. While the above allows for grandfathering of current employees it would seem to disallow any family member of an individual who receives support coordination from CSB to be employed at a CSB.	There is no reference to 15 days that could be found. This will be addressed in the manual. 2. Located in the DD CM section. DMAS will not make this change at this time. 3. Edits have been made to address this.

31.	Citizen	1. 12VAC30-50-440 and 12VAC30-50-490 outline expectations and requirements for Support Coordination differently for those with a diagnosed Intellectual Disability (440) and those with a diagnosed Developmental Disability (490) despite the merger of the ID and DD Waivers. It would seem that the requirements for Support Coordination providers, definitions of the service and knowledge, skills and abilities would be the same. These sections of the regulations do not align and show there is a disparity in the service and expectations depending on the individuals diagnosis. 2. 12VAC30-50-490 A2. Discusses placement on wait list for individuals with DD diagnosis whereas this is not referenced for individuals with ID diagnosis in 12VA30-50-440. Individuals are placed on the waitlist regardless of diagnosis when slots are not available. These sections also allow for individuals with ID and DD diagnosis to receive Support Coordination services while on the Waiver wait list but makes it time limited and more restrictive for individuals with DD diagnosis. With DD and ID systems merged there is nothing of which I am aware that would show that individuals with DD diagnoses would not have the same need for SPO Support Coordination as those with ID diagnoses. Support Coordinator qualifications should allow an option for entry level Support Coordinators who possess a Human Services degree but lack the experience to provide services under a QDDP to gain the required experience similar to QMHP-Eligible.	Both 1 & 2 are related to 2 sepaerate State Plan Amendments, which have been reviewed and approved by CMS. DMAS must adhere to the requirements that exist in these State Plan Amendments until further notice.
32.	Fairfax/Falls Ch CSB	12 VAC 30-122-190 C1- clarify whether quarterly ISP review means every 90 days. Elaborate regarding ISP review grace period.	Edits made.
33.	Johnston/Vector Industries	DMAS and DBHDS should create the option for a single agency to have one Plan for Supports per individual regardless of the number of services provided to an individual in order to streamline documentation and reduce the number of quarterly reports required. This was a unanimous recommendation of the DBHDS's own Provider Issues Resolution Workgroup (PIRW) in its report published August 2018.	See Line 19.
34.	Susan Keenan, Community Living Alternatives	In general, Community Living Alternatives supports and endorses the comments of vaACCSES with emphasis placed on the following points: Such documentation shall be written on the date of service delivery. Strike or change to as soon as practicable but no longer than one week after the service. This is in keeping with the definition of Progress Note from this chapter. Support changing the 10-day requirement to a 15-day requirement for service providers to submit quarterly reports. C5. The orientation is a knowledge-based assessment, while the competencies are both knowledge and action based. On many of the competencies, you are required to assess action and knowledge. Where I have found the deficiencies to be is in the action part of the competencies. Therefore, retaking the orientation test is not a valid way of training for action. Having statewide readily available online training tools for the competencies from department would be helpful. A.1- Delete "to 72" and add "or older" after "years of age." If the SIS is only validated to age 72 then language should be added to automatically assign all individuals age 72 or older to Level 5, Tier 4. Level 5 is the highest level denoting significant need in general	Edits made to progress note definition. 10-15 day requirement - this will be addressed in the manual A1 - edits have been made E - There is no independent review body to conduct this.

		but not specifying it to medical or behavioral. Tier 4 is mid-range denoting significant need, which is appropriate for an aging population. However, there should be a statement that these individuals shall not be excluded from consideration of an individualize rate because of medical or behavioral needs. Add a new E.- “An automatic, independent review of the SIS administration process and results when an individual’s SIS Score changes despite a lack of change in their health or other circumstances, upon request.”	
35.	La Voyce B. Reid/Arlington CSB	B 2.a. “The ISP shall be revised as appropriate . . .the support coordinator shall inform DMAS and DBHDS that that the individual must be terminated from waiver services.” How shall this notification be made to DMAS and DBHDS? By notice of appeal? Does this include when the VIDES is not met in conjunction with the annual planning meeting? Can the regs address this area: Under what circumstances, if any, shall a VIDES be redone? If an individual, at the time of the annual planning, no longer meets the VIDES, what procedures should be followed? Should DMAS/DBHDS be notified right away that waiver services need to be terminated? Should a supervisor complete the VIDES? Should the CSB reach out to a neighboring CSB to complete an objective VIDES? My experience is that there have been a number of variations (for this scenario) across CSBs and perhaps across regions. Can the regs offer some guidance and consistency on what steps should be followed when someone does not meet the VIDES “at the time of annual planning”? C.d. “A new psychological or other diagnostic evaluation shall be required whenever the individual’s functioning has undergone significant change, . . .” Is this a funded mandate? I think I know the answer is, “No,” but concerned that not all CSBs will be able to absorb costs for re-evaluations such as this (and individuals might not be able to absorb the cost). Depending on the area, it may not be feasible to find a Medicaid provider for such evaluations. Just a thought	B2a - Yes, notification shall be made by notice of appeal - see the appeals section for more detail. The regulations describe when a VIDES shall be redone. This is addressed under the functional assessment - it should be redone annually or as needed. Also see the criteria in the regulations for completing the VIDES. Cd - No changes will be made - an indivdual must have appropriate pshcyological or diagnostic evaluation.

Comments related to 12VAC30-122-200

2.	Citizen	12VAC30-122-200. Supports Intensity Scale® requirements; Virginia Supplemental Questions; levels of support; supports packages. • A.1- Delete “to 72” and add “or older” after “years of age.” If the SIS is only validated to age 72 then language should be added to automatically assign all individuals age 72 or older to Level 5, Tier 4. Level 5 is the highest level denoting significant need in general but not specifying it to medical or behavioral. Tier 4 is mid-range denoting significant need, which is appropriate for an aging population. However, there should be a statement that these individuals shall not be excluded from consideration of an individualize rate because of medical or behavioral needs. • Recommend the addition of “Individuals who are older than 72 years of age shall be assessed using either the SIS or an alternative instrument (alternative instrument or instruments to be named in the regulations).” • A.2.a - Change “three” to “four” to stay consistent with the CL application • A.4.- DELETE. The specific scoring protocol should be in a Medicaid Memo, not in the regulations. • D – DELETE entre section/paragraph. This is a reserved section intended to explain the establishment of supports packages as a profile of the mix and extent of services anticipated to be needed by individuals with similar levels, needs and abilities. Due to 2019 General Assembly budget language which prohibits the implementation of supports packages unless specifically authorized by the General Assembly, this section is not necessary. • Add a new D – “Requires that the results of the SIS be provided within 10 days of scoring in an understandable format and that the service coordinated be required to explain the results and implications of the SIS score and avenues of appeal.” • Add a new E.- “An automatic, independent review of the SIS administration process and results when an individual’s SIS Score changes despite a lack of change in their health or other circumstances, upon request.”	Edits made.
3.	Citizen	The SIS® is an assessment tool that identifies the practical supports required by individuals to live successfully in their communities. DBHDS shall use the SIS® Child for individuals who are five years through 15 years of age. DBHDS shall use the SIS® Adult for individuals who are 16 to 72 years of age. Individuals who are younger than five years of age shall be assessed using either the SIS® or an age-appropriate alternative instrument, such as the Early Learning Assessment Profile, as approved by DBHDS". Recognizing adults receiving waiver services who are over the age of 72, what tool will DBHDS use to determine support levels/tiers going forward? Are there other means-tested tools available? If not, will this have an impact on tier adjustments?	Edits made.
4.	Lucy Beadnell, Virginia Ability Alliance	DMAS-62 form that scores medical needs and eligibility nursing care hours under DD Waiver system does not include all possible medical needs. Some with complex and unusual needs can't get nursing hours their care team recommends- the needs are not reflected on the form. **Regulations should clarify the providing medical team's advice should be considered to determine nursing hours**. Heavy reliance on SIS to determine service availability, with all indications that such reliance will increase in the future. Imperfect in seeing the full picture of someone’s life. Because specialists (e.g., medical and behavioral providers) have invaluable insights re support needs of individuals they	Nursing not addressed in this section. Per SIS reassesment - not appealable. Process may be reassessed.

		serve, **their written statements should be taken into account, along with SIS responses, to determine final SIS scores. SIS scores should be able to be appealed when the SIS fails to take into account critical care information not captured in the assessment.**	
5.	DDWAC	1. A.1- Delete "to 72" and add "or older" after "years of age." [If the SIS is only validated to age 72 then language should be added to automatically assign all individuals age 72 or older to Level 5, Tier 4; the text (Appendix D-1) from the most recent Waiver Application is: "To assess other support needs, each individual 22 years of age and older has the Supports Intensity Scale® (SIS®) completed every four years or when the individual's needs change significantly. 2. A.2.a - Change "three" to "four" to stay consistent with the CL application 3. A.4.- The specific scoring protocol should be in a Medicaid Memo, not in the regulations. 4. D - Strike entre paragraph Add a new D – "Requires that the results of the SIS be provided within 10 days of scoring in an understandable format and that the support coordinator be required to explain the results and implications of the SIS score and avenues of appeal." 5. Add a new E.- "An automatic, independent review of the SIS administration process and results when an individual's SIS Score changes despite a lack of change in their health or other circumstances, upon request."	1. Edits made. 2. Edits made. 3. This information will remain in regulations. 4. No - additional information to be added to final regs Also, we cannot mandate 10 day window - not possible to provide SIS within 10 days due to other considerations. Family-friendly report is provided. SOP is provided at meeting which includes process on reconsideration and how to access. 5. Reassessment process currently exists to request a review when an individual's needs change such that current SIS no longer reflects current tx
6.	Loudoun CSB L. Snider	Indicates SIS stops at age 72. How individuals older than 72 assessed for intensive support needs to ensure ability of providers to continue to serve individuals?	Edits made.
7.	Harrison-Rock'ham CSB/ Slaughbaugh	Indicates SIS stops at age 72. How are these older than 72 assessed for intensive support needs to ensure ability of providers to continue to serve individuals?	Edits made.
8.	Family Sharing/Farrell	A.1- Delete "to 72" and add "or older" after "years of age." If the SIS is only validated to age 72 then language should be added to automatically assign all individuals age 72 or older to Level 5, Tier 4 or their SIS tier at time of reaching age of 72, whichever is greater. Add a new E.- "An automatic, independent review of the SIS administration process and results when an individual's SIS Score changes despite a lack of change in their health or other circumstances, upon request."	Edits made. See Line 5.

9.	Henrico Area MHDS	A.1. What about people over 72 years of age? A.1 refers to individuals age 16-72 while A.2.a. refers to individuals aged 16 and older. This is significant since providers have been told publicly that the SIS will no longer be used for individuals over age 72 since it has not been validated. This is a serious issue for providers supporting older individuals whose needs typically increase as they get older while reimbursement would remain static based on a SIS administered prior to age 72. The language here should be consistent and there will need to be a method adopted for those over age 72, if the SIS is no longer going to be administered. If the chart for figuring SIS scores are included in these regulations, then the practice of how SIS scores are figured should conform to this chart and changes should be made outside of these charts.	Edits made.
10.	Citizen	A.1- Delete “to 72” and add “or older” after “years of age.” If the SIS is only validated to age 72 then language should be added to automatically assign all individuals age 72 or older to Level 5, Tier 4 or their SIS tier at time of reaching the age of 72, whichever is greater. Add a new E.- “An automatic, independent review of the SIS administration process and results when an individual’s SIS Score changes despite a lack of change in their health or other circumstances, upon request.”	Edits made. See Line 5.
11.	Blue Ridge Beh Healthcare A. Monti	Indicates SIS stops at age 72. How are those older than 72 assessed for intensive support needs to ensure ability of providers to continue to serve individuals?	Edits made.
12.	Hartwood Foundation, Inc.	A1 – Clarify what assessment and rate reimbursement determinant structure is to be used for individuals older than 72. A2a – Remove “three” and replace with “four” years for consistency with the state waiver application to CMS. A2d – Remove “six” months and replace with “two” months. Providers regularly support individuals following surgeries and other medical events/conditions wherein it is immediately known and/or highly predictable that the individual’s supports needs have, or will have, changed significantly for an extended time period but also likely to last less than six months before returning to baseline. A4 - Remove scoring protocols from regulations and communicate to providers via some other means.	A1. Edits made. A2a. Edits made. A2d. DMAS will not change 6 months to 2 months post hospitalization - 2 months (in general) does not consistute a sustained change). A4. See line 5.
13.	RBHA/M Harrison	Indicates SIS stops at age 72. How are those older than 72 assessed for intensive support needs to ensure ability of providers to continue to serve individuals?	Edits made.
14.	S. Wilbers-DSP Residential Home	agree with others sis	See responses to other comments.
15.	Collins and Collins, Inc. & Citizen	Concerns about the SIS requirement stopping at 72 years. For potential new providers for individuals 72 or over, could this not affect a providers ability to determine their ability to supports.	Edits made.

16.	Collins and Collins, Inc. & Citizen	Virginia has changed the way that the SIS is responded to and scored. When the SIS first was utilized in Virginia, providers were trained on how to assist individuals with the appropriate responses to the SIS to be able to correctly capture the correct amount of support needed, the frequency and the amount of time. The way in which we were trained initially has not been the method being utilized by the assessors and it doesn't appear that the methodology in which we were initially trained has been changed. Providers with this change have experienced overwhelming reduction in tiers thus lowering our reimbursement rates. There have been providers, advocates, parents etc. raising concern about this issue and where the methodology has gone awry. **If this system is going to be utilized, we would recommend that not only the independent assessor be trained on the appropriate data to be collected from the responses of the individual but also the providers be trained as well. In our experience, there is too much discrepancy from the aid's scoring clarifications and the application of these clarifications in SIS's that we as the provider have attended.**	The SIS assessors are all trained according to AAIDD SIS administration requirements. If there's concern that an assessor is not following proper protocol, there is the opportunity to request a SOP review from DBHDS.
17.	Harrison-Rockingham CSB/J Malone	As SIS scores have become a significant determiner of funding levels for many services, we should support an accessible and transparent appeal process for scoring.	See Line 16.
18.	Citizen	1. A.1- Delete “to 72” and add “or older” after “years of age.” If the SIS is only validated to age 72 then language should be added to automatically assign all individuals age 72 or older to Level 5, Tier 4. Level 5 is the highest level denoting significant need in general but not specifying it to medical or behavioral. Tier 4 is mid-range denoting significant need, which is appropriate for an aging population. However, there should be a statement that these individuals shall not be excluded from consideration of an individualize rate because of medical or behavioral needs. 2. A.2.a - Change “three” to “four” to stay consistent with the CL application 3. A.4.- DELETE. The specific scoring protocol should be in a Medicaid Memo, not in the regulations. 4. D – DELETE entre section/paragraph. This is a reserved section intended to explain the establishment of supports packages as a profile of the mix and extent of services anticipated to be needed by individuals with similar levels, needs and abilities. Due to 2019 General Assembly budget language which prohibits the implementation of supports packages unless specifically authorized by the General Assembly, this section is not necessary. 5. Add a new D – “Requires that the results of the SIS be provided within 10 days of scoring in an understandable format and that the service coordinated be required to explain the results and implications of the SIS score and avenues of appeal.” 6. Add a new E.- “An automatic, independent review of the SIS administration process and results when an individual’s SIS Score changes despite a lack of change in their health or other circumstances, upon request.”	See Line 5.

19.	VA Board for People with Disabilities	**Subdivision A 1: The Board recommends deleting "to 72" and adding "or older" after "years of age" as follows:** "DBHDS shall use the SIS Adult for individuals who are 16 to 72 years of age <u>or older.</u>" If the SIS is only validated to age 72, then language should be added to automatically assign individuals age 72 or older to Level 5, Tier 4. Level 5 is the highest level denoting significant need in general but not specifying it to medical or behavioral needs. Tier 4 is mid-range denoting significant need, which is appropriate for an aging population.	Edits made.
20.	Valley CSB T. Martina	Adult SIS used for ages 16 to 72 - many of our individuals are going beyond the 72 years and require a higher level of supports to reside in the community. What is the reason why the SIS assessment is not completed for this age group? Final note, we have concerns about the significant amount of inconsistent and incorrect information throughout and recommend not being approved until these items have been accurately addressed.	Edits made.
21.	Weatherspoon Wall Res, Inc.	1. A.1- Delete "to 72" and add "or older" after "years of age." [If the SIS is only validated to age 72 then language should be added to automatically assign all individuals age 72 or older to Level 5, Tier 4; the text (Appendix D-1) from the most recent Waiver Application is: "To assess other support needs, each individual 22 years of age and older has the Supports Intensity Scale® (SIS®) completed every four years or when the individual's needs change significantly. 2. A.2.a - Change "three" to "four" to stay consistent with the CL application 3. D - Strike entre paragraph 4. Add a new D – "Requires that the results of the SIS be provided within 10 days of scoring in an understandable format and that the support coordinator be required to explain the results and implications of the SIS score and avenues of appeal." 5. Add a new E.- "An automatic, independent review of the SIS administration process and results when an individual's SIS Score changes despite a lack of change in their health or other circumstances, upon request." 6. Allow for providers of services to request an automatic, independent review of the SIS results when results do not align with the individuals support needs as identified by the treatment team.	See Line 18.
22.	J Ciffizari Wall Res, In.	Same as Line 21.	See Line 18.
23.	Citizen	Same as Line 21.	See Line 18.

24.	Karen Tefelski - vaACCSES	12VAC30-122-200. Supports Intensity Scale® requirements; Virginia Supplemental Questions; levels of support; supports packages. A.1- Delete “to 72” and add “or older” after “years of age.” If the SIS is only validated to age 72 then language should be added to automatically assign all individuals age 72 or older to Level 5, Tier 4. Level 5 is the highest level denoting significant need in general but not specifying it to medical or behavioral. Tier 4 is mid-range denoting significant need, which is appropriate for an aging population. However, there should be a statement that these individuals shall not be excluded from consideration of an individualize rate because of medical or behavioral needs. Recommend the addition of “Individuals who are older than 72 years of age shall be assessed using either the SIS or an alternative instrument (alternative instrument or instruments to be named in the regulations).” A.2.a - Change “three” to “four” to stay consistent with the CL application A.4.- DELETE. The specific scoring protocol should be in a Medicaid Memo, not in the regulations. D – DELETE entre section/paragraph. This is a reserved section intended to explain the establishment of supports packages as a profile of the mix and extent of services anticipated to be needed by individuals with similar levels, needs and abilities. Due to 2019 General Assembly budget language which prohibits the implementation of supports packages unless specifically authorized by the General Assembly, this section is not necessary. Add a new D – “Requires that the results of the SIS be provided within 10 days of scoring in an understandable format and that the service coordinated be required to explain the results and implications of the SIS score and avenues of appeal.” Add a new E.- “An automatic, independent review of the SIS administration process and results when an individual’s SIS Score changes despite a lack of change in their health or other circumstances, upon request.”	See Line 5.
25.	M. Ingram/Wall Res., Inc.	1. A.1- Delete “to 72” and add “or older” after “years of age.” [If the SIS is only validated to age 72 then language should be added to automatically assign all individuals age 72 or older to Level 5, Tier 4; the text (Appendix D-1) from the most recent Waiver Application is: “To assess other support needs, each individual 22 years of age and older has the Supports Intensity Scale® (SIS®) completed every four years or when the individual's needs change significantly. 2. A.2.a - Change “three” to “four” to stay consistent with the CL application 3. D - Strike entre paragraph 4. Add a new D – “Requires that the results of the SIS be provided within 10 days of scoring in an understandable format and that the support coordinator be required to explain the results and implications of the SIS score and avenues of appeal.” 5. Add a new E.- “An automatic, independent review of the SIS administration process and results when an individual’s SIS Score changes despite a lack of change in their health or other	See Line 5.

		circumstances, upon request.” 6. Allow for providers of services to request an automatic, independent review of the SIS results when results do not align with the individuals support needs as identified by the treatment team.	
26.	Henrico Area MHDS	A.1. What about people over 72 years of age? A.1 refers to individuals age 16-72 while A.2.a. refers to individuals aged 16 and older. This is significant since providers have been told publicly that the SIS will no longer be used for individuals over age 72 since it has not been validated. This is a serious issue for providers supporting older individuals whose needs typically increase as they get older while reimbursement would remain static based on a SIS administered prior to age 72. The language here should be consistent and there will need to be a method adopted for those over age 72, if the SIS is no longer going to be administered. If the charts for figuring SIS scores are included in these regulations, then the practice of how SIS scores are figured should conform to this chart and changes should be made outside of these charts.	See Line 5.
27.	R. Ledingham, Wall Res.	A.1- Delete “to 72” and add “or older” after “years of age.” [If the SIS is only validated to age 72 then language should be added to automatically assign all individuals age 72 or older to Level 5, Tier 4; the text (Appendix D-1) from the most recent Waiver Application is: “To assess other support needs, each individual 22 years of age and older has the Supports Intensity Scale® (SIS®) completed every four years or when the individual's needs change significantly. A.2.a - Change “three” to “four” to stay consistent with the CL application. D - Strike entre paragraph. Add a new D – “Requires that the results of the SIS be provided within 10 days of scoring in an understandable format and that the support coordinator be required to explain the results and implications of the SIS score and avenues of appeal.” Add a new E.- “An automatic, independent review of the SIS administration process and results when an individual’s SIS Score changes despite a lack of change in their health or other circumstances, upon request.” Allow for providers of services to request an automatic, independent review of the SIS results when results do not align with the individuals support needs as identified by the treatment team.	See Line 5.
28.	M. Rosenbaum, Wall Res	Same as Line 21.	See Line 5.
29.	K. Black-Hope House	A.1- Delete “to 72” and add “or older” after “years of age.” [If the SIS is only validated to age 72 then language should be added to automatically assign all individuals age 72 or older to Level 5, Tier 4]. A.2.a - Change “three” to “four” to stay consistent with the CL application. A.4. - The specific scoring protocol should be in a Medicaid Memo, not in the regulations. D - Strike entre paragraph. Add a new D – “Requires that the results of the SIS be provided within 10 days of scoring in an understandable format and that the service coordinated be required to explain the results and implications of the SIS score and avenues of appeal.” Add a new E. - “An automatic, independent review of the SIS administration	See Line 5.

		process and results when an individual's SIS Score changes despite a lack of change in their health or other circumstances, upon request."	
30.	J Orchant Aceto/MVLE	A.1- Delete "to 72" and add "or older" after "years of age." If the SIS is only validated to age 72 then language should be added to automatically assign all individuals age 72 or older to Level 5, Tier 4. Level 5 is the highest level denoting significant need in general but not specifying it to medical or behavioral. Tier 4 is mid-range denoting significant need, which is appropriate for an aging population. However, there should be a statement that these individuals shall not be excluded from consideration of an individualize rate because of medical or behavioral needs	See Line 5.
31.	B Huffman - VersAbility Resources	12VAC30-122-200. Supports Intensity Scale® requirements; Virginia Supplemental Questions; levels of support; supports packages. A.1- Delete "to 72" and add "or older" after "years of age." If the SIS is only validated to age 72 then language should be added to automatically assign all individuals age 72 or older to Level 5, Tier 4. Level 5 is the highest level denoting significant need in general but not specifying it to medical or behavioral. Tier 4 is mid-range denoting significant need, which is appropriate for an aging population. However, there should be a statement that these individuals shall not be excluded from consideration of an individualize rate because of medical or behavioral needs. Recommend the addition of "Individuals who are older than 72 years of age shall be assessed using either the SIS or an alternative instrument (alternative instrument or instruments to be named in the regulations)." A.2.a - Change "three" to "four" to stay consistent with the CL application A.4.- DELETE. The specific scoring protocol should be in a Medicaid Memo, not in the regulations. D – DELETE entre section/paragraph. This is a reserved section intended to explain the establishment of supports packages as a profile of the mix and extent of services anticipated to be needed by individuals with similar levels, needs and abilities. Due to 2019 General Assembly budget language which prohibits the implementation of supports packages unless specifically authorized by the General Assembly, this section is not necessary. Add a new D – "Requires that the results of the SIS be provided within 10 days of scoring in an understandable format and that the service coordinated be required to explain the results and implications of the SIS score and avenues of appeal." Add a new E.- "An automatic, independent review of the SIS administration process and results when an individual's SIS Score changes despite a lack of change in their health or other circumstances, upon request."	See Line 5.
32.	C Skelly, DD Committee, Arlington CSB	Assessment. The recommendations of medical and behavioral health care professionals should be considered in the SIS process. These providers may be the professionals most familiar with the level of support needed to maintain a client's health and behavior based on direct, daily involvement with the client and	Although these staff do not complete the documentation, they are welcome

		supports. We also that ask DBHDS establish an appeals process for SIS scores. In addition, the regulations should emphasize that the SIS assesses the client's needs in the absence of existing supports (page 2 of the VAA letter).	to attend the SIS meeting to be respondents and/or submit a letter of recommendations.
33.	D Reynolds, Fair Haven Residential Services	I agree with the posts addressing the need to change the way the SIS is used in Virginia, how the levels are assigned and the reliance on "a day" as the sole reimbursement unit in group home and sponsored placement settings. In our small agency, at least one Individual has been negatively impacted by each of these issues. I also agree with the changes that were recommended by John Malone and others from other CSBs.	See Line 2.
34.	Elliott/Hanover CSB	Support Intensity Scale - DBHDS shall use the SIS® Adult for individuals who are 16 to 72 years of age - Please list the assessment that will be used for individuals over the age of 72.	Edits made
35.	Beatty/VA Alliance	1) The DMAS-62 form that scores medical need and eligibility for hours of nursing care under the DD Waiver system does not include all possible medical needs. Some people w/complex needs aren't able to get nursing hrs their care team recommends, as the needs aren't reflected on the form. The regulations should clarify advice of the providing medical team should be taken into account in determining nursing hrs. 2) There is heavy reliance upon the Supports Intensity Scale (SIS) in determining service availability, with all indications that such reliance will increase in the future. Like all assessments, it is imperfect in seeing the full picture of someone's life. Because specialists (e.g., medical and behavioral providers) have invaluable insights into the support needs of individuals they serve, their written statements should be taken into account, along with SIS responses, to determine final SIS scores. SIS scores should be able to be appealed when the SIS fails to take into account critical care information not captured in the assessment.	1. DMAS 62 not in this section 2. See line 32.
36.	Jan Williams, ServiceSource	Supports Intensity Scale® requirements; Virginia Supplemental Questions; levels of support; supports packages.A.1 refers to individuals age 16-72 while A.2.a. refers to individuals aged 16 and older. We suggest the following language, "Individuals who are older than 72 years of age shall be assessed using either the SIS or an alternative instrument [alternative instrument or instruments to be named in the regulations]." A.2.a - Change "three" to "four" in order to be consistent with the CL application; A.4.- The specific scoring protocol should be in a Medicaid Memorandum AND the Medicaid Waiver manual, not in the regulations. D - Strike entre paragraph based on 2019 General Assembly action AND add a new paragraph D: "Requires that the results of the SIS be provided within 10 days of scoring in an understandable format and that the support coordinator be required to explain the results and implications of the SIS score." Add a new E.- "An automatic, independent review by the support coordinator of the SIS administration process and results when an individual's SIS Score changes despite a lack of change in their health or other circumstances, upon request."	See Line 5.

37.	Dennis Brown, Consultant	I am concerned that the use of the SIS® is proposed to be limited to individuals under age 72. The individuals that providers support generally experience significant increases in support needs as they age and stopping the use of the SIS at age 72 to assess these needs is completely counterintuitive. Relying on an outdated assessment for older individuals is unsafe to the individuals. Additionally it imposes an additional burden on providers who are forced to rely on reimbursement rates based on outdated and inaccurate SIS scores. I therefore support that "**Individuals who are older than 72 years of age shall be assessed using either the SIS or an alternative instrument** (with this alternative instrument or instruments to be named in the regulations)."	Edits made
38.	Dominion Waiver/Koke	• A.1- Delete "to 72" and add "or older" after "years of age." If the SIS is only validated to age 72 then language should be added to automatically assign all individuals age 72 or older to Level 5, Tier 4. Level 5 is the highest level denoting significant need in general but not specifying it to medical or behavioral. Tier 4 is mid-range denoting significant need, which is appropriate for an aging population. However, there should be a statement that these individuals shall not be excluded from consideration of an individualize rate because of medical or behavioral needs. • Recommend the addition of "Individuals who are older than 72 years of age shall be assessed using either the SIS or an alternative instrument (alternative instrument or instruments to be named in the regulations)." • A.2.a - Change "three" to "four" to stay consistent with the CL application • A.4.- DELETE. The specific scoring protocol should be in a Medicaid Memo, not in the regulations. • D – DELETE entre section/paragraph. This is a reserved section intended to explain the establishment of supports packages as a profile of the mix and extent of services anticipated to be needed by individuals with similar levels, needs and abilities. Due to 2019 General Assembly budget language which prohibits the implementation of supports packages unless specifically authorized by the General Assembly, this section is not necessary. • Add a new D – "Requires that the results of the SIS be provided within 10 days of scoring in an understandable format and that the service coordinated be required to explain the results and implications of the SIS score and avenues of appeal." • Add a new E.- "An automatic, independent review of the SIS administration process and results when an individual's SIS Score changes despite a lack of change in their health or other circumstances, upon request."	See Line 5.
39.	Renon/Wall Res.	See Line 21.	See Line 5.
40.	Fairfax/Falls Ch CSB	12-VAC30-122-200 A1 -2b – clarification needed regarding SIS requirement for individuals over 72 years old and frequency of SIS for individuals between 5-15 years old.	Edits made.

41.	Johnston/Vector Industries	2VAC30-122-200. Supports Intensity Scale® requirements; Virginia Supplemental Questions; levels of support; supports packages. • A.1- Delete “to 72” and add “or older” after “years of age.” If the SIS is only validated to age 72 then language should be added to automatically assign all individuals age 72 or older to Level 5, Tier 4. Level 5 is the highest level denoting significant need in general but not specifying it to medical or behavioral. Tier 4 is mid-range denoting significant need, which is appropriate for an aging population. However, there should be a statement that these individuals shall not be excluded from consideration of an individualize rate because of medical or behavioral needs. • Recommend the addition of “Individuals who are older than 72 years of age shall be assessed using either the SIS or an alternative instrument (alternative instrument or instruments to be named in the regulations).” • A.2.a - Change “three” to “four” to stay consistent with the CL application • A.4.- DELETE. The specific scoring protocol should be in a Medicaid Memo, not in the regulations. • D – DELETE entre section/paragraph. This is a reserved section intended to explain the establishment of supports packages as a profile of the mix and extent of services anticipated to be needed by individuals with similar levels, needs and abilities. Due to 2019 General Assembly budget language which prohibits the implementation of supports packages unless specifically authorized by the General Assembly, this section is not necessary. • Add a new D – “Requires that the results of the SIS be provided within 10 days of scoring in an understandable format and that the service coordinated be required to explain the results and implications of the SIS score and avenues of appeal.” • Add a new E.- “An automatic, independent review of the SIS administration process and results when an individual’s SIS Score changes despite a lack of change in their health or other circumstances, upon request.”	See Line 5
42.	Susan Keenan, Community Living Alternatives	In general, Community Living Alternatives supports and endorses the comments of vaACCSES with emphasis placed on the following points: Such documentation shall be written on the date of service delivery. Strike or change to as soon as practicable but no longer than one week after the service. This is in keeping with the definition of Progress Note from this chapter. Support changing the 10-day requirement to a 15-day requirement for service providers to submit quarterly reports. C5. The orientation is a knowledge-based assessment, while the competencies are both knowledge and action based. On many of the competencies, you are required to assess action and knowledge. Where I have found the deficiencies to be is in the action part of the competencies. Therefore, retaking the orientation test is not a valid way of training for action. Having statewide readily available online training tools for the competencies from department would be helpful. A.1- Delete “to 72” and add “or older” after “years of age.” If the	C5. See 12VAC30-122-180, Line 22. A1 and new E. See Line 5.

		SIS is only validated to age 72 then language should be added to automatically assign all individuals age 72 or older to Level 5, Tier 4. Level 5 is the highest level denoting significant need in general but not specifying it to medical or behavioral. Tier 4 is mid-range denoting significant need, which is appropriate for an aging population. However, there should be a statement that these individuals shall not be excluded from consideration of an individualize rate because of medical or behavioral needs. Add a new E.- "An automatic, independent review of the SIS administration process and results when an individual's SIS Score changes despite a lack of change in their health or other circumstances, upon request."	
43.	Citizen	The SIS® is an assessment tool that identifies the practical supports required by individuals to live successfully in their communities. DBHDS shall use the SIS® Child for individuals who are five years through 15 years of age. DBHDS shall use the SIS® Adult for individuals who are 16 to 72 years of age. Individuals who are younger than five years of age shall be assessed using either the SIS® or an age-appropriate alternative instrument, such as the Early Learning Assessment Profile, as approved by DBHDS. The SIS shall be given to adults who live longer than age of 72, or another assessment should be named in the regulation for appropriate measuring of the person's medical or behavioral change or need. As it stands the SIS assessment tool is given to measure Tier support levels needed in the DBHDS community but has limitations if the person is over the age of 72.	Edits made
44.	Maureen Hollowell, VA Assoc of Centers for Independent Living	1) A.1. Modify the first sentence to reflect that the SIS does not identify services required by the individual. In practical application, the SIS assessors are not always familiar with the DD Waivers services, available providers and other factors that impact service availability or service choices made by the individual; 2) D. Clarify that the supports packages are not established ranges of service types, services hours or other restrictions that impact how an individual chooses to live.	1. It is commonly understood the SIS assessors are not always equipped to know what resources are available in each commuity. However, this is a function the SC provides throughout the process. 2. Additional clarification will be included.
45.	Virginia Board for People with Disabilities	Subdivision A 2: The Board recommends revising the regulation to reflect a four-year time frame for re-administration of the SIS for individuals 16 years or older, rather than three years. The Renewal Application for the Community Living Waiver changes SIS administration for this population to every four years or sooner if needed. The Board supports this change.	See Line 2.
46.	Virginia Board for People with Disabilities	Subdivision A 4: The Board recommends removing the scoring protocol. This should be included in a Medicaid Memo or the Manual, not in regulations, in the event the scoring rubric changes.	See Line 2.

47.	Virginia Board for People with Disabilities	Subsection D: The Board recommends striking this subsection, which is a reserved section intended to explain the establishment of supports packages as a profile of the mix and extent of services anticipated to be needed by individuals with similar levels, needs, and abilities. In light of 2019 General Assembly budget language which prohibits the implementation of supports package unless specifically authorized by the General Assembly, this section is not necessary.	See Line 2.
48.	Virginia Board for People with Disabilities	Subsection D: The Board recommends replacing the current reserved subsection D and adding a new subsection D which requires (i) that the results of the SIS be provided within 10 days of scoring to the individual and family in an understandable format and (ii) that the service coordinator be required to explain the results and implications of the SIS score and avenues of appeal. Currently families do not receive their SIS score, receive it on a delayed basis, and/or do not understand the implications of the scores since they are not explained.	See Line 2.
49.	Virginia Board for People with Disabilities	Subsection E: The Board recommends adding a new subsection requiring an independent review, upon request of the individual or family, of the SIS administration process and results when an individual's SIS Score changes but their health or other life circumstances have not. Many families have indicated that their loved ones' SIS scores has changed, in most cases to a lower score, without a change in circumstances. Since the SIS Score is not appealable, only the process, a re-administration upon request would best serve individuals and families.	There are no funds available for independent reviewers. Also, SIS scores can change over time even if their health or life circumstances do not: the SIS is about support needs, which may increase or decrease. Lastly, there is a process to request a "reassessment review" if, after a period of time (6 months), the person's needs change significantly.

Comments related to 12VAC30-122-210

2.	DDWAC	A.4.e.- Change "individuals" to "each individual's needs"	Edits made.
3.	Loudoun CSB L. Snider	Inconsistent with 12VAC122-360 For Electronic Home based services, 12VAC30-122-210 C.3 indicates is the $5000 limit per calendar year while 12VAC30-122-360 C. 1. indicates limit is $5000 per ISP plan year?	Edits made.
4.	Dville/Pittvania CSB/S. Craddock	Inconsistent with 12VAC122-360 For Electronic Home based services, 12VAC30-122-210 C.3 indicates is the $5000 limit per calendar year while 12VAC30-122-360 C. 1. indicates limit is $5000 per ISP plan year?	Edits made.
5.	Citizen	12VAC30-122-210 - A.4.e - change "individuals" to "each individual's needs" - the original language is not person centered	Edits made.

6.	Harrison-Rock'ham CSB/ Slaughbaugh	Inconsistent with 12VAC122-360 For Electronic Home based services, 12VAC30-122-210 C.3 indicates is the $5000 limit per **calendar year** while 12VAC30-122-360 C. 1. indicates limit is $5000 per **ISP plan year**?	Edits made.
7.	Blue Ridge Beh Healthcare A. Monti	Inconsistent with 12VAC122-360 For Electronic Home based services, 12VAC30-122-210 C.3 indicates is the $5000 limit per calendar year while 12VAC30-122-360 C. 1. indicates limit is $5000 per ISP plan year?	Edits made.
8.	RBHA/M Harrison	Inconsistent with 12VAC122-360 For Electronic Home based services, 12VAC30-122-210 C.3 indicates is the $5000 limit per calendar year while 12VAC30-122-360 C. 1. indicates limit is $5000 per ISP plan year?	Edits made.
9.	Citizen	Semi-Annual Supervisory Notes for DSPs including "individual's satisfaction with service provision" Req. should be eliminated or changed per comments below: Community Coaching (122-310.E.2), Community Engagement (122-320.E.2), Group Day (122-380.D.5.), Group Residential (122-390.D.5), Crisis Support Services (122-350.E.2) and Center-Based Crisis Support Services (122-300.E.2) all have additional burdensome requirements under Service Documentation or Provider requirements that state that there must be written supervision notes for each DSP, signed by the supervisor and included semi-annual documentation of individual's satisfaction by the supervisor. (Center-based Crisis Supports does not include the semi-annual requirement.) Semi-Annual supervisory documentation of an individual's "Satisfaction with service provision" or "observation of satisfaction" is also required. - This is duplicative of the initial and annual thereafter required documentation of proficiency of staff competencies included under 122-180. Not to mention, much more stringent. Why some services and not others? Consistency between the services does not exist. Group Day requires documentation of "observation of satisfaction". The requirement of semi-annual notes in the DSP supervision note regarding "satisfaction of the individual" or "observation of satisfaction of the individual" is not consistent with the already required individualized documentation. If anyone should be documenting an "individual's satisfaction with service provision" or "observation of satisfaction" – it should be the support coordinator/case manager during their regular visits. Someone other than the provider should be evaluating whether an individual is satisfied with the service they are receiving from the provider. It's like the proverbial "rooster guarding the hen house". The support coordinator/case manager is the more appropriate person and, if required, it should be required for all waiver services and not just some services. The requirement of proscribed supervisory notes on a regular semi-annual basis is another added administrative burden layered on top of the annual DSP staff competency requirement which was added after the waiver rates were set. Both cumbersome doc requirements are not included in any rate.	This comment is not related to this section.

10.	Citizen	1. A.4.e. – Modify the language to "The DMAS designee shall review **each** individual's **needs** on at least….." An individual's needs are being reviewed not an individual themselves. 2. C.1. Recommend an increase to the $5,000 annual limit on assistive technology deemed appropriate to the cost and utility of today's technology. The current limit is years old and has not kept up with changes in technology and/or the emphasis on expanding the use of technology to replace more cost intensive staffing services. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years, etc. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new assistive technology without raising the overall multi-year dollar limits. The limit is also included in 12VAC30-122-270 Assistive technology service. 3. C 1: Recommend an increase to the $5,000 annual limit for environmental modifications from the current maximum annual cap of $5,000 to a level deemed appropriate to the cost of such modifications. This limit is years old and it is increasingly difficult for families and individuals to secure modifications that will allow them to remain in their homes over their lifespan for this small amount of funding. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new environmental modifications without raising the overall multi-year dollar limits.	1. Edits made. 2. Rate changes must be approved by the General Assembly. 3. Edits made.
11.	VA Board for People with Disabilities	Subdivision A 4e: The Board recommends modifying the wording to state, "The DMAS designee shall review each individual's needs on at least…." Individuals themselves are not being reviewed, but rather their needs.	Edits made.

12.	Karen Tefelski - vaACCSES	A.4.e. – Modify the language to "The DMAS designee shall review each individual's needs on at least….." An individual's needs are being reviewed not an individual themselves. C.1. Recommend an increase to the $5,000 annual limit on assistive technology deemed appropriate to the cost and utility of today's technology. The current limit is years old and has not kept up with changes in technology and/or the emphasis on expanding the use of technology to replace more cost intensive staffing services. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years, etc. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new assistive technology without raising the overall multi-year dollar limits. The limit is also included in 12VAC30-122-270 Assistive technology service. C 1: Recommend an increase to the $5,000 annual limit for environmental modifications from the current maximum annual cap of $5,000 to a level deemed appropriate to the cost of such modifications. This limit is years old and it is increasingly difficult for families and individuals to secure modifications that will allow them to remain in their homes over their lifespan for this small amount of funding. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new environmental modifications without raising the overall multi-year dollar limits. C 3. Recommend an increase to the cost of electronic home-based supports from the current maximum of $5,000 per calendar year. This limit is not sufficient for up-to-date technology as well as any associated monthly monitoring fees. The purpose of these supports is to enable individuals who so desire to live more independently with less staff intrusion into their lives. The benefit should be consistent with the average cost of this type of support. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new electronic home-based supports technology without raising the overall multi-year dollar limits. 4.b. The current application for customized Waiver rates requests data for the previous six months. If the provider has already served the individual for six months with a 1:1 ratio that is effectively supporting the individual to reduce behaviors, the provider should be allowed to submit data from the service period before 1:1 staffing began.	See Line 17.
13.	K. Black-Hope House	A.4.b.- Strike 'with higher qualifications (e.g. direct support professionals with four-year degree) and replace with 'that have received the training consistent with section 180'	This section does not relate to competencies.
14.	H Denman/Arc of Harrisonburg	<u>Community Engagement (CE) Rate Refresh:</u> Comparing apples to apples (individuals served at the time of waiver redesign), the rate increases for Community Engagement over the old waiver rates equaled 13% while staffing requirements for CE increased by 57%. In 2018 we provided additional transportation for CE in excess of 65,000 miles. At the 2018 gov rate of 54.5 cents/mile = $354,250.00. This does not reflect capital outlay for vehicles.	Rate changes must be approved by the General Assembly.

		Further, CE activity and admission fees for DSPs come out of the agencies budget. Rates are woefully inadequate and have caused the agency to diminish its reserve fund thereby threatening its sustainability. Community engagement is a superior service and a more robust rate would allow for it to be adopted more widely across the commonwealth.	
15.	B Huffman - VersAbility Resources	A.4.e. – Modify the language to "The DMAS designee shall review each individual's needs on at least….." An individual's needs are being reviewed not an individual themselves. C.1. Recommend an increase to the $5,000 annual limit on assistive technology deemed appropriate to the cost and utility of today's technology. The current limit is years old and has not kept up with changes in technology and/or the emphasis on expanding the use of technology to replace more cost intensive staffing services. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years, etc. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new assistive technology without raising the overall multi-year dollar limits. The limit is also included in 12VAC30-122-270 Assistive technology service. C 1: Recommend an increase to the $5,000 annual limit for environmental modifications from the current maximum annual cap of $5,000 to a level deemed appropriate to the cost of such modifications. This limit is years old and it is increasingly difficult for families and individuals to secure modifications that will allow them to remain in their homes over their lifespan for this small amount of funding. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new environmental modifications without raising the overall multi-year dollar limits. C 3. Recommend an increase to the cost of electronic home-based supports from the current maximum of $5,000 per calendar year. This limit is not sufficient for up-to-date technology as well as any associated monthly monitoring fees. The purpose of these supports is to enable individuals who so desire to live more independently with less staff intrusion into their lives. The benefit should be consistent with the average cost of this type of support. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new electronic home-based supports technology without raising the overall multi-year dollar limits. 4.b. The current application for customized Waiver rates requests data for the previous six months. If the provider has already served the individual for six months with a 1:1 ratio that is effectively supporting the individual to reduce behaviors, the provider should be allowed to submit data from the service period before 1:1 staffing began.	See Line 12.

16.	Jan Williams, ServiceSource	C.1. Recommend an increase to the $5,000 annual limit on assistive technology deemed appropriate to the cost and utility of today's technology. The current limit is years old and has not kept up with changes in technology and/or the emphasis on expanding the use of technology to replace more cost intensive staffing services. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years, etc. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new assistive technology without raising the overall multi-year dollar limits. The limit is also included in 12VAC30-122-270 Assistive technology service. ?	Rate changes must be approved by the General Assembly.
17.	Citizen	Payment for covered services (tiers). • A.4.e. – Modify the language to "The DMAS designee shall review each individual's needs on at least….." An individual's needs are being reviewed not an individual themselves. • C.1. Recommend an increase to the $5,000 annual limit on assistive technology deemed appropriate to the cost and utility of today's technology. The current limit is years old and has not kept up with changes in technology and/or the emphasis on expanding the use of technology to replace more cost intensive staffing services. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years, etc. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new assistive technology without raising the overall multi-year dollar limits. The limit is also included in 12VAC30-122-270 Assistive technology service. • C 1: Recommend an increase to the $5,000 annual limit for environmental modifications from the current maximum annual cap of $5,000 to a level deemed appropriate to the cost of such modifications. This limit is years old and it is increasingly difficult for families and individuals to secure modifications that will allow them to remain in their homes over their lifespan for this small amount of funding. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new environmental modifications without raising the overall multi-year dollar limits. • C 3. Recommend an increase to the cost of electronic home-based supports from the current maximum of $5,000 per calendar year. This limit is not sufficient for up-to-date technology as well as any associated monthly monitoring fees. The purpose of these supports is to enable individuals who so desire to live more independently with less staff intrusion into their lives. The benefit should be consistent with the average cost of this type of support. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new electronic home-based supports technology without raising the overall multi-year dollar limits. • 4.b. The current application for customized Waiver rates requests data for the previous six months. If the provider has already served the individual for six months with a 1:1 ratio that is effectively supporting the individual to reduce behaviors, the provider should	Edits made. 4.B. It is essential to assess the current functioning in order to determine if additional supports are needed and if current services are sufficient.

		be allowed to submit data from the service period before 1:1 staffing began.	
18.	Dominion Waiver/Koke	• A.4.e. – Modify the language to "The DMAS designee shall review each individual's needs on at least….." An individual's needs are being reviewed not an individual themselves. • C.1. Recommend an increase to the $5,000 annual limit on assistive technology deemed appropriate to the cost and utility of today's technology. The current limit is years old and has not kept up with changes in technology and/or the emphasis on expanding the use of technology to replace more cost intensive staffing services. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years, etc. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new assistive technology without raising the overall multi-year dollar limits. The limit is also included in 12VAC30-122-270 Assistive technology service. • C 1: Recommend an increase to the $5,000 annual limit for environmental modifications from the current maximum annual cap of $5,000 to a level deemed appropriate to the cost of such modifications. This limit is years old and it is increasingly difficult for families and individuals to secure modifications that will allow them to remain in their homes over their lifespan for this small amount of funding. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new environmental modifications without raising the overall multi-year dollar limits.	Edits made
19.	Dominion Waiver/Koke	• C 3. Recommend an increase to the cost of electronic home-based supports from the current maximum of $5,000 per calendar year. This limit is not sufficient for up-to-date technology as well as any associated monthly monitoring fees. The purpose of these supports is to enable individuals who so desire to live more independently with less staff intrusion into their lives. The benefit should be consistent with the average cost of this type of support. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new electronic home-based supports technology without raising the overall multi-year dollar limits. • 4.b. The current application for customized Waiver rates requests data for the previous six months. If the provider has already served the individual for six months with a 1:1 ratio that is effectively supporting the individual to reduce behaviors, the provider should be allowed to submit data from the service period before 1:1 staffing began.	Edits made
20.	Wormley, Kerns, Collier, Lester, Hauley - VersAbility Rsc	Same as Line 15.	See Line 12.
21.	Johnston/Vector Industries	Same as Line 15.	See Line 12.

22.	Virginia Board for People with Disabilities	Subdivision C 1: The Board recommends a review of the $5,000 annual limit on assistive technology and, based on the results of the review, consider increasing the annual maximum to a level deemed appropriate to the cost and utility of today's technology. The current limit is years old and has not kept up with changes in technology and/or the emphasis on expanding the use of technology to replace more cost intensive staffing services. If raising the overall limit is not feasible at this time, then the Board recommends adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new assistive technology without raising the overall multi-year dollar limits. The limit is also included in 12VAC30-122-270 Assistive technology service.	Rate changes must be approved by the General Assembly.
23.	Virginia Board for People with Disabilities	Subdivision C 1: The Board recommends a review of the $5,000 annual limit increasing the annual limit for environmental modifications from the current maximum annual cap of $5,000 to a level deemed appropriate to the cost of such modifications. This limit is years old and it is increasingly difficult for families and individuals to secure modifications that will allow them to remain in their homes over their lifespan for this small amount of funding. If raising the overall limit is not feasible at this time, then the Board recommends adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new environmental modifications without raising the overall multi-year dollar limits.	Rate changes must be approved by the General Assembly.
24.	Virginia Board for People with Disabilities	Subdivision C 3: The Board recommends a review of the cost of electronic home-based supports to determine whether the individual maximum of $5,000 per calendar year is sufficient for up-to-date technology as well as any associated monthly monitoring fees. The purpose of these supports is to enable individuals who so desire to live more independently with less staff intrusion into their lives. The benefit should be consistent with the average cost of this type of support. If raising the overall limit is not feasible at this time, then the Board recommends adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new electronic home-based supports technology without raising the overall multi-year dollar limits.	Rate changes must be approved by the General Assembly.

Comments related to 12VAC30-122-240

2.	Lucy Beadnell, Virginia Ability Alliance	The BI Waiver does not allow for Personal Care Attendants or crisis support services. Additionally, many "Tier 1" individuals receive the BI Waiver and are then only eligible for up to 10 weekly hours of Independent Living Services. Limits can prevent individuals who would otherwise thrive withWaiver from accepting it. **The use of limited Personal Care hours and crisis support services would make this Waiver a realistic option and increase independent living.**	The waivers support different individual needs. This waiver was designed for individuals who need minimal services. The BI waiver waiver does include all 3 crisis services. It does not include personal care, but individuals can receive up to 21 hours of

			independent living supports.
3.	DDWAC	Add Agency and CD Companion and Personal Assistance, and Individual & Caregiver Training	The waivers support different individual needs. This waiver was designed for individuals who need minimal services. The BI waiver waiver does include all 3 crisis services. It does not include personal care, but individuals can receive up to 21 hours of independent living supports.
4.	Citizen	Add Agency and CD Companion and Personal Assistance, and Individual & Caregiver Training to the BIS waiver. With the addition of these services, there may be more interest in utilizing this lower cost waiver by persons on the Priority 1 waiting list.	The waivers support different individual needs. This waiver was designed for individuals who need minimal services. The BI waiver waiver does include all 3 crisis services. It does not include personal care, but individuals can receive up to 21 hours of independent living supports.
5.	VA Board for People with Disabilities	**Subsection B: The Board recommends adding personal assistance services (agency and consumer-directed), companion services (agency and consumer-directed), individual and family caregiving, and workplace assistance to the BI waiver.** These are all services that can benefit individuals on the BI waiver without significant additional cost. The BI waiver is meant for individuals with less significant needs; this means that there is likely a larger proportion of individuals with physical developmental disabilities on this waiver. Personal Assistance services is a key service to maintaining independence. Companion services can assist these individuals with skill building in the community and workplace assistance can help people on this waiver maintain employment, facilitating even greater independence. Individual and family caregiver training should be in all waivers. With the addition of these services, there may be more interest in utilizing this lower cost waiver by persons on the Priority 1 waiting list, helping to resolve the issue of the Commonwealth awarding BI slots to persons on the Priority 2 and 3 waiting lists.	The waivers support different individual needs. This waiver was designed for individuals who need minimal services. The BI waiver waiver does include all 3 crisis services. It does not include personal care, but individuals can receive up to 21 hours of independent living supports.

6.	Karen Tefelski - vaACCSES	Add Agency and CD Companion and Personal Assistance, and Individual & Caregiver Training to the BIS waiver. With the addition of these services, there may be more interest in utilizing this lower cost waiver by persons on the Priority 1 waiting list.	See Line 4.
7.	K. Black-Hope House	B.19.-Include therapeutic consultation services as a covered service. B.19.-Include in-home support services as a covered service	The waivers support different individual needs. This waiver was designed for individuals who need minimal services. The BI waiver waiver does include all 3 crisis services. It does not include personal care, but individuals can receive up to 21 hours of independent living supports. Individuals in this waiver would not normally have a need for consultation services and in-home support services.
8.	B Huffman - VersAbility Resources	Add Agency and CD Companion and Personal Assistance, and Individual & Caregiver Training to the BIS waiver. With the addition of these services, there may be more interest in utilizing this lower cost waiver by persons on the Priority 1 waiting list.	See Line 4.
9.	Elliott/Hanover CSB	Please consider adding Personal Care and Companion Service to the BI Waiver. This is a much needed service that many individuals on the BI waiver could use and may provide the necessary supports someone who only needs personal care services in his/her own home could use along with the other services under this waiver to access the community.	See Line 5.
10.	Citizen	Add Agency and CD Companion and Personal Assistance, and Individual & Caregiver Training to the BI waiver. With the addition of these services, there may be more interest in utilizing this lower cost waiver by persons on the Priority 1 waiting list.	The waivers support different individual needs. This waiver was designed for individuals who need minimal services. The BI waiver waiver does include all 3 crisis services. It does not include personal care, but individuals can receive up to 21 hours of independent living supports.

11.	Citizen	(proposed 12VAC30-122-240). the Independent living support service described in proposed 12VAC30-122-420 is available to adults 18 years of age and older to provide the skill building and supports "necessary to secure and reside in an independent living situation." Nowhere in the regulations, however, is the phrase "independent living" as used in these sections defined.	Definition of independent living added to 12VAC30-122-20.
12.	Citizen	Services covered in the Building Independence Waiver. • Add Agency and CD Companion and Personal Assistance, and Individual & Caregiver Training to the BIS waiver. With the addition of these services, there may be more interest in utilizing this lower cost waiver by persons on the Priority 1 waiting list.	The waivers support different individual needs. This waiver was designed for individuals who need minimal services. The BI waiver waiver does include all 3 crisis services. It does not include personal care, but individuals can receive up to 21 hours of independent living supports.
13.	H Hines/Reg. 10 CSB	Regulations regarding WSAC are not clear - states regional for BI only (not for other Waivers). BI has a separate process. CL and FIS determined by WSAC. Is this a change in the way this will be done or just worded incorrectly?	There is a system for the regional distribution of BI slots. See Section 12 VAC 30-122-90.
14.	Dominion Waiver/Koke	• Add Agency and CD Companion and Personal Assistance, and Individual & Caregiver Training to the BIS waiver. With the addition of these services, there may be more interest in utilizing this lower cost waiver by persons on the Priority 1 waiting list.	The waivers support different individual needs. This waiver was designed for individuals who need minimal services. The BI waiver waiver does include all 3 crisis services. It does not include personal care, but individuals can receive up to 21 hours of independent living supports.
15.	Frontier Health K Honeycutt	Independent Living – Add a definition. The term is used throughout the proposed regulations with no definition. Proposed 12VAC30-122-90 defines the eligibility criteria for the Priority One waiting list to include young adults who are no longer eligible for IDEA services and who are transitioning to "independent living." The regulations describe the individuals whom the Building Independence Waiver is designed to support as "individuals who reside in an integrated, independent living arrangement...." (proposed 12VAC30-122-240). Additionally, the Independent living support service described in proposed 12VAC30-122-420 is available to adults 18 years of age and older to provide the skill building and supports "necessary to secure and reside in an	Definition of independent living added to 12VAC30-122-20.

		independent living situation." Nowhere in the regulations, however, is the phrase "independent living" as used in these sections defined.	
16.	Wormley, Kerns, Collier, Lester, Hauley -VersAbility Rsc	Add Agency and CD Companion and Personal Assistance, and Individual & Caregiver Training to the BIS waiver. With the addition of these services, there may be more interest in utilizing this lower cost waiver by persons on the Priority 1 waiting list.	See Line 4.

Comments related to 12VAC30-122-250

2.	DDWAC	Add Family and Caregiver Training	DMAS will consider this suggestion. Adding this component would require funding from the General Assembly plus federal approval.
3.	Family Sharing/Farrell	Add Family and Caregiver Training	See Line 2.
4.	Citizen	Add Family and Caregiver Training	See Line 2.
5.	The Arc of VA T. Milling	**Community Living (CL) Waiver Descriptions - Introduction** In the introduction to the new waivers, the language on the CL waiver should be more inclusive of all living situation types. While nothing in the wording prohibits someone living in their own home using the CL waiver, we believe the term "24/7 residential support" could be mistaken to only mean group home settings. There are many people using the CL waiver now, living in their own home and receiving 24/7 support services. The Arc of Virginia suggests clarifying in the description of CL Waiver, that any setting may be included. Recommend "This amended waiver will remain a comprehensive waiver that includes the option of 24/7 support services in a person's residence".	Edits made.
6.	Citizen	Add Family and Caregiver Training. This service is applicable to all individuals and families and should not be limited to the FIS waiver.	See Line 2.
7.	VA Board for People with Disabilities	**Subsection B: The Board recommends adding individual and family caregiver training to this waiver.** There is no reason why this service should only be in the FIS waiver as it is applicable to all individuals and their families.	See Line 2.
8.	Karen Tefelski - vaACCSES	Add Family and Caregiver Training. This service is applicable to all individuals and families and should not be limited to the FIS waiver.	See Line 2.
9.	B Huffman - VersAbility Resources	Same as Line 8.	See Line 2.
10.	Citizen	Add Family and Caregiver Training. This service is applicable to all individuals and families and should not be limited to the FIS waiver	See Line 2.

11.	Citizen	Services covered in the Community Living Waiver. • Add Family and Caregiver Training. This service is applicable to all individuals and families and should not be limited to the FIS waiver.	See Line 2.
12.	Dominion Waiver/Koke	• Add Family and Caregiver Training. This service is applicable to all individuals and families and should not be limited to the FIS waiver.	See Line 2.
13.	Wormley, Kerns, Collier, Lester, Hauley -VersAbility Rsc	Add Family and Caregiver Training. This service is applicable to all individuals and families and should not be limited to the FIS waiver.	See Line 2.

Comments related to 12VAC30-122-260

2.	DDWAC	Add Independent Living	There are a variety of residential service options in the FIS Waiver that can be used such as supportive living, personal assistance, and in-home.
3.	Family Sharing/Farrell	Add Independent Living	See Line 2.
4.	Citizen	Add Independent Living	See Line 2.
5.	Citizen	Add Independent Living Services to the FIS waiver. This service can assist individuals living on their own or wishing to live on their own.	See Line 2.
6.	VA Board for People with Disabilities	**Subsection B: The Board recommends adding the Independent Living Services to the FIS waiver.** This service can assist those living on their own or wishing to live on their own to be more independent.	See Line 2.
7.	Karen Tefelski - vaACCSES	Add Independent Living Services to the FIS waiver. This service can assist individuals living on their own or wishing to live on their own.	See Line 2.
8.	K. Black-Hope House	Add Independent Living	See Line 2.
9.	B Huffman - VersAbility Resources	Same as Line 7.	See Line 2.

10.	Citizen	Many individuals on the FIS waiver, living independently of their families, are often dependent on "natural supports" (often their parents) to handle tasks such as: 1) budgeting, shopping, & bill paying; 2) hiring, scheduling, and supervising staff; 3) completing annual Medicaid paperwork; 4) completing SSA monthly income reporting (for those who work); 5) developing weekly schedules; 6) arranging transportation; 7) making doctors' appointments. When parents age or die and no other natural supports are available to handle such tasks, what will happen? Will the only option be for these individuals to be transferred to the CL waiver so that they can receive such supports from a Group Home or SR provider? Or would a more economical option be to create a category of service to address this need so that a person on the FIS waiver could remain in his current living situation?	An individual could receive a variety of services in this waiver that would support them appropriately without going to the CL Waiver. If there are needs that would only be met in a congregate setting, then recommendations and referrals could be made for that placement.
11.	Citizen	Add Independent Living Services to the FIS waiver. This service can assist individuals living on their own or wishing to live on their own	See Line 2.
12.	Citizen	Services covered: Family and Individual Support Waiver. • Add Independent Living Services to the FIS waiver. This service can assist individuals living on their own or wishing to live on their own.	See Line 2.
13.	Dominion Waiver/Koke	• Add Independent Living Services to the FIS waiver. This service can assist individuals living on their own or wishing to live on their own.	See Line 2.
14.	Wormley, Kerns, Collier, Lester, Hauley -VersAbility Rsc	Add Independent Living Services to the FIS waiver. This service can assist individuals living on their own or wishing to live on their own.	See Line 2.

Comments related to 12VAC30-122-270

2.	Lucy Beadnell, Virginia Ability Alliance	Under the regulations, Assistive Technology vendors cannot add a markup to purchases. The result is that it became incredibly difficult to find AT vendors, let alone a choice of vendors. Allowing the 30% mark-up to be reinstated would help in service availability.	The current process allows vendors to charge and bill for usual and customary charges associated with the product. The provider's charge for Assistive Technology may include a charge for the product, and other charges associated with procuring the product. Additional guidance will be provided in the Manual.

3.	Lucy Beadnell, Virginia Ability Alliance	Page 25 of the proposed regulations uses the term "Elder or Disabled with Consumer Direction Waiver" and "Technology Assisted Waiver" instead of using the terminology for the new Commonwealth Coordinated Care Plus Waiver.	The CCC+ regulations are not yet final (emergency regulations are in place). The text will be revised once the CCC+ regualtions are final.
4.	DDWAC	1. A.(ii)- Strike "with the environment in which they live" 2. A.- Add a new (iii) "actively participate in other waiver services which are part of their plan."	Edits made.
5.	Dville/Pittvania CSB/S. Craddock	Clarification needed if the "start date of the authorization" means date authorized?	Edits made.
6.	Harrison-Rock'ham CSB/ Slaughbaugh	Service Requirements states done in least expensive, cost effective manner. Who determines least expensive cost effective manner?	CMS and the states make this determination.
7.	Harrison-Rock'ham CSB/ Slaughbaugh	Clarification needed if the "start date of the authorization" means date authorized?	Edits made.
8.	Henrico Area MHDS	C.2. Clarify that Assistive Technology can be used in the recreational, leisure and educational environments but for the purposes outlined in the service description. 1. Assistive technology service (12VAC30-122-270); 2. Benefits planning service (12VAC30-122-280 - reserved); and 6. Community guide service (12VAC30-122-320 - reserved); And 18. Nonmedical transportation service (12VAC30-122-440 - reserved) 19. Peer support service (12VAC30-122-450 - reserved); **Should include information from the newly approved regulations and these should match the September 4th Medicaid memo.** 5. Community coaching service (12VAC30-122-310); 7. Community engagement service (12VAC30-122-330); 12. Group day service (12VAC30-122-380); 13. Group home residential service (12VAC30-122-390); Supervision: In each of the above services, there is a section (E. 2. E or D.5.e.) All have component under Service documentation or Provider requirements that state there must be written supervision notes for each DSP, signed by supervisor and includes Semiannual documentation by supervisor re the individual's satisfaction with service provision. Actual language may vary but the underlined sections are the same. In Group Day it says "observation of satisfaction". This requirement of semiannual notes in the DSP supervision note regarding satisfaction of the individual is not consistent with individualized documentation. In addition the requirement of proscribed supervisory notes on a regular basis is an added administrative burden which is not included in any rate. **The regulation should be changed to require on-going and regular supervision but not be as prescriptive as to the parameters listed in each of these sections.** **It is further suggested that this section on supervision be**	C.2 This is allowed within the current language/ yes, new services are included in the final regulations/ AT does not included a supervision component

		moved under chapter 120 to ensure consistency across services	
9.	Blue Ridge Beh Healthcare A. Monti	Service Requirements states done in least expensive, cost effective manner. Who determines least expensive cost effective manner?	See Line 6.
10.	Blue Ridge Beh Healthcare A. Monti	Clarification needed if the "start date of the authorization" means date authorized?	Edits made.
11.	RBHA/M Harrison	Service Requirements states done in least expensive, cost effective manner. Who determines least expensive cost effective manner?	See Line 6.
12.	RBHA/M Harrison	Clarification needed if the "start date of the authorization" means date authorized?	Edits made.
13.	The Arc of VA T. Milling	Assistive Technology - 12VAC30-122-270; This service can be invaluable in helping a person gain independence and access to opportunities to be included. The use of AT is an investment that has potential for a high return on investment for the State. Some forms of AT can increase a person's independence and decrease their need for staffing, thereby saving an ongoing cost from a one-time investment. There are currently examples of this in Virginia, where AT has been purchased for around $20,000 that resulted in an ongoing savings that is much higher. Most of these technologies will cost more than the $5,000 limit. Writing the regulation with such a hard stop, stifles innovation and misses the opportunity for ongoing costs savings year after year when a person's need for staff is decreased. Additionally, the benefit to the person using services is tremendous when the insertion of people into their home and lives can be decreased. The Arc of Virginia recommends allowing the option to spend over $5,000 by submitting for approval a detailed Cost Benefit Analysis that outlines the anticipated savings following the initial investment. Additionally, it is important to allow for creative AT that is part of today's everyday advances in technology, not just disability-specific technology.	DMAS is not able to make this change at this time. Additional funding would need to be allocated by the General Assembly for an increase in the $5000 limit.
14.	Citizen	A.(ii)- STRIKE "with the environment in which they live" and ADD a new (iii) "actively participate in other waiver services that are part of their plan." Renumber the current item (iii) to item (iv). AT should be available to support any service in a person's ISP. It should not be limited to the environment in which the individual lives. It should be available to support an individual in any approved service and promote inclusion in all aspects of an individual's life.	See Line 4.

15.	VA Board for People with Disabilities	**Subdivision A: The Board recommends striking "with the environment in which they live" from item (ii), adding a new (iii) "actively participate in other waiver services which are part of their plan, and renumbering the current item (iii) to item (iv).** The new section would read as follows: "AT services shall entail the provision of specialized medical equipment and supplies including…that (i) enable individuals to increase their abilities to perform activities of daily living; (ii) enable individuals to perceive, control, or communicate with the environment in which they live; (iii) <u>actively participate in other waiver services that are part of their plan</u>; or (iv) are necessary for life support…" Waiver services and supports are designed to promote inclusion in all aspects of community life. They are not and should not be limited to the environment in which the individual lives. AT should be available to support any service in a person's ISP.	See Line 4.
16.	Karen Tefelski - vaACCSES	A.(ii)- STRIKE "with the environment in which they live" and ADD a new (iii) "actively participate in other waiver services that are part of their plan." Renumber the current item (iii) to item (iv). AT should be available to support any service in a person's ISP. It should not be limited to the environment in which the individual lives. It should be available to support an individual in any approved service and promote inclusion in all aspects of an individual's life.	See Line 4.
17.	Henrico Area MHDS	C.2. Clarify that Assistive Technology can be used in the recreational, leisure and educational environments but for the purposes outlined in the service description. 1. Assistive technology service (12VAC30-122-270); 2. Benefits planning service (12VAC30-122-280 - reserved); and 6. Community guide service (12VAC30-122-320 - reserved); And 18. Nonmedical transportation service (12VAC30-122-440 - reserved); 19. Peer support service (12VAC30-122-450 - reserved); Should include information from the newly approved regulations and these should match the September 4th Medicaid memo.	See Line 4.
18.	K. Black-Hope House	A.(ii)- Strike "with the environment in which they live" A. - Add a new (iii) "actively participate in other waiver services which are part of their ISP." B.1.- Increase the limit of AT service per calendar year and allow for carryover when the AT item exceeds the limit set per calendar year. B.1.- Strike "to specifically improve the individual's personal functioning' and replace with 'increase their ability to control their environment, support ISP outcomes as identified and live safely and independently in the least restrictive community setting.	See Line 4 and Line 13. Edits made.
19.	B Huffman - VersAbility Resources	A.(ii)- STRIKE "with the environment in which they live" and ADD a new (iii) "actively participate in other waiver services that are part of their plan." Renumber the current item (iii) to item (iv). AT should be available to support any service in a person's ISP. It should not be limited to the environment in which the individual lives. It should be available to support an individual in any approved service and promote inclusion in all aspects of an individual's life.	See Line 4.

20.	Jan Williams, ServiceSource	A. (ii)- STRIKE "with the environment in which they live" and ADD a new (iii) "actively participate in other waiver services that are part of their plan." Renumber the current item (iii) to item (iv). AT should be available to support any service in a person's ISP. It should not be limited to the environment in which the individual lives. It should be available to support an individual in any approved service and promote inclusion in all aspects of an individual's life. C.2. The language is restrictive in NOT allowing assistive technology to be used for recreation or leisure activities, "The AT service shall not be approved for purposes of convenience of the caregiver or restraint of the individual, recreation or leisure activities, or educational purposes." We recommend STRIKING the reference to "recreation or leisure activities" Assistive Technology can be invaluable in helping a person gain independence and access to community opportunities. The use of assistive technology is actually an investment that has potential for a high return on investment for the State. Some forms of assistive technology can increase a person's independence and decrease their need for staffing, thereby saving an ongoing cost from a one-time investment.	See Line 4. / Medicaid services are not to pay for recreation but AT can be used in those environments.
21.	Citizen	A.(ii)- STRIKE "with the environment in which they live" and ADD a new (iii) "actively participate in other waiver services that are part of their plan." Renumber the current item (iii) to item (iv). AT should be available to support any service in a person's ISP. It should not be limited to the environment in which the individual lives. It should be available to support an individual in any approved service and promote inclusion in all aspects of an individual's life.	See Line 4.
22.	Dominion Waiver/Koke	• A.(ii)- STRIKE "with the environment in which they live" and ADD a new (iii) "actively participate in other waiver services that are part of their plan." Renumber the current item (iii) to item (iv). AT should be available to support any service in a person's ISP. It should not be limited to the environment in which the individual lives. It should be available to support an individual in any approved service and promote inclusion in all aspects of an individual's life.	See Line 4.
23.	Wormley, Kerns, Collier, Lester, Hauley -VersAbility Rsc	A.(ii)- STRIKE "with the environment in which they live" and ADD a new (iii) "actively participate in other waiver services that are part of their plan." Renumber the current item (iii) to item (iv). AT should be available to support any service in a person's ISP. It should not be limited to the environment in which the individual lives. It should be available to support an individual in any approved service and promote inclusion in all aspects of an individual's life.	See Line 4.

Comments related to 12VAC30-122-280

2.	Citizen	This service is now available (Medicaid Memo Sept. 4, 2018). It should be included in the final DD Waiver regulations out for public comment.	Edits made.
3.	VA Board for People	This section is reserved; however, benefits planning is now an available service and the Board recommends addressing the service in the regulations.	Edits made.

	with Disabilities		
4.	Karen Tefelski - vaACCSES	This service is now available (Medicaid Memo Sept 4, 2018). It should be included in the final DD Waiver regulation out for public comment.	Edits made.
5.	B Huffman - VersAbility Resources	This service is now available (Medicaid Memo Sept. 4, 2018). It should be included in the final DD Waiver regulations out for public comment.	Edits made.
6.	Citizen	Benefits Planning Services (reserved). • This service is now available (Medicaid Memo Sept. 4, 2018). It should be included in the final DD Waiver regulations out for public comment.	Edits made.
7.	Dominion Waiver/Koke	• This service is now available (Medicaid Memo Sept. 4, 2018). It should be included in the final DD Waiver regulations out for public comment.	Edits made.
8.	Wormley, Kerns, Collier, Lester, Hauley - VersAbility Rsc	This service is now available (Medicaid Memo Sept. 4, 2018). It should be included in the final DD Waiver regulations out for public comment.	Edits made.

Comments related to 12VAC30-122-290

2.	Dville/Pittvania CSB/S. Craddock	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made
3.	Harrison-Rock'ham CSB/ Slaughbaugh	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made
4.	RBHA/M Harrison	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made

Comments related to 12VAC30-122-300

2.	DDWAC	A- After means add "planned crisis prevention and emergency crisis stabilization services provided to"; strike "a service" [This brings it in line with Center-based Crisis	Edits made.
3.	Citizen	After means add "planned crisis prevention and emergency crisis stabilization services provided to"; strike "a service". This brings it in line with Center-based Crisis.	Edits made.
4.	Karen Tefelski - vaACCSES	After means add "planned crisis prevention and emergency crisis stabilization services provided to"; strike "a service". This brings it in line with Center-based Crisis.	Edits made.

5.	B Huffman - VersAbility Resources	A- After barriers add “or to support an individual’s participation when there is an ongoing barrier to participation” Seedefinition. C.3- Strike “This service shall not be provided within a group setting.” This sentence is not necessary and has the potential the individual from learning how to interact and communicate with others in a community engagement setting – the entire purpose of the service. Requiring the service to be one-on-one issufficient.	These comments do not relate to this section.
6.	Citizen	After means add “planned crisis prevention and emergency crisis stabilization services provided to”; strike “a service”. This brings it in line with Center-based Crisis.	Edits made.
7.	Dominion Waiver/Koke	• After means add “planned crisis prevention and emergency crisis stabilization services provided to”; strike “a service”. This brings it in line with Center-based Crisis.	Edits made.
8.	Wormley, Kerns, Collier, Lester, Hauley - VersAbility Rsc	A- After barriers add “or to support an individual’s participation when there is an ongoing barrier to participation” See definition. C.3- Strike “This service shall not be provided within a group setting.” This sentence is not necessary and has the potential the individual from learning how to interact and communicate with others in a community engagement setting – the entire purpose of the service. Requiring the service to be one-on-one is sufficient.	See Line 5.

Comments related to 12VAC30-122-310

2.	DDWAC	1. A- After barriers add “or to support an individual’s participation when there is an ongoing barrier to participation” [See definition] 2. C.3- Strike “This service shall not be provided within a group setting.” [This is not necessary and potential prevents the individual from learning how to interact with others as in a community engagement setting]	There is no time limit on the authorization for this service and the service is designed for people to get to communicty engagement. Community engagment allows for a 1:1 ratio if needed. Individuals in community coaching may interact with others as part of the service.
3.	Dville/Pittvania CSB/S. Craddock	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.
4.	Citizen	12VAC30-122-310 - A - after barriers add "or to support an individual's participation when there is an ongoing barrier to participation" C.3 - Strike "this service shall not be provided within a group setting". Too restrictive and also implies seclusion of the individual owing to the barrier/participation in service. How is the purpose and intention of Community Coaching supporting indviduals to integrate into community engagement going to be successful if the individual does not experience group settings? Additionally - if the individual's barrier is related to difficulties with group settings the current language will not allow for the service to be facilitated.	See Line 2.

5.	Harrison-Rock'ham CSB/ Slaughbaugh	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.
6.	RBHA/M Harrison	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.
7.	Citizen	1. A- After barriers add "or to support an individual's participation when there is an ongoing barrier to participation" See definition. 2. C.3- Strike "This service shall not be provided within a group setting." This sentence is not necessary and has the potential the individual from learning how to interact and communicate with others in a community engagement setting – the entire purpose of the service. Requiring the service to be one-on-one is sufficient.	See Line 2.
8.	VA Board for People with Disabilities	**Subdivision C 3: The Board recommends striking the sentence, "This service shall not be provided within a group setting."** This sentence is not necessary and has the potential to prevent the individual from learning how to interact and communicate with others in a community engagement setting, the entire purpose of the service. Requiring the service to be one-on-one is sufficient.	See Line 2.
9.	Weatherspoon Wall Res, Inc.	1. A- After *barriers* add "or to support an individual's participation when there is an ongoing barrier to participation" [See definition] 2. Provide the opportunity for a variance which would allow a sponsor provider family member to provide the service if it is determined that this is the best or only alternative. This request would be submitted through the support coordinator to the PA Consultant at the time of the Service Authorization request.	1. See Line 2. 2. The sponsor family is already responsible for the individual and paid a per diem. To provide this service to the same individual would be a duplication of service.
10.	J Ciffizari Wall Res, In.	Same as Line 9.	See Line 9.
11.	Citizen	Same as Line 9.	See Line 9.
12.	Karen Tefelski - vaACCSES	A- After barriers add "or to support an individual's participation when there is an ongoing barrier to participation" See definition. C.3- Strike "This service shall not be provided within a group setting." This sentence is not necessary and has the potential the individual from learning how to interact and communicate with others in a community engagement setting – the entire purpose of the service. Requiring the service to be one-on-one is sufficient.	See Line 2.
13.	M. Ingram/Wall Res., Inc.	1. A- After *barriers* add "or to support an individual's participation when there is an ongoing barrier to participation" [See definition] 2. Provide the opportunity for a variance which would allow a sponsor provider family member to provide the service if it is determined that this is the best or only alternative. This request would be submitted through the support coordinator to the PA Consultant at the time of the Service Authorization request.	See Line 2 and Line 9.
14.	R. Ledingham, Wall Res.	Same as Line 13.	See Line 2.
15.	M. Rosenbaum, Wall Res	Same as Line 13.	See Line 2.

16.	K. Black-Hope House	A- After *barriers* add "or to support an individual's participation when there is an ongoing barrier to participation" [See definition]	See Line 2.
17.	Citizen	Community coaching service. • A- After barriers add "or to support an individual's participation when there is an ongoing barrier to participation" See definition. • C.3- Strike "This service shall not be provided within a group setting." This sentence is not necessary and has the potential the individual from learning how to interact and communicate with others in a community engagement setting – the entire purpose of the service. Requiring the service to be one-on-one is sufficient.	See Line 2.
18.	Renon/Wall Res.	A- After barriers add "or to support an individual's participation when there is an ongoing barrier to participation" [See definition] Provide the opportunity for a variance which would allow a sponsor provider family member to provide the service if it is determined that this is the best or only alternative. This request would be submitted through the support coordinator to the PA Consultant at the time of the Service Authorization request.	See Line 2. / The sponsor family is already responsible for the individual and paid a per diem. To provide this service to the same individual would be a duplication of service.
19.	Citizen	1) A- After barriers add "or to support an individual's participation when there is an ongoing barrier to participation" See definition. 2) C.3- Strike "This service shall not be provided within a group setting." This sentence is not necessary and has the potential the individual from learning how to interact and communicate with others in a community engagement setting – the entire purpose of the service. Requiring the service to be one-on-one is sufficient	See Line 2.
20.	Cil Hurd-Burks/Day Supp Mgr	<u>A supervisor meeting the requirements of **12VAC35-105** shall provide supervision of direct support professional staff.</u> 1) This standard is excessive and should not be put into regulation. Each Waiver provider currently performs monthly supervision with their staff that follows the expectations of their organizations policies. Adding the additional burden for waiver supervisors to complete the below mentioned task as a part of their monthly supervisory notes exceeds standards applicable to clinicians, administrative personnel, and all other health related services in DD, MH, and hospital systems. 2) Supervision is not just about the employee's performance, but necessary supports, mentorship, professional development, employee needs, and other issues addressed by the supervisor or employee as needed. This requirement is too prescriptive and limits the purpose of the supervisory session and should not be put into regulation. Supervisor's should be required to have records of their supervision that meets the standards of their organizations, and not be dictated to but any funder. A requirement to document monthly to document is excessive (A_D) for this service 3) E. Semiannual documentation by the supervisor concerning the individual's satisfaction with service provision. - excessive as supervision is not about the individuals served but the employee who is being paid by the organization. Supervision should not be used as a satisfaction survey or instrument.	This regulatory package is not related to the licensing regulation, however there was a change made in E.2.e to reduce to annual perfoirmance review documation. Edits made to documentation of individual's satisfaction.

21.	Dominion Waiver/Koke	12VAC30-122-310 - Community coaching service. • A- After barriers add "or to support an individual's participation when there is an ongoing barrier to participation" See definition.• C.3- Strike "This service shall not be provided within a group setting." This sentence is not necessary and has the potential the individual from learning how to interact and communicate with others in a community engagement setting – the entire purpose of the service. Requiring the service to be one-on-one is sufficient.	See Line 2.
22.	D Boyette/Wall Res.	I agree with Rebecca Ledingham's (Wall Residences) comments regarding the changes to be made to the regulations. **Especially under the Community Coaching and Community Engagement to have the opportunity for a variance which would allow a Sponsored Provider family member to provide the service if it is determined that this is the best or only alternative**. This request would be submitted through the support coordinator to the PA Consultant at the time of the Service Authorization request.	The sponsor family is already responsible for the individual and paid a per diem. To provide this service to the same individual would be a duplication of service.

Comments related to 12VAC30-122-320

2.	DDWAC	D – correct numbering	Edits made
3.	Dville/Pittvania CSB/S. Craddock	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made
4.	Harrison-Rock'ham CSB/ Slaughbaugh	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made
5.	Henrico Area MHDS	E.2.e. CM documents satisfaction with services why does the provider's supervisor need to document satisfaction with services semiannually?	Edits made
6.	RBHA/M Harrison	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made
7.	Cabiness Consultants, LLC	As a private provider I would be interested in getting licensed for this service if the following is addressed 1. There needs to be only ONE plan to work off of. 2. Clarification of "different" staff for group home and community engagement when they are not available. 3. Most activities that service speaks to take place in spring and fall based on the weather. Instead of the hours per month we would prefer the hours be by year. 4. The amount of time it takes to get a plan approved takes entirely too long. 5. The amount of time it takes from the time the service gets approved until the we actually get paid for the service is entirely too long.	1. While not included in these regulations, efforts continue to review opporunities to streamline the plan for supports for like services 2. This is not prohibited in regulations 3. DMAS is unable to change this at this time due to substantial changes to the Medicaid Information System.

8.	Weatherspoon Wall Res, Inc.	Provide the opportunity for a variance that would allow a sponsor provider family member to provide the service if it is determined that this is the best or only alternative. This request would be submitted through the support coordinator to the PA Consultant at the time of the Service Authorization request.	The sponsor family is already responsible for the individual and paid a per diem. To provide this service to the same individual would be a duplication of service.
9.	J Ciffizari Wall Res, In.	Same as Line 8.	See Line 8.
10.	Citizen	Same as Line 8.	See Line 8.
11.	Karen Tefelski - vaACCSES	This service is now available (Medicaid Memo Sept. 4, 2018). It should be included in the final DD Waiver regulations out for public comment.	Edits made
12.	M. Ingram/Wall Res., Inc.	Provide the opportunity for a variance that would allow a sponsor provider family member to provide the service if it is determined that this is the best or only alternative. This request would be submitted through the support coordinator to the PA Consultant at the time of the Service Authorization request.	The sponsor family is already responsible for the individual and paid a per diem. To provide this service to the same individual would be a duplication of service.
13.	Henrico Area MHDS	E.2.e. CM documents satisfaction with services why does the provider's supervisor need to document satisfaction with services semiannually?	See Line 5.
14.	R. Ledingham, Wall Res.	Same as Line 8.	See Line 8.
15.	M. Rosenbaum, Wall Res	Same as Line 8.	See Line 8.

16.	J Orchant Aceto/MVLE	E Service documentation and requirements: 1 c. Documentation confirming the individual's attendance and the amount of the individual's time in the service and providing specific information regarding the individual's response to various settings and supports. Observations of the individual's responses to the service shall be available in at least a daily note. Data shall be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized and then clearly documented in the progress notes or support checklist. RESPONSE/ CONCERNS: It is expected that DSP is analyzing the strategies to determine if they are effective? This seems unclear and places a great deal of expectations on the DSP if that is the expectation. 1.d Documentation to support units or service delivered, and the documentation shall correspond with billing. Providers shall maintain separate documentation for each type of service rendered for an individual. RESPONSE/ CONCERNS: There has been discussion that some of this was being alleviated. the notes for each service or quarterly for each service? This statement about documentation refers again to separate notes/ separate quarterlies. 2: sections about supervision of staff documented bi annually (this is throughout the document for all services) 2e semiannual documentation by the supervisor concerning the individual's satisfaction with service provision. RESPONSE/ CONCERNS: Staff's caseloads can change during any given time. Is this individual satisfaction with service provision to be tied back to the staff supervision? It is confusing as written. A neutral party such as Support Coordinator can better obtain unbiased information from an individual as to the person's level of satisfaction.	This task is delegated to the provider. DMAS does not determine or assign types of staff to do this. Efforts around minimizing documentation continue to be explored related to the ISP however, combined notes and quarterlies are not being discussed at this time. / Edits made.
17.	B Huffman - VersAbility Resources	This service is now available (Medicaid Memo Sept. 4, 2018). It should be included in the final DD Waiver regulations out for publiccomment.	Edits made
18.	Dominion Waiver/Koke	• This service is now available (Medicaid Memo Sept. 4, 2018). It should be included in the final DD Waiver regulations out for public comment.	Edits made
19.	Renon/Wall Res.	Same as Line 8.	See Line 8.

Comments related to 12VAC30-122-330

2.	VA Board for People with Disabilities	This section is reserved; however community guide is now an available service and the Board recommends addressing it in the regulations	Edits made.
3.	Citizen	Community Guide Service. (reserved); • This service is now available (Medicaid Memo Sept. 4, 2018). It should be included in the final DD Waiver regulations out for public comment.	Edits made.
4.	Citizen	This service is now available (Medicaid Memo Sept. 4, 2018). It should be included in the final DD Waiver regulations out for public comment.	Edits made.

Comments related to 12VAC30-122-340

2.	DDWAC	1. C.1- Strike second sentence [While the occasions might be rare, this service can support those who can otherwise function reasonably independently at a modest cost – the 8 hour per day limitation can interfere with that] 2. D.4.b- Replace with "Providers that are licensed by DBHDS, a supervisor meeting the requirements of 12VAC35-105 shall provide supervision of direct support professional staff." [This brings it in line with other similar services]	1. DMAS is not able to make this change at this time. 2. Edits made.
3.	Loudoun CSB L. Snider	Concern that a non-sponsor family member living in the same home cannot provide CD services. There may be limited circumstances where this may be the only option. Recommend this must be done with Objective Documentation this is the option.	DMAS is not able to make this change at this time.
4.	Loudoun CSB L. Snider	Concern that a family member cannot provide CD services. There may be limited circumstances where this may be the only option. Recommend this must be done with Objective Documentation this is the option.	DMAS is not able to make this change at this time.
5.	Dville/Pittvania CSB/S. Craddock	Concern that a non-sponsor family member living in the same home cannot provide CD services. There may be limited circumstances where this may be the only option. Recommend this must be done with Objective Documentation this is the option.	DMAS is not able to make this change at this time.
6.	Dville/Pittvania CSB/S. Craddock	Concern that a family member cannot provide CD services. There may be limited circumstances where this may be the only option. Recommend this must be done with Objective Documentation this is the option.	DMAS is not able to make this change at this time.
7.	Harrison-Rock'ham CSB/ Slaughbaugh	Concern that a non-sponsor family member living in the same home cannot provide CD services. There may be limited circumstances where this may be the only option. Recommend this must be done with Objective Documentation this is the option.	DMAS is not able to make this change at this time.
8.	Harrison-Rock'ham CSB/ Slaughbaugh	Concern that a family member cannot provide CD services. There may be limited circumstances where this may be the only option. Recommend this must be done with Objective Documentation this is the option.	DMAS is not able to make this change at this time.
9.	Henrico Area MHDS	C.9. Clarify family member of the individual served or the provider?	This cannot be the immediate family member of the individual served.
10.	Blue Ridge Beh Healthcare A. Monti	Concern that a non-sponsor family member living in the same home cannot provide CD services. There may be limited circumstances where this may be the only option. Recommend this must be done with Objective Documentation this is the option.	DMAS is not able to make this change at this time.
11.	Blue Ridge Beh Healthcare A. Monti	Concern that a family member cannot provide CD services. There may be limited circumstances where this may be the only option. Recommend this must be done with Objective Documentation this is the option.	DMAS is not able to make this change at this time.
12.	RBHA/M Harrison	Concern that a non-sponsor family member living in the same home cannot provide CD services. There may be limited circumstances where this may be the only option. Recommend this must be done with Objective Documentation this is the option.	DMAS is not able to make this change at this time.
13.	RBHA/M Harrison	Concern that a family member cannot provide CD services. There may be limited circumstances where this may be the only option. Recommend this must be done with Objective Documentation this is the option.	DMAS is not able to make this change at this time.

14.	VA Board for People with Disabilities	**Subdivision C 1: The Board recommends eliminating the limit of the service to eight hours per 24 hour per day.** The waivers already allow a combination of various services to flexibly accommodate an individual's needs. Companion services are inexpensive and there may be times when an individual requires more than eight hours of this service in a given day. The authorization should be an annual amount of hours that can be used as the individual needs them. Eight hours per day is an arbitrary cap. Other services don't have a daily limit.	See Line 2.
15.	Karen Tefelski - vaACCSES	C.1- Strike second sentence and limiting the service to eight hours per 24-hour day. While the occasions might be rare, this service can support those who can otherwise function reasonably independently at a modest cost – the 8 hour per day limitation can interfere with that. The waivers already allow a combination of various services to flexibly accommodate an individual's needs. Companion services are inexpensive and there may be times when an individual requires more than eight hours of this service in a given day. The authorization should be an annual amount or hours that can be used as the individual needs them. Eight hours per day is an arbitrary cap. D.4.b- Replace with "Providers that are licensed by DBHDS, a supervisor meeting the requirements of 12VAC35-105 shall provide supervision of direct support professional staff." This brings it in line with other similar services.	See Line 2.
16.	Henrico Area MHDS	C.9. Clarify family member of the individual served or the provider?	See Line 9.
17.	B Huffman - VersAbility Resources	C.1- Strike second sentence and limiting the service to eight hours per 24-hour day. While the occasions might be rare, this service can support those who can otherwise function reasonably independently at a modest cost – the 8 hour per day limitation can interfere with that. The waivers already allow a combination of various services to flexibly accommodate an individual's needs. Companion services are inexpensive and there may be times when an individual requires more than eight hours of this service in a given day. The authorization should be an annual amount or hours that can be used as the individual needs them. Eight hours per day is an arbitrarycap. D.4.b- Replace with "Providers that are licensed by DBHDS, a supervisor meeting the requirements of 12VAC35-105 shall provide supervision of direct support professional staff." This brings it in line with other similarservices.	See Line 2.
18.	Citizen	• C.1- Strike second sentence and limiting the service to eight hours per 24-hour day. While the occasions might be rare, this service can support those who can otherwise function reasonably independently at a modest cost – the 8 hour per day limitation can interfere with that. The waivers already allow a combination of various services to flexibly accommodate an individual's needs. Companion services are inexpensive and there may be times when an individual requires more than eight hours of this service in a given day. The authorization should be an annual amount or hours that can be used as the individual needs them. Eight hours per day is an arbitrary cap.	See Line 2.

19.	Citizen	C.1- Strike second sentence and limiting the service to eight hours per 24-hour day. While the occasions might be rare, this service can support those who can otherwise function reasonably independently at a modest cost – the 8 hour per day limitation can interfere with that. The waivers already allow a combination of various services to flexibly accommodate an individual's needs. Companion services are inexpensive and there may be times when an individual requires more than eight hours of this service in a given day. The authorization should be an annual amount or hours that can be used as the individual needs them. Eight hours per day is an arbitrary cap. • D.4.b- Replace with "Providers that are licensed by DBHDS, a supervisor meeting the requirements of 12VAC35-105 shall provide supervision of direct support professional staff." This brings it in line with other similar services.	See Line 2.
20.	Dominion Waiver/Koke	• C.1- Strike second sentence and limiting the service to eight hours per 24-hour day. While the occasions might be rare, this service can support those who can otherwise function reasonably independently at a modest cost – the 8 hour per day limitation can interfere with that. The waivers already allow a combination of various services to flexibly accommodate an individual's needs. Companion services are inexpensive and there may be times when an individual requires more than eight hours of this service in a given day. The authorization should be an annual amount or hours that can be used as the individual needs them. Eight hours per day is an arbitrary cap. • D.4.b- Replace with "Providers that are licensed by DBHDS, a supervisor meeting the requirements of 12VAC35-105 shall provide supervision of direct support professional staff." This brings it in line with other similar services.	See Line 2.
21.	Wormley, Kerns, Collier, Lester, Hauley -VersAbility Rsc	C.1- Strike second sentence and limiting the service to eight hours per 24-hour day. While the occasions might be rare, this service can support those who can otherwise function reasonably independently at a modest cost – the 8 hour per day limitation can interfere with that. The waivers already allow a combination of various services to flexibly accommodate an individual's needs. Companion services are inexpensive and there may be times when an individual requires more than eight hours of this service in a given day. The authorization should be an annual amount or hours that can be used as the individual needs them. Eight hours per day is an arbitrarycap. D.4.b- Replace with "Providers that are licensed by DBHDS, a supervisor meeting the requirements of 12VAC35-105 shall provide supervision of direct support professional staff." This brings it in line with other similarservices.	See Line 2.
22.	Maureen Hollowell, VA Assoc of Centers for Independent Living	C.3. Clarify whether the individual may have more than one EOR.	The individual may not have more than one EOR.

Comments related to 12VAC30-122-350

2.	Lucy Beadnell, Virginia Ability Alliance	Eligibility for center-based crisis and community-based crisis services mandates history of involvement with psychiatric hospitalization, incarceration, a loss of residential or day placement, or behavior at risk of jeopardizing "placement." The terminology about a "jeopardized placement" does not clearly reflect risks to individuals living in family homes, which is not "placement" in the general usage of the term. **The regulations should be amended to clarify that individuals living in family homes with behaviors making those living environments unsafe are eligible.**	DMAS changed "placement" to "current living situation."
3.	DDWAC	The three level described here are not included in the two other crisis support services – they should be consistent!	This service includes a prevention component and therefore, the three levels belong to this service only.
4.	Dville/Pittvania CSB/S. Craddock	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.
5.	Harrison-Rock'ham CSB/ Slaughbaugh	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.
6.	Blue Ridge Beh Healthcare A. Monti	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.
7.	RBHA/M Harrison	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.
8.	Citizen	The three-levels described here are not included in the other two crisis support services – they should be consistent.	See Line 3.
9.	Citizen	The three-levels described here are not included in the other two crisis support services – they should be consistent	See Line 3.
10.	Dominion Waiver/Koke	The three-levels described here are not included in the other two crisis support services – they should be consistent.	See Line 3.
11.	Dominion Waiver/Koke	The three-levels described here are not included in the other two crisis support services – they should be consistent.	See Line 3.
12.	Wormley, Kerns, Collier, Lester, Hauley - VersAbility Rsc	The three-levels described here are not included in the other two crisis support services – they should beconsistent.	See Line 3.
13.	Johnston/Vector Industries	The three-levels described here are not included in the other two crisis support services – they should be consistent.	See Line 3.
14.	Karen Tefelski - vaACCSES	The three-levels described here are not included in the other two crisis support services – they should be consistent.	See Line 3.

Comments related to 12VAC30-122-360

2.	DDWAC	B.1.- Strike “physically”	Edits made.
3.	Loudoun CSB L. Snider	Inconsistent with 12VAC122-210 For Electronic Home based services, 12VAC30-122-210 C.3 indicates is the $5000 limit per calendar year while 12VAC30-122-360 C. 1. indicates limit is $5000 per ISP plan year?	Edits made.
4.	Dville/Pittvania CSB/S. Craddock	Inconsistent with 12VAC122-210 For Electronic Home based services, 12VAC30-122-210 C.3 indicates is the $5000 limit per calendar year while 12VAC30-122-360 C. 1. indicates limit is $5000 per ISP plan year?	Edits made.
5.	Harrison-Rock’ham CSB/ Slaughbaugh	Inconsistent with 12VAC122-210 For Electronic Home based services, 12VAC30-122-210 C.3 indicates is the $5000 limit per **calendar year** while 12VAC30-122-360 C. 1. indicates limit is $5000 per **ISP plan year**?	Edits made.
6.	Blue Ridge Beh Healthcare A. Monti	Inconsistent with 12VAC122-210 For Electronic Home based services, 12VAC30-122-210 C.3 indicates is the $5000 limit per calendar year while 12VAC30-122-360 C. 1. indicates limit is $5000 per ISP plan year?	Edits made.
7.	RBHA/M Harrison	Inconsistent with 12VAC122-210 For Electronic Home based services, 12VAC30-122-210 C.3 indicates is the $5000 limit per calendar year while 12VAC30-122-360 C. 1. indicates limit is $5000 per ISP plan year?	Edits made.
8.	VA Board for People with Disabilities	**Subdivision B 1: The Board recommends removing the word “physically**.” The section notes that the individual must be “physically” capable of using the equipment provided via EHBS service. Some EHBS services may be voice activated and not require physical manipulation. Although voice activation could be considered “physical,” this provision could be misunderstood.	Edits made.
9.	K. Black-Hope House	A.- Strike ‘while decreasing’ and add ‘which may decrease’. B.1.- Strike “physically”. C.- Increase the limit of EHBS service per calendar year and allow for carryover when the EHBS identified the meet the support and service need exceeds the limit set per calendar year	A. The purpose is to decrease the staff supports/B. Edits made./ DMAS is not able to make this change at this time.
10.	Citizen	B.1.- STRIKE “physically”. The section notes that the individual must be “physically” capable of using the equipment provided via EHBS service. Some EHBS services may be voice activated and not require physical manipulation. Although voice activation could be considered “physical”, this provision could be misunderstood and, thus, misapplied by authorizers or auditors. • C.1. Recommend an increase to the cost of electronic home-based supports from the current maximum of $5,000 per calendar year. This limit is not sufficient for up-to-date technology as well as any associated monthly monitoring fees. The purpose of these supports is to enable individuals who so desire to live more independently with less staff intrusion into their lives. The benefit should be consistent with the average cost of this type of support. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to	Edits made / DMAS is not able to make this change at this time.

		accommodate upfront costs of purchasing new electronic home-based supports technology without raising the overall multi-year dollar limits.	
11.	Dominion Waiver/Koke	• B.1.- STRIKE "physically". The section notes that the individual must be "physically" capable of using the equipment provided via EHBS service. Some EHBS services may be voice activated and not require physical manipulation. Although voice activation could be considered "physical", this provision could be misunderstood and, thus, misapplied by authorizers or auditors.• C.1. Recommend an increase to the cost of electronic home-based supports from the current maximum of $5,000 per calendar year. This limit is not sufficient for up-to-date technology as well as any associated monthly monitoring fees. The purpose of these supports is to enable individuals who so desire to live more independently with less staff intrusion into their lives. The benefit should be consistent with the average cost of this type of support. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new electronic home-based supports technology without raising the overall multi-year dollar limits.	Edits made / DMAS is not able to make this change at this time.
12.	Wormley, Kerns, Collier, Lester, Hauley -VersAbility Rsc	Same as Line 11.	See Line 11.
13.	Karen Tefelski - vaACCSES	Same as Line 11.	See Line 11.
14.	Virginia Board for People with Disabilities	Subdivision C 1: As recommended in previous sections of these comments, the Board recommends that DMAS examine whether $5,000 is an adequate annual limit, particularly with respect to home-based monitoring services which can mitigate the need for in-person supports.	See Line 11.

Comments related to 12VAC30-122-370

2.	Lucy Beadnell, Virginia Ability Alliance	The allowable usages of Environmental Modifications are quite narrow, not allowing changes for safety, including items like keypads on doors to prevent individuals from eloping. These and other safety-based modifications are critical to allowing many individuals to access their communities and safely live at home.	Edits made.
3.	DDWAC	C.6.- We recommend that an exception process be put into place for the uncommon circumstance in which the expansion of square footage to the home (which is prohibited) is an incidental result of a modification that will enable the individual to remain in the home, e.g., a larger, accessible bathroom. Limits could be put into place for how much additional square footage would be allowable in an exceptions process.	DMAS is not able to make this change at this time.
4.	Dville/Pittvania CSB/S. Craddock	Clarification if possible to receive Environmental modification on multiple vehicles (i.e. one at the residence and possible another that an person uses to give the individual a ride to appointments).	Modifications are allowed only on the primary vehicle

5.	Harrison-Rock'ham CSB/ Slaughbaugh	Clarification if possible to receive Environmental modification on multiple vehicles (i.e. one at the residence and possible another that a person uses to give the individual a ride to appointments).	Modifications are allowed only on the primary vehicle
6.	Blue Ridge Beh Healthcare A. Monti	Clarification if possible to receive Environmental modification on multiple vehicles (i.e. one at the residence and possible another that an person uses to give the individual a ride to appointments).	Modifications are allowed only on the primary vehicle
7.	RBHA/M Harrison	Clarification if possible to receive Environmental modification on multiple vehicles (i.e. one at the residence and possible another that an person uses to give the individual a ride to appointments).	Modifications are allowed only on the primary vehicle
8.	VA Board for People with Disabilities	**Subdivision C 2: As noted previously, the Board recommends a review of the $5,000 annual limit increasing the annual limit for environmental modifications from the current maximum annual cap of $5,000 to a level deemed appropriate to the cost of such modifications.** This limit is years old and it is increasingly difficult for families and individuals to secure modifications that will allow them to remain in their homes over their lifespan for this small amount of funding. If raising the overall limit is not feasible at this time, then the Board recommends adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new environmental modifications without raising the overall multi-year dollar limits.	Additional funding would need to be appropriated by the General Assembly.
9.	Weatherspoon Wall Res, Inc.	1. C.6.- We recommend that an exception process be put into place for the uncommon circumstance in which the expansion of square footage to the home (which is prohibited) is an incidental result of a modification that will enable the individual to remain in the home, e.g., a larger, accessible bathroom. Limits could be put into place for how much additional square footage would be allowable in an exceptions process. 2. Allow individuals living in Sponsored Residential homes to access environmental modifications in their Sponsored Residential location when there are changing needs requiring such funding. This would happen after an individual has been living in the sponsored home, not at the time of referral or admission to the home.	1. DMAS is not able to make this change at this time. 2. EM cannot be provided to those sites that receive federal funding because they are required by the ADA to be compliant. Sponsored homes receive federal funding.
10.	J Ciffizari Wall Res, In.	Same as Line 9.	See Line 9.
11.	Citizen	Same as Line 9.	See Line 9.
12.	M. Ingram/Wall Res., Inc.	1. C.6.- We recommend that an exception process be put into place for the uncommon circumstance in which the expansion of square footage to the home (which is prohibited) is an incidental result of a modification that will enable the individual to remain in the home, e.g., a larger, accessible bathroom. Limits could be put into place for how much additional square footage would be allowable in an exceptions process. 2. Allow individuals living in Sponsored Residential homes to access environmental modifications in their Sponsored Residential location when there are changing needs requiring such funding. This would	1. DMAS is not able to make this change at this time. 2. EM cannot be provided to those sites that receive federal funding because they

		happen after an individual has been living in the sponsored home, not at the time of referral or admission to the home.	are required by the ADA to be compliant. Sponsored homes receive federal funding.
13.	R. Ledingham, Wall Res.	C.6.- We recommend that an exception process be put into place for the uncommon circumstance in which the expansion of square footage to the home (which is prohibited) is an incidental result of a modification that will enable the individual to remain in the home, e.g., a larger, accessible bathroom. Limits could be put into place for how much additional square footage would be allowable in an exceptions process. Allow individuals living in Sponsored Residential homes to access environmental modifications in their Sponsored Residential location when there are changing needs requiring such funding. This would happen after an individual has been living in the sponsored home, not at the time of referral or admission to the home.	DMAS is not able to make this change at this time.
14.	M. Rosenbaum, Wall Res	Same as Line 9.	See Line 9.
15.	K. Black-Hope House	Strike 'of a remedial or medical benefit offered'. Strike 'specifically improve the individual's personal functioning' and replace with 'increase their ability to control their environment, support ISP outcomes identified and live safely and independently in the least restrictive community setting. C.2.- Increase the limit of EM service per calendar year and allow for carryover when the EM item exceeds the limit set per calendar year	Edits made. / Additional funds would need to be appropriated by the General Assembly.
16.	Citizen	Environmental Modification Service. • C.2. Recommend an increase to the $5,000 annual limit for environmental modifications from the current maximum annual cap of $5,000 to a level deemed appropriate to the cost of such modifications. This limit is years old and it is increasingly difficult for families and individuals to secure modifications that will allow them to remain in their homes over their lifespan for this small amount of funding. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new environmental modifications without raising the overall multi-year dollar limits. • C.6.- We recommend that an exception process be put into place for the uncommon circumstance in which the expansion of square footage to the home (which is prohibited) is an incidental result of a modification that will enable the individual to remain in the home (e.g. a larger, accessible bathroom). Limits could be put into place for how much additional square footage would be allowable in an exceptions process.	1. Additional funds would need to be appropriated by the General Assembly. 2. DMAS is not able to make this change at this time.
17.	Dominion Waiver/Koke	• C.2. Recommend an increase to the $5,000 annual limit for environmental modifications from the current maximum annual cap of $5,000 to a level deemed appropriate to the cost of such modifications. This limit is years old and it is increasingly difficult for families and individuals to secure modifications that will allow them to remain in their homes over their lifespan for this small amount of funding. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals	See Line 16.

		to accommodate upfront costs of purchasing new environmental modifications without raising the overall multi-year dollar limits. • C.6.- We recommend that an exception process be put into place for the uncommon circumstance in which the expansion of square footage to the home (which is prohibited) is an incidental result of a modification that will enable the individual to remain in the home (e.g. a larger, accessible bathroom). Limits could be put into place for how much additional square footage would be allowable in an exceptions process.	
18.	Wormley, Kerns, Collier, Lester, Hauley -VersAbility Rsc	C.2. Recommend an increase to the $5,000 annual limit for environmental modifications from the current maximum annual cap of $5,000 to a level deemed appropriate to the cost of such modifications. This limit is years old and it is increasingly difficult for families and individuals to secure modifications that will allow them to remain in their homes over their lifespan for this small amount of funding. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new environmental modifications without raising the overall multi-year dollar limits. C.6.- We recommend that an exception process be put into place for the uncommon circumstance in which the expansion of square footage to the home (which is prohibited) is an incidental result of a modification that will enable the individual to remain in the home (e.g. a larger, accessible bathroom). Limits could be put into place for how much additional square footage would be allowable in an exceptions process.	See Line 16.
19.	Renon/Wall Res.	Same as Line 9.	See Line 9.
20.	Karen Tefelski - vaACCSES	Same as Line 17.	See Line 17.
21.	Virginia Board for People with Disabilities	Subdivision C 6: The Board recommends that an exception process be put into place for the uncommon circumstance in which the expansion of square footage to the home (which is prohibited) is an incidental result of a modification that will enable the individual to remain in their home, e.g., a larger, accessible bathroom. Limits could be put into place for how much additional square footage would be allowable in an exceptions process.	See Line 16.

Comments related to 12VAC30-122-380

2.	Lucy Beadnell, Virginia Ability Alliance	Regs don't allow more than 24 hours of billing overlap for job discovery while someone is accessing a day service. It can take more than 24 hours to find correct job and work with employer on job prep, such as customized employment. Minimum should be increased to further remove barriers to employment.	The 24 hours can be spread out over the course of several days to several weeks, as needed.
3.	Dville/Pittvania CSB/S. Craddock	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made
4.	Harrison-Rock’ham CSB/ Slaughbaugh	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made

5.	RBHA/M Harrison	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made
6.	Henrico Area MHDS	12. Group day service (12VAC30-122-380); - B. There should be consistency across the renewal applications and these regulations. It is suggested that both routine supports (defined as ADL's) and safety supports be included in the final version of both regulations. - D.2. There is inconsistency in what the license is for services. Current providers have center-based and non-centered based day support licenses. Newer providers with a "community based license". There should be notation in the regs that a current license is needed, but clarification is needed to ensure those whose license is not up for renewal still meets the regulations with the old title.	B. Safety supports are in E. D2 This is a licensing issue and DMAS will not make a change to the regulations at this time. The license may be called something else at DBHDS.
7.	Citizen	1. B.1. Support the addition of the following that are included in the new CL waiver renewal application but are not currently included in the proposed final regulations: 2. Participation in community volunteer opportunities or education programs; 3. Staff coverage for transportation of the individual between service activity sites. Transportation is included as part of the service. The provider may be reimbursed for the time spent transporting the individual to community locations as part of the waiver billing 4. Personal types of activities (i.e. assistance with ADLs). These allowable activities are critical for individuals that need them but are not necessarily "skill building". 5. C. Add 6. Recommend annual allocation for Group Day and Community Engagement hours to allow increased flexibility. Currently, Group Day hours and Community Engagement hours are authorized on a monthly basis with additional estimated "flex hours". We recommend that there period of authorization be lengthened to allow more flexibility and consumer choice. For example, individuals choose whether they want to go out in the community or stay in a center on any given day. Because of weather or other personal circumstances of the individual, the individual may want to stay in the center more often in the winter and in the community more often in the Spring/Summer/Fall. Hours could then be drawn from a quarterly, semi-annual or annual "pool" of hours based on their person-centered plan.	DMAS is unable to do this at this time due to IT limitations.

8.	Karen Tefelski - vaACCSES	B.1. Support the addition of the following that are included in the new CL waiver renewal application but are not currently included in the proposed final regulations: Participation in community volunteer opportunities or education programs; Staff coverage for transportation of the individual between service activity sites. Transportation is included as part of the service. The provider may be reimbursed for the time spent transporting the individual to community locations as part of the waiver billing Personal types of activities (i.e. assistance with ADLs). These allowable activities are critical for individuals that need them but are not necessarily "skill building". Allowable activity of "providing safety supports in a variety of community settings": This allowable activity is not included in the CL Waiver renewal application. Further, the CL renewal application includes "personal care types of activities (i.e. assistance with ADLs)" yet this allowable activity is not listed in either these proposed regulations nor in the "2016" version of regulations. These refer to activities rather than the requirement for skill-building; this phrase offers more flexibility for providers who are spending significant time in personal care than in skill-building. Consistent language should be included in these proposed regulations. C. Add 6. Recommend annual allocation for Group Day and Community Engagement hours to allow increased flexibility. Currently, Group Day hours and Community Engagement hours are authorized on a monthly basis with additional estimated "flex hours". We recommend that there period of authorization be lengthened to allow more flexibility and consumer choice. For example, individuals choose whether they want to go out in the community or stay in a center on any given day. Because of weather or other personal circumstances of the individual, the individual may want to stay in the center more often in the winter and in the community more often in the Spring/Summer/Fall. Hours could then be drawn from a quarterly, semi-annual or annual "pool" of hours based on their person-centered plan. D.5. Supervision - There is NO reference to Licensing regulations to define "supervisor." Licensing does not define a "supervisor" but does define a QDDP. The 2016 version of the Waiver regulations included the phrase "or a provider who has documented equivalent experience" to allow providers to substitute experience for a college degree, but this phrase is not included in either the new (2018) Licensing regulations or within the definition of QDDP in these Waiver regulations. Providers request consistency and clarity within and between regulations when defining QDDP since there are numerous QDDP responsibilities within these regulations.	B1 - See Line 7. / See Line 6, item B. / C6 - See Line 7. / D5 -s ee Line 6, Item D2.

9.	J Orchant Aceto/MVLE	B.1. Support the addition of the following that are included in the new CL waiver renewal application but are not currently included in the proposed final regulations: Participation in community volunteer opportunities or education programs; Staff coverage for transportation of the individual between service activity sites. Transportation is included as part of the service. The provider may be reimbursed for the time spent transporting the individual to community locations as part of the waiver billing. Personal types of activities (i.e. assistance with ADLs). These allowable activities are critical for individuals that need them but are not necessarily “skill building”. C. Add 6. Recommend annual allocation for Group Day and Community Engagement hours to allow increased flexibility. Currently, Group Day hours and Community Engagement hours are authorized on a monthly basis with additional estimated “flex hours”. We recommend that there period of authorization be lengthened to allow more flexibility and consumer choice. For example, individuals choose whether they want to go out in the community or stay in a center on any given day. Because of weather or other personal circumstances of the individual, the individual may want to stay in the center more often in the winter and in the community more often in the Spring/Summer/Fall. Hours could then be drawn from a quarterly, semi-annual or annual “pool” of hours based on their person-centered plan	See Line 7.
10.	B Huffman - VersAbility Resources	B.1. Support the addition of the following that are included in the new CL waiver renewal application but are not currently included in the proposed final regulations: Participation in community volunteer opportunities or education programs; Staff coverage for transportation of the individual between service activity sites. Transportation is included as part of the service. The provider may be reimbursed for the time spent transporting the individual to community locations as part of the waiver billing Personal types of activities (i.e. assistance with ADLs). These allowable activities are critical for individuals that need them but are not necessarily “skill building”. Allowable activity of “providing safety supports in a variety of community settings”: This allowable activity is not included in the CL Waiver renewal application. Further, the CL renewal application includes “personal care types of activities (i.e. assistance with ADLs)” yet this allowable activity is not listed in either these proposed regulations nor in the “2016” version of regulations. These refer to activities rather than the requirement for skill-building; this phrase offers more flexibility for providers who are spending significant time in personal care than in skill-building. Consistent language should be included in these proposed regulations. C. Add 6. Recommend annual allocation for Group Day and Community Engagement hours to allow increased flexibility. Currently, Group Day hours and Community Engagement hours are authorized on a monthly basis with additional estimated “flex hours”. We recommend that there period of authorization be lengthened to allow more flexibility and consumer choice. For example, individuals choose whether they want to go out in the community or stay in a center on any given day. Because of weather or other personal circumstances of the individual, the individual may want to stay in the center more often in the winter and in the community more often in	See Line 8.

		the Spring/Summer/Fall. Hours could then be drawn from a quarterly, semi-annual or annual "pool" of hours based on their person-centered plan. D.5. Supervision - There is NO reference to Licensing regulations to define "supervisor." Licensing does not define a "supervisor" but does define a QDDP. The 2016 version of the Waiver regulations included the phrase "or a provider who has documented equivalent experience" to allow providers to substitute experience for a college degree, but this phrase is not included in either the new (2018) Licensing regulations or within the definition of QDDP in these Waiver regulations. Providers request consistency and clarity within and between regulations when defining QDDP since there are numerous QDDP responsibilities within these regulations.	
11.	Jan Williams, ServiceSource	Include the allowable activity of "providing safety supports in a variety of community settings". This allowable activity is included in the CL Waiver renewal application. Further, the CL renewal application includes "personal care types of activities (i.e. assistance with ADLs)" yet this allowable activity is not listed in either these proposed regulations or in the 2016 version of regulations. These refer to support activities rather than the requirement for skill building; we recommend that this phrase offers more flexibility for providers who are spending significant time in personal care supports other than in skill-building. D.5. Supervision – Licensing regulations do not define a "supervisor" but do define a QDDP. If in fact these regulations are meant to refer to a QDDP, we note that the 2016 version of the Waiver regulations included the phrase "or a provider who has documented equivalent experience" to allow providers to substitute experience for a college degree. This phrase is not included in either the new (2018) Licensing regulations or within the definition of QDDP in these Waiver regulations. Providers request consistency and clarity within and between regulations.	See Line 8.

12.	Citizen	12VAC30-122-380 - Group Day Service. • B.1. Support the addition of the following that are included in the new CL waiver renewal application but are not currently included in the proposed final regulations: o Participation in community volunteer opportunities or education programs; o Staff coverage for transportation of the individual between service activity sites. Transportation is included as part of the service. The provider may be reimbursed for the time spent transporting the individual to community locations as part of the waiver billing o Personal types of activities (i.e. assistance with ADLs). These allowable activities are critical for individuals that need them but are not necessarily "skill building". o Allowable activity of "providing safety supports in a variety of community settings": This allowable activity is not included in the CL Waiver renewal application. Further, the CL renewal application includes "personal care types of activities (i.e. assistance with ADLs)" yet this allowable activity is not listed in either these proposed regulations nor in the "2016" version of regulations. These refer to activities rather than the requirement for skill-building; this phrase offers more flexibility for providers who are spending significant time in personal care than in skill-building. Consistent language should be included in these proposed regulations.• C. Add 6. Recommend annual allocation for Group Day and Community Engagement hours to allow increased flexibility. Currently, Group Day hours and Community Engagement hours are authorized on a monthly basis with additional estimated "flex hours". We recommend that there period of authorization be lengthened to allow more flexibility and consumer choice. For example, individuals choose whether they want to go out in the community or stay in a center on any given day. Because of weather or other personal circumstances of the individual, the individual may want to stay in the center more often in the winter and in the community more often in the Spring/Summer/Fall. Hours could then be drawn from a quarterly, semi-annual or annual "pool" of hours based on their person-centered plan. • D.5. Supervision - There is NO reference to Licensing regulations to define "supervisor." Licensing does not define a "supervisor" but does define a QDDP. The 2016 version of the Waiver regulations included the phrase "or a provider who has documented equivalent experience" to allow providers to substitute experience for a college degree, but this phrase is not included in either the new (2018) Licensing regulations or within the definition of QDDP in these Waiver regulations. Providers request consistency and clarity within and between regulations when defining QDDP since there are numerous QDDP responsibilities within these regulations.	See Line 8.

13.	Dominion Waiver/Koke	• B.1. Support the addition of the following that are included in the new CL waiver renewal application but are not currently included in the proposed final regulations: o Participation in community volunteer opportunities or education programs; o Staff coverage for transportation of the individual between service activity sites. Transportation is included as part of the service. The provider may be reimbursed for the time spent transporting the individual to community locations as part of the waiver billing o Personal types of activities (i.e. assistance with ADLs). These allowable activities are critical for individuals that need them but are not necessarily "skill building". o Allowable activity of "providing safety supports in a variety of community settings": This allowable activity is not included in the CL Waiver renewal application. Further, the CL renewal application includes "personal care types of activities (i.e. assistance with ADLs)" yet this allowable activity is not listed in either these proposed regulations nor in • C. Add 6. Recommend annual allocation for Group Day and Community Engagement hours to allow increased flexibility. Currently, Group Day hours and Community Engagement hours are authorized on a monthly basis with additional estimated "flex hours". We recommend that there period of authorization be lengthened to allow more flexibility and consumer choice. For example, individuals choose whether they want to go out in the community or stay in a center on any given day. Because of weather or other personal circumstances of the individual, the individual may want to stay in the center more often in the winter and in the community more often in the Spring/Summer/Fall. Hours could then be drawn from a quarterly, semi-annual or annual "pool" of hours based on their person-centered plan. • D.5. Supervision - There is NO reference to Licensing regulations to define "supervisor." Licensing does not define a "supervisor" but does define a QDDP. The 2016 version of the Waiver regulations included the phrase "or a provider who has documented equivalent experience" to allow providers to substitute experience for a college degree, but this phrase is not included in either the new (2018) Licensing regulations or within the definition of QDDP in these Waiver regulations. Providers request consistency and clarity within and between regulations when defining QDDP since there are numerous QDDP responsibilities within these regulations.	See Line 8.

14.	Dominion Waiver/Koke	• B.1. Support the addition of the following that are included in the new CL waiver renewal application but are not currently included in the proposed final regulations: o Participation in community volunteer opportunities or education programs; o Staff coverage for transportation of the individual between service activity sites. Transportation is included as part of the service. The provider may be reimbursed for the time spent transporting the individual to community locations as part of the waiver billing o Personal types of activities (i.e. assistance with ADLs). These allowable activities are critical for individuals that need them but are not necessarily "skill building". o Allowable activity of "providing safety supports in a variety of community settings": This allowable activity is not included in the CL Waiver renewal application. Further, the CL renewal application includes "personal care types of activities (i.e. assistance with ADLs)" yet this allowable activity is not listed in either these proposed regulations nor in • C. Add 6. Recommend annual allocation for Group Day and Community Engagement hours to allow increased flexibility. Currently, Group Day hours and Community Engagement hours are authorized on a monthly basis with additional estimated "flex hours". We recommend that there period of authorization be lengthened to allow more flexibility and consumer choice. For example, individuals choose whether they want to go out in the community or stay in a center on any given day. Because of weather or other personal circumstances of the individual, the individual may want to stay in the center more often in the winter and in the community more often in the Spring/Summer/Fall. Hours could then be drawn from a quarterly, semi-annual or annual "pool" of hours based on their person-centered plan. • D.5. Supervision - There is NO reference to Licensing regulations to define "supervisor." Licensing does not define a "supervisor" but does define a QDDP. The 2016 version of the Waiver regulations included the phrase "or a provider who has documented equivalent experience" to allow providers to substitute experience for a college degree, but this phrase is not included in either the new (2018) Licensing regulations or within the definition of QDDP in these Waiver regulations. Providers request consistency and clarity within and between regulations when defining QDDP since there are numerous QDDP responsibilities within these regulations.	See Line 8.

15.	Wormley, Kerns, Collier, Lester, Hauley - VersAbility Rsc	B.1. Support the addition of the following that are included in the new CL waiver renewal application but are not currently included in the proposed final regulations: Participation in community volunteer opportunities or education programs; Staff coverage for transportation of the individual between service activity sites. Transportation is included as part of the service. The provider may be reimbursed for the time spent transporting the individual to community locations as part of the waiver billing Personal types of activities (i.e. assistance with ADLs). These allowable activities are critical for individuals that need them but are not necessarily “skill building”. Allowable activity of “providing safety supports in a variety of community settings”: This allowable activity is not included in the CL Waiver renewal application. Further, the CL renewal application includes “personal care types of activities (i.e. assistance with ADLs)” yet this allowable activity is not listed in either these proposed regulations nor in the “2016” version of regulations. These refer to activities rather than the requirement for skill-building; this phrase offers more flexibility for providers who are spending significant time in personal care than in skill-building. Consistent language should be included in these proposed regulations. C. Add 6. Recommend annual allocation for Group Day and Community Engagement hours to allow increased flexibility. Currently, Group Day hours and Community Engagement hours are authorized on a monthly basis with additional estimated “flex hours”. We recommend that there period of authorization be lengthened to allow more flexibility and consumer choice. For example, individuals choose whether they want to go out in the community or stay in a center on any given day. Because of weather or other personal circumstances of the individual, the individual may want to stay in the center more often in the winter and in the community more often in the Spring/Summer/Fall. Hours could then be drawn from a quarterly, semi-annual or annual “pool” of hours based on their person-centered plan. D.5. Supervision - There is NO reference to Licensing regulations to define “supervisor.” Licensing does not define a “supervisor” but does define a QDDP. The 2016 version of the Waiver regulations included the phrase “or a provider who has documented equivalent experience” to allow providers to substitute experience for a college degree, but this phrase is not included in either the new (2018) Licensing regulations or within the definition of QDDP in these Waiver regulations. Providers request consistency and clarity within and between regulations when defining QDDP since there are numerous QDDP responsibilities within these regulations.	See Line 8.

16.	Johnston/Vector Industries	B.1. Support the addition of the following that are included in the new CL waiver renewal application but are not currently included in the proposed final regulations: o Participation in community volunteer opportunities or education programs; o Staff coverage for transportation of the individual between service activity sites. Transportation is included as part of the service. The provider may be reimbursed for the time spent transporting the individual to community locations as part of the waiver billing o Personal types of activities (i.e. assistance with ADLs). These allowable activities are critical for individuals that need them but are not necessarily “skill building”. o Allowable activity of “providing safety supports in a variety of community settings”: This allowable activity is not included in the CL Waiver renewal application. Further, the CL renewal application includes “personal care types of activities (i.e. assistance with ADLs)” yet this allowable activity is not listed in either these proposed regulations nor in the “2016” version of regulations. These refer to activities rather than the requirement for skill-building; this phrase offers more flexibility for providers who are spending significant time in personal care than in skill-building. Consistent language should be included in these proposed regulations. • C. Add 6. Recommend annual allocation for Group Day and Community Engagement hours to allow increased flexibility. Currently, Group Day hours and Community Engagement hours are authorized on a monthly basis with additional estimated “flex hours”. We recommend that there period of authorization be lengthened to allow more flexibility and consumer choice. For example, individuals choose whether they want to go out in the community or stay in a center on any given day. Because of weather or other personal circumstances of the individual, the individual may want to stay in the center more often in the winter and in the community more often in the Spring/Summer/Fall. Hours could then be drawn from a quarterly, semi-annual or annual “pool” of hours based on their person-centered plan. • D.5. Supervision - There is NO reference to Licensing regulations to define “supervisor.” Licensing does not define a “supervisor” but does define a QDDP. The 2016 version of the Waiver regulations included the phrase “or a provider who has documented equivalent experience” to allow providers to substitute experience for a college degree, but this phrase is not included in either the new (2018) Licensing regulations or within the definition of QDDP in these Waiver regulations. Providers request consistency and clarity within and between regulations when defining QDDP since there are numerous QDDP responsibilities within these regulations.	See Line 8.

Comments related to 12VAC30-122-390

2.	Lucy Beadnell, Virginia Ability Alliance	We understand the rationale behind allowing providers of certain residential services to bill for 344 days per year and receive 365 days' worth of funding, it has created barriers for providers. Providers must guess at the beginning of the plan year when vacations or out-of-home time will happen, as it is not consistently planned a full year in advance, so they can balance out planning and billing. Otherwise, they risk getting to the end of the year and finding they cannot bill for three weeks of the final month of the plan year. Difficult especially for Sponsored Residential providers who serve one individual and receive Waiver reimbursement as their sole source of income. **Instead, allowing providers to go without reimbursement for up to two days per month and recoup that income at the end of the plan year based upon days actually spent out of the home would help level off the income dips and offer some safeguards.** As Waiver prohibits individuals from billing more than a year after a service is received and sometimes denials for insignificant reasons occur, **a policy to allow this option with a grace period for the billing would be an appropriate solution.**	Providers are being paid for the delivery of care over 365 days. Please reference extentisve information on the rate methodolgoy on the DBH website. The income methodology has been reviewed and approved by CMS.
3.	DDWAC	1. E.1.c- Change "at least a daily note" to "a Progress Note" [This makes it consistent with other requirements] 2. Move C.3 under letter D [It is under this section in other service descriptions]	Changes are being made to this section to reference documentation requirements in another section. / Changed to D6.
4.	Dville/Pittvania CSB/S. Craddock	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.
5.	Citizen	12VAC30-122-390 - E.1.c - strike "at least a daily note" and replace with "a progress note" - to remain consistent with definition and other sections	See Line 3.
6.	Harrison-Rock'ham CSB/ Slaughbaugh	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.
7.	Hartwood Foundation, Inc.	E1C – Change "daily note" to "**progress note**"	See Line 3.
8.	RBHA/M Harrison	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.
9.	Citizen	1. E.1.c- Change "at least a daily note" to "a Progress Note". This makes it consistent with other requirements. See previous comments under "General Comments". 2. Move C.3 under letter D. It is under this section in other service descriptions.	See Line 3.
10.	Weatherspoon Wall Res, Inc.	1. E.1.c- Change "at least a daily note" to "a Progress Note" [This makes it consistent with other requirements] 2. Move C.3 under letter D [It is under this section in other service descriptions]	See Line 3.
11.	J Ciffizari Wall Res, In.	1. E.1.c- Change "at least a daily note" to "a Progress Note" [This makes it consistent with other requirements] 2. Move C.3 under letter D [It is under this section in other service descriptions]	See Line 3.

12.	Citizen	1. E.1.c- Change “at least a daily note” to “a Progress Note” [This makes it consistent with other requirements] 2. Move C.3 under letter D [It is under this section in other service descriptions]	See Line 3.
13.	Karen Tefelski - vaACCSES	1. E.1.c- Change “at least a daily note” to “a Progress Note” [This makes it consistent with other requirements] 2. Move C.3 under letter D [It is under this section in other service descriptions]	See Line 3.
14.	M. Ingram/Wall Res., Inc.	1. E.1.c- Change “at least a daily note” to “a Progress Note” [This makes it consistent with other requirements] 2. Move C.3 under letter D [It is under this section in other service descriptions]	See Line 3.
15.	R. Ledingham, Wall Res.	E.1.c- Change “at least a daily note” to “a Progress Note” [This makes it consistent with other requirements] Move C.3 under letter D [It is under this section in other service descriptions]	See Line 3.
16.	M. Rosenbaum, Wall Res	1. E.1.c- Change “at least a daily note” to “a Progress Note” [This makes it consistent with other requirements] 2. Move C.3 under letter D [It is under this section in other service descriptions]	See Line 3.
17.	B Huffman - VersAbility Resources	1. E.1.c- Change “at least a daily note” to “a Progress Note” [This makes it consistent with other requirements] 2. Move C.3 under letter D [It is under this section in other service descriptions]	See Line 3.
18.	Citizen	Group Home Residential Service. • E.1.c- Change “at least a daily note” to “a Progress Note”. This makes it consistent with other requirements. See previous comments under “General Comments”. • Move C.3 under letter D. It is under this section in other service descriptions.	See Line 3.
19.	Dominion Waiver/Koke	• E.1.c- Change “at least a daily note” to “a Progress Note”. This makes it consistent with other requirements. See previous comments under “General Comments”. • Move C.3 under letter D. It is under this section in other service descriptions. 12VAC30-122-400 - Group and Individual Supported Employment Service. • Add Employment Services Organizations (ESOs) as qualified providers of Employment & Community Transportation Services. • Add Employment Services Organizations (ESOs) as qualified providers of Peer Mentor Support Services. • Add Employment Services Organizations (ESOs) as qualified providers of Community Guide Services. • A.3.a. – Strike limited” after but reimbursement shall not. (2nd sentence, 4th line) • B.1. – Add “and enrolled in school” after for individuals younger than 22 years of age. Strike “for the individual enrolled in the waiver”. • C.3. – Strike “and individual”. Individual SE must be able to be provided in an individual’s home for purposes of self-employment or other individuals that work from home for other employers (telecommuting, etc.) • C.4. – Strike “service” after employment. Strike “in combination with other day service or residential service” and Change to “concurrently with other waiver services for purposes of job discovery”. Should read as follows: “For time limited and service authorized periods (not to exceed 24 hours) individual supported employment service may be provided in combination with concurrently with other waiver services for purposes of job discovery.” This revision helps with clarity. • D.4. – Second paragraph under this Provider Requirements section is duplicative to 400.A.3.b (Service Description) and is not related to Provider Requirements. • E.1.c. – Sentence needs to be reworked. “Documentation confirming	Changes are being made to this section to reference documentation requirements in another section. / Edits made. / See employment section for remainder of answers as well as in-home

		the individual's time in service" is for Group Supported Employment (GSE) only. "Daily note" is only applicable to GSE as well. Strike "daily note" and insert "progress note" to be consistent with other sections and definition of "progress note" in Section 122-20. • E.1.f. - Sentence needs to be reworked. Should read "Documentation that indicates the date, type of service rendered, and the number of hours provided, including specific timeframe. An attendance log or similar document shall be maintained for Group Supported employment". An attendance log or similar document is not required for ISE since the individual is competitively employed. • E.1.i. – After group, Insert "for Group Supported Employment". 12VAC30-122-410 - In-Home Support Service. • C2 Strike "medically necessary" and replace with "when a health and/or safety issue is present". - C5- Add "Back up plan may include agency support". This is the most viable option for individuals who do not have a primary caregiver. While not specifically stated in the current regulations, families and individuals have historically been advised by case managers that the back-up plan must be a family member. Since an agency is providing the in-home service, it makes sense that a provider could also provide the back-up support. But, it should be optional and clarified that it is an option. • Recommend that In-Home Services hours be authorized quarterly, semi-annually or annually – a "pool" of hours that would include and accommodate "periodic support hours". Current regulations do not limit adding an average number of "periodic support hours". However, in practice, this is an ongoing implementation issue with additional flexible hours not being approved. A longer period of authorization would help allow flexibility when an individual must stay home from group day or employment, community engagement. Most importantly, it supports choice.	
20.	Wormley, Kerns, Collier, Lester, Hauley - VersAbility Rsc	Same as Line3.	See Line 3.
21.	Renon/Wall Res.	Same as Line 10.	See Line 10.
22.	Sean McGinnis, Hartwood Foundation, Inc.	1) The proposed regulations establish "a day" as the unit of service for reimbursement for group home residential support. This is harmful to individuals and residential providers. Reimbursement rates are based on two factors; SIS score and size of home with the SIS score carrying the most weight. The SIS measures intensity, duration and frequency of supports. The latter two variables are significantly effected when an individual stays home (does not attend a day placement/supported employment) for any reason. Along with an aging population that is unable or uninterested in attending available day support options, many of the individuals supported suffer acute and chronic health conditions which increase the intensity, duration and frequency of supports provided (scheduling/coordinating and carrying out medical appointments, eg.) while reducing their attendance to day programs. 2) Periodic Supports for residential supports should be reinstitued for this very reason.	This change would require the approval of the General Assembly and CMS.
23.	K Johnston/Vector Industries	1. E.1.c- Change "at least a daily note" to "a Progress Note" [This makes it consistent with other requirements] 2. Move C.3 under letter D [It is under this section in other service descriptions]	See Line 3.

Comments related to 12VAC30-122-400

2.	DDWAC	1. Add Employment Services Organizations (ESOs) as qualified providers of Employment & Community Transportation Services. 2. Add Employment Services Organizations (ESOs) as qualified providers of Peer Mentor Support Services. 3. Add Employment Services Organizations (ESOs) as qualified providers of Community Guide Services. 4. A.3.a. – Strike "limited" after but reimbursement shall not. (2nd sentence, 4th line) 5. B.1. – Add "and enrolled in school" after for individuals younger than 22 years of age. Strike "for the individual enrolled in the waiver". 6. C.3. – Strike "and individual". Individual SE must be able to be provided in an individual's home for purposes of self-employment or other individuals that work from home for other employers (telecommuting, etc.) 7. C.4. – Strike "service" after employment. Strike "in combination with other day service or residential service"- Change to "concurrently w/other waiver svs for purposes of job discovery". 8. D.4. – Second paragraph under this Provider Requirements section is duplicative to 400.A.3.b (Service Description) and is not related to Provider Requirements. 9. E.1.c. – Sentence needs to be reworked. "Documentation confirming the individual's time in service" is for Group Supported Employment (GSE) only. "Daily note" is only applicable to GSE as well. Strike "daily note" and insert "progress note" to be consistent with other sections and definition of "progress note" in Section 122-20. 10. E.1.f. - Sentence needs to be reworked. Should read "Documentation that indicates the date, type of service rendered, and the number of hours provided, including specific timeframe. An attendance log or similar document shall be maintained for Group Supported Employment". An attendance log or similar document is not required for ISE since the individual is competitively employed. 11. E.1.i. – After group, Insert "for Group Supported Employment".	1. This is a DBHDS regulation. 2. This is a DBHDS regulation. 3. This is a DBHDS regulation. 4. Edits made. 5. Edits made. 6. Edits made. 7. Edits made. 8. Edits made. 9. Edits made. 10. Edits made. 11. Edits made.

3.	Citizen	1. Add Employment Services Organizations (ESOs) as qualified providers of Employment & Community Transportation Services. 2. Add Employment Services Organizations (ESOs) as qualified providers of Peer Mentor Support Services. 3. Add Employment Services Organizations (ESOs) as qualified providers of Community Guide Services. 4. A.3.a. – Strike "limited" after but reimbursement shall not. (2nd sentence, 4th line) 5. B.1. – Add "and enrolled in school" after for individuals younger than 22 years of age. Strike "for the individual enrolled in the waiver". 6. C.3. – Strike "and individual". Individual SE must be able to be provided in an individual's home for purposes of self-employment or other individuals that work from home for other employers (telecommuting, etc.) 7. .4. – Strike "service" after employment. Strike "in combination with other day service or residential service" and Change to "concurrently with other waiver services for purposes of job discovery". Should read as follows: "For time limited and service authorized periods (not to exceed 24 hours) individual supported employment servicemay be provided in combination with concurrently with other waiver services for purposes of job discovery." This revision helps with clarity. 8. CD.4. – Second paragraph under this Provider Requirements section is duplicative to 400.A.3.b (Service Description) and is not related to Provider Requirements. 9. E.1.c. – Sentence needs to be reworked. "Documentation confirming the individual's time in service" is for Group Supported Employment (GSE) only. "Daily note" is only applicable to GSE as well. Strike "daily note" and insert "progress note" to be consistent with other sections and definition of "progress note" in Section 122-20. 10. E.1.f. - Sentence needs to be reworked. Should read "Documentation that indicates the date, type of service rendered, and the number of hours provided, including specific timeframe. An attendance log or similar document shall be maintained for Group Supported Employment". An attendance log or similar document is not required for ISE since the individual is competitively employed. 11. E.1.i. – After group, Insert "for Group Supported Employment".	See Line 2.
4.	VA Board for People with Disabilities	**Subdivision B 1: The Board recommends restricting this provision for clarity as follows:** "Only activities that specifically pertain to the individual shall be allowable activities under this service, and DMAS shall cover this service only after determining that the individual enrolled in the waiver cannot receive this service from DARS or for individuals under 22 years of age, and still enrolled in school, from the local school system.	See Line 2, #5.

5.	Karen Tefelski - vaACCSES	Add Employment Services Organizations (ESOs) as qualified providers of Employment & Community Transportation Services. Add Employment Services Organizations (ESOs) as qualified providers of Peer Mentor Support Services. Add Employment Services Organizations (ESOs) as qualified providers of Community Guide Services. A.3.a. – Strike "limited" after but reimbursement shall not. (2nd sentence, 4th line) B.1. – Add "and enrolled in school" after for individuals younger than 22 years of age. Strike "for the individual enrolled in the waiver". C.3. – Strike "and individual". Individual SE must be able to be provided in an individual's home for purposes of self-employment or other individuals that work from home for other employers (telecommuting, etc.) C.4. – Strike "service" after employment. Strike "in combination with other day service or residential service" and Change to "concurrently with other waiver services for purposes of job discovery". Should read as follows: "For time limited and service authorized periods (not to exceed 24 hours) individual supported employment service may be provided in combination with concurrently with other waiver services for purposes of job discovery." This revision helps with clarity. D.4. – Second paragraph under this Provider Requirements section is duplicative to 400.A.3.b (Service Description) and is not related to Provider Requirements. E.1.c. – Sentence needs to be reworked. "Documentation confirming the individual's time in service" is for Group Supported Employment (GSE) only. "Daily note" is only applicable to GSE as well. Strike "daily note" and insert "progress note" to be consistent with other sections and definition of "progress note" in Section 122-20. E.1.f. - Sentence needs to be reworked. Should read "Documentation that indicates the date, type of service rendered, and the number of hours provided, including specific timeframe. An attendance log or similar document shall be maintained for Group Supported Employment". An attendance log or similar document is not required for ISE since the individual is competitively employed. E.1.i. – After group, Insert "for Group Supported Employment".	See Line 2.
6.	J Orchant Aceto/MVLE	A1. Group and individual supported employment service shall be provided in work settings where persons without disabilities are employed. RESPONSE/ CONCERNS: Is the intent of this statement that individuals are in integrated employment settings with non-disabled peers? It is possible other persons with disabilities can be employed at the same place (think large manufacturing plant/ hotel setting) …. The statement as written can be interpreted as NO OTHER persons with disabilities would be employed at that work setting.	That is not the intent of the statement and is instead intended to ensure that we are not creating work environments for the sole purpose of hiring people with disabilities.

7.	B Martin - CHOICE Group	14. Group and individual supported employment service; C. (3) - Group and individual supported employment service shall take place in nonresidential settings separate from the individual's home. Recommendation – change wording as job development could likely take place in an individual's residence (applying for jobs). (4). For time-limited and service authorized periods (not to exceed 24 hours) individual supported employment service may be provided in combination with day service or residential service for purposes of job discovery – Recommendation – change wording - "Individual supported employment may be provided concurrently (or simultaneously) with other Waiver services for the purposes of job discovery" – Include other Waiver services with which discovery could take place simultaneously using "concurrently" to make the language uniform; E. 1 a-i. This section confuses what is needed for individual and group Supported Employment services. Both services: a and b; d, e, g and h. Individual services: Should state: "Service is documented with a progress note for each service contact. " The definition of the progress note should suffice for the details needed. Here is what was in old regulations: Documentation must confirm the individual's attendance, the amount of time in service and must provide specific information regarding the individual's response to supports agreed upon in the individual's objectives. Results should be available in at least a daily note or weekly summary	C3 and C4 - See Line 2. E1 a-I see Line 2 about separating group documentation and ISE documentation.
8.	B Huffman - VersAbility Resources	Add Employment Services Organizations (ESOs) as qualified providers of Employment & Community Transportation Services. Add Employment Services Organizations (ESOs) as qualified providers of Peer Mentor Support Services. Add Employment Services Organizations (ESOs) as qualified providers of Community Guide Services. A.3.a. – Strike "limited" after but reimbursement shall not. (2nd sentence, 4th line) B.1. – Add "and enrolled in school" after for individuals younger than 22 years of age. Strike "for the individual enrolled in the waiver". C.3. – Strike "and individual". Individual SE must be able to be provided in an individual's home for purposes of self-employment or other individuals that work from home for other employers (telecommuting, etc.) C.4. – Strike "service" after employment. Strike "in combination with other day service or residential service" and Change to "concurrently with other waiver services for purposes of job discovery". Should read as follows: "For time limited and service authorized periods (not to exceed 24 hours) individual supported employment service may be provided in combination with concurrently with other waiver services for purposes of job discovery." This revision helps with clarity. D.4. – Second paragraph under this Provider Requirements section is duplicative to 400.A.3.b (Service Description) and is not related to Provider Requirements. E.1.c. – Sentence needs to be reworked. "Documentation confirming the individual's time in service" is for Group Supported Employment (GSE) only. "Daily note" is only applicable to GSE as well. Strike "daily note" and insert "progress note" to be consistent with other sections and definition of "progress note" in Section 122-20. E.1.f. - Sentence needs to be reworked. Should read "Documentation that indicates the date, type of service rendered, and the number of hours provided, including specific timeframe. An attendance log or	See Line 2.

		similar document shall be maintained for Group Supported Employment". An attendance log or similar document is not required for ISE since the individual is competitively employed. E.1.i. – After group, Insert "for Group Supported Employment".	
9.	Jan Williams, ServiceSource	This section needs clarity as to which statements apply to either GSE or ISE, or to both. A.3.a. includes the phrase "reimbursement shall not be limited for the supervisory activities." The previous regulations used the term "rendered" instead of "limited." Is this an intentional change or an error? We recommend substituting the term "rendered" and striking "limited". B.1. – Add "and enrolled in school" after for individuals younger than 22 years of age. Strike "for ?the individual enrolled in the waiver". ? B.4.a. Add "with or without the individual present" C.3. – Strike "and individual". Individual SE must be able to be provided in an individual's home for purposes of self-employment or other individuals who work from home for other employers (telecommuting, etc.) ? C.4. – Strike "service" after employment. Strike "in combination with other day service or residential service" and substitute reference to Waiver services and strike the parenthetical reference to 24 hours. Expand text after job development. Recommended revision: "For time-limited service authorized periods, individual supported employment may be provided for purposes of job discovery, individualized job development, negotiation with respective employers, and ongoing support necessary to ensure job retention with or without the individual present ". C.7. This documented ineligibility requirement is unclear as to who is responsible for obtaining and/or maintaining ineligibility in records. We recommend that it be the support coordinator's responsibility. D.4. – Second paragraph under this Provider Requirements section is duplicative to 400.A.3.b (Service Description) and is not related to Provider Requirements. STRIKE. E.1.c. – Sentence needs to be reworked. "Documentation confirming the individual's time in service" is for Group Supported Employment (GSE) only. "Daily note" is only applicable to GSE as well. Strike "daily note" and insert "progress note" to be consistent with other sections and definition of "progress note" in Section 122-20. E.1.f. - Sentence needs to be reworked. Should read "*Documentation that indicates the date, type of service rendered, and the number of hours provided, including specific timeframe. An attendance log or similar document shall be maintained for Group Supported Employment*". An attendance log or similar document is not required for ISE since the individual is competitively employed. E.1.i. – After *group,* Insert "for Group Supported Employment".	See Line 2. B.4.a- job discovery and assessment require a person to be present- these are not job development which can be done without the person present. C.7 It can be the case manager's requirement as part of the referral to employment to provide this information but they are still required to have the information.

10.	Citizen	Add Employment Services Organizations (ESOs) as qualified providers of Employment & Community Transportation Services. • Add Employment Services Organizations (ESOs) as qualified providers of Peer Mentor Support Services. • Add Employment Services Organizations (ESOs) as qualified providers of Community Guide Services. • A.3.a. – Strike “limited” after but reimbursement shall not. (2nd sentence, 4th line) • B.1. – Add “and enrolled in school” after for individuals younger than 22 years of age. Strike “for the individual enrolled in the waiver”. • C.3. – Strike “and individual”. Individual SE must be able to be provided in an individual’s home for purposes of self-employment or other individuals that work from home for other employers (telecommuting, etc.) • C.4. – Strike “service” after employment. Strike “in combination with other day service or residential service” and Change to “concurrently with other waiver services for purposes of job discovery”. Should read as follows: “For time limited and service authorized periods (not to exceed 24 hours) individual supported employment service may be provided in combination with concurrently with other waiver services for purposes of job discovery.” This revision helps with clarity. • D.4. – Second paragraph under this Provider Requirements section is duplicative to 400.A.3.b (Service Description) and is not related to Provider Requirements. • E.1.c. – Sentence needs to be reworked. “Documentation confirming the individual’s time in service” is for Group Supported Employment (GSE) only. “Daily note” is only applicable to GSE as well. Strike “daily note” and insert “progress note” to be consistent with other sections and definition of “progress note” in Section 122-20. • E.1.f. - Sentence needs to be reworked. Should read “Documentation that indicates the date, type of service rendered, and the number of hours provided, including specific timeframe. An attendance log or similar document shall be maintained for Group Supported Employment”. An attendance log or similar document is not required for ISE since the individual is competitively employed. • E.1.i. – After group, Insert “for Group Supported Employment”.	See Line 2.
11.	Wormley, Kerns, Collier, Lester, Hauley -VersAbility Rsc	Same as Line 9.	See Line 2.

12.	Henrico Area MHDS	14. Group and individual supported employment service (12VAC30-122-400); A.3.a. Remove the word "limited" from the last sentence. It is an error. B.1. Chance final section to read "younger than 22 years of age who are enrolled in school" to clarify who this affects. C3. Clarify the sentence regarding where the service shall take place. The intent is to ensure community employment. However, many activities such as job development activities like completing applications, discussing job opportunities and even some work from home opportunities may take place in the individual's home. Clarify that the setting should be community based. C.4. change the word in this regulation from "combination" to "concurrently" to insure it is understood that some time may be overlapping in regards to job discovery. C.6.a. eliminate the strict time definition of how long the service can be concurrent; it is not often easy nor is one able to estimate exactly how long it will take for an individual to be "stable". The final sentence should read: "Individual Supported Employment and workplace assistance may be provided concurrently for a time period that leads to stability as defined in their ISP plan. E. 1 a-i. This section confuses what is needed for individual and group Supported Employment services. Both services: a and b; d, e, g and h. Individual services: Should state: "Service is documented with a progress note for each service contact. " The definition of the progress note should suffice for the details needed. Here is what was in old regulations: Documentation must confirm the individual's attendance, the amount of time in service and must provide specific information regarding the individual's response to supports agreed upon in the individual's objectives. Results should be available in at least a daily note or weekly summary. Group SE services: c. Should be amended to conform with work place assistance and individual SE : "Observations of the individual's responses to service shall be available in a daily note or at a minimum, a weekly summary. " "Data shall be collected as described in the plan for supports, reviewed, summarized, and included in the regular progress note documentation." f. and i.	See Line 2. C6a - DMAS is not able to make this change at this time.
13.	Virginia Board for People with Disabilities	Subdivision C 3: The Board recommends striking "and individual" as follows: "Group and individual supported employment service shall take place in nonresidential settings separate from the individual's home." Individual supported employment must be able to be provided in an individual's home for purposes of self-employment or other individuals that work from home for other employers (telecommuting, etc.).	See Line 2.
14.	Virginia Board for People with Disabilities	Subdivision C 4: The Board recommends striking the word "service" after employment, and striking "in combination with other day service or residential service" and revising to "concurrently with other waiver services for purposes of job discovery." The sentence would read as follows: "For time limited and service authorized periods (not to exceed 24 hours) individual supported employment service may be provided in combination with concurrently with day service or residential services for purposes of job discovery." This revision helps with clarity.	See Line 2.

15.	Virginia Board for People with Disabilities	Subdivision D 4: The Board recommends deleting the second paragraph in this subdivision. It is duplicative of Subdivision A 3b ("Service Description") in the same section, and is not related to Provider Requirements.	See Line 2.

Comments related to 12VAC30-122-410

2.	DDWAC	C5- Add "Back up plan may include agency support" [This is the most viable option for individuals who do not have a primary caregiver]	Providers are allowed to send whatever staff are needed to provide the service. If those staff are not available, the individual must have a back up plan.
3.	Dville/Pittvania CSB/S. Craddock	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.
4.	Harrison-Rock'ham CSB/ Slaughbaugh	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.
5.	RBHA/M Harrison	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.
6.	The Arc of VA T. Milling	**In Home Support Services - 12VAC30-122-410 - Section C2;** The reference to medically necessary again may be misinterpreted to mean a physician order is necessary for this service to be provided for 24 hours when briefly needed. The need for the 24 hour support should be documented in the person centered plan. **The Arc of Virginia recommends deleting "medically", in "medically necessary".**	Edits made.
7.	The Arc of VA T. Milling	"The individual shall have a back-up plan for times when in-home supports cannot occur as regularly scheduled". First, this assumes that every person needs back-up when in-home supports has to be cancelled. For some people simply rescheduling the in-home service will work well for them. Second, some people do depend on the supports for daily needs, and may not be able to make their own backup plan and would instead depend on the agency to provide a backup plan. **The Arc of Virginia recommends including agency backup plans for this requirement.**	See Line 2.

8.	Citizen	1. C5- Add "Back up plan may include agency support". This is the most viable option for individuals who do not have a primary caregiver. While not specifically stated in the current regulations, families and individuals have historically been advised by case managers that the back-up plan must be a family member. Since an agency is providing the in-home service, it makes sense that a provider could also provide the back-up support. But, it should be optional and clarified that it is an option. 2. Recommend that In-Home Services hours be authorized quarterly, semi-annually or annually – a "pool" of hours that would include and accommodate "periodic support hours". Current regulations do not limit adding an average number of "periodic support hours". However, in practice, this is an ongoing implementation issue with additional flexible hours not being approved. A longer period of authorization would help allow flexibility when an individual must stay home from group day or employment, community engagement. Most importantly, it supports choice.	1. See Line 2. / 2. IT systems will not allow for this change at this time
9.	VA Board for People with Disabilities	**Subdivision C 5: The Board recommends proactively adding to the requirement for a back-up plan that an agency can provide back-up support.** While not specifically stated in the regulation, families and individuals have historically been advised by case managers that the back-up plan must be a family member. Since an agency is providing the in-home service, it makes sense that they could also provide the back-up support. Some individuals do not have family members who can provide this service. This should also be clarified in the provider manual.	See Line 2.
10.	Karen Tefelski - vaACCSES	C5- Add "Back up plan may include agency support". This is the most viable option for individuals who do not have a primary caregiver. While not specifically stated in the current regulations, families and individuals have historically been advised by case managers that the back-up plan must be a family member. Since an agency is providing the in-home service, it makes sense that a provider could also provide the back-up support. But, it should be optional and clarified that it is an option. Recommend that In-Home Services hours be authorized quarterly, semi-annually or annually – a "pool" of hours that would include and accommodate "periodic support hours". Current regulations do not limit adding an average number of "periodic support hours". However, in practice, this is an ongoing implementation issue with additional flexible hours not being approved. A longer period of authorization would help allow flexibility when an individual must stay home from group day or employment, community engagement. Most importantly, it supports choice.	See Line 8.
11.	K. Black-Hope House	C5- Add "Back up plan may include agency support" [This is the most viable option for individuals who do not have a primary caregiver]	See Line 2.

12.	B Huffman - VersAbility Resources	C5- Add "Back up plan may include agency support". This is the most viable option for individuals who do not have a primary caregiver. While not specifically stated in the current regulations, families and individuals have historically been advised by case managers that the back-up plan must be a family member. Since an agency is providing the in-home service, it makes sense that a provider could also provide the back-up support. But, it should be optional and clarified that it is an option. Recommend that In-Home Services hours be authorized quarterly, semi-annually or annually – a "pool" of hours that would include and accommodate "periodic support hours". Current regulations do not limit adding an average number of "periodic support hours". However, in practice, this is an ongoing implementation issue with additional flexible hours not being approved. A longer period of authorization would help allow flexibility when an individual must stay home from group day or employment, community engagement. Most importantly, it supports choice.	See Line 8.
13.	Citizen	In-Home Support Service. • C5- Add "Back up plan may include agency support". This is the most viable option for individuals who do not have a primary caregiver. While not specifically stated in the current regulations, families and individuals have historically been advised by case managers that the back-up plan must be a family member. Since an agency is providing the in-home service, it makes sense that a provider could also provide the back-up support. But, it should be optional and clarified that it is an option. • Recommend that In-Home Services hours be authorized quarterly, semi-annually or annually – a "pool" of hours that would include and accommodate "periodic support hours". Current regulations do not limit adding an average number of "periodic support hours". However, in practice, this is an ongoing implementation issue with additional flexible hours not being approved. A longer period of authorization would help allow flexibility when an individual must stay home from group day or employment, community engagement. Most importantly, it supports choice.	See Line 8.
14.	Cheryl Emory, Parent & L'Arche Metro Richmond	**"Medically" is problematic in "Medically Necessary"** The term, "Medically Necessary" is a long-standing criteria for health insurance coverage, yet it is not appropriate for disabilities related services such as community engagement, companion care, and supported employment. While managed care is a viable route for cost containment and to promote appropriate services, existing health insurance definitions and methods do not always fit. It seems that we're trying to fit a square peg into a round hole. "Medical necessity" for payment implies that services must have a physician's order and not be developed by the Person-Centered planning process. Please strike the word, "medically" from the term "medically necessary" in the following sections. 12VAC30-122 B 1. - Legal Authority 12VAC30-122-20. Definitions. The term and definition: " 'Medically necessary' means an item or service provided for the diagnosis or treatment of an individual's condition consistent with community standards of medical practice as determined by DMAS" don't fit with some waiver services that are not medical (e.g. community engagement, companion care, and supported employment). Perhaps there is a need to add a definition for necessity that is not medical. 12VAC30-122-120. Provider requirements. A. 5. 12VAC30-122-410. In-home support	Edits made.

		service. C. 2. Note: The term "medically necessary" does seem appropriate for private duty nursing and skilled nursing.	
15.	Wormley, Kerns, Collier, Lester, Hauley -VersAbility Rsc	C5- Add “Back up plan may include agency support”. This is the most viable option for individuals who do not have a primary caregiver. While not specifically stated in the current regulations, families and individuals have historically been advised by case managers that the back-up plan must be a family member. Since an agency is providing the in-home service, it makes sense that a provider could also provide the back-up support. But, it should be optional and clarified that it is an option. Recommend that In-Home Services hours be authorized quarterly, semi-annually or annually – a “pool” of hours that would include and accommodate “periodic support hours”. Current regulations do not limit adding an average number of “periodic support hours”. However, in practice, this is an ongoing implementation issue with additional flexible hours not being approved. A longer period of authorization would help allow flexibility when an individual must stay home from group day or employment, community engagement. Most importantly, it supports choice.	See Line 8.

Comments related to 12VAC30-122-420

2.	Karen Tefelski - vaACCSES	A – Add following receiving this service “lives, or is preparing to live, alone . . .”; strike “typically”. This service should be available to those planning to transition to more independent living and not just those already living independently. A- Add “or FIS waiver” at the end of the last sentence. There are individuals that wish to live independently in the FIS waiver who wish to live independently, particularly transition age you who could benefit from this service. It should not be limited to those already in an independent living setting. C.1.- Add “If the hours consistently exceed 21 hours per month, the individual shall be immediately eligible for a reserve slot.” E.1.c. – add “observations of individual’s responses to services shall be available in Progress notes” E.1.d – strike “and the documentation will correspond with billing”	A. Edits made. A. DMAS is not able to make this change at this time. C1. This would require an increase in the number of waiver slots, and that is not possible without additional approporiations from the General Assembly. E1c. Edits have been

			made to section 12 VAC 30-122-120 E 10 e to require documentation of responses. E1d. DMAS is not able to make this change at this time.
3.	Wormley, Kerns, Collier, Lester, Hauley - VersAbility Rsc	A – Add following receiving this service "lives, or is preparing to live, alone . . ."; strike "typically". This service should be available to those planning to transition to more independent living and not just those already living independently. A- Add "or FIS waiver" at the end of the last sentence. There are individuals that wish to live independently in the FIS waiver who wish to live independently, particularly transition age you who could benefit from this service. It should not be limited to those already in an independent living setting. C.1.- Add "If the hours consistently exceed 21 hours per month, the individual shall be immediately eligible for a reserve slot." E.1.c. – add "observations of individual's responses to services shall be available in Progress notes" E.1.d – strike "and the documentation will correspond with billing"	See Line 2.
4.	Virginia Board for People with Disabilities	Subsection A: The Board recommends revision of the second sentence as follows: "An individual receiving this service typically lives alone <u>or is preparing to live alone</u>." Since this service is designed to provide skill-building necessary to securing and residing in an independent living situation, it should be available to those planning to transition to more independent living, not just those already living independently.	See Line 2.
5.	Virginia Board for People with Disabilities	Subsection A: The Board recommends revision to the final sentence under the service description as follows: "Independent Living support service shall be covered in the BI <u>and FIS waiver</u>." There are many individuals in the FIS waiver who wish to live independently, particularly transition age youth who could benefit from this service. It should not be limited to those already in an independent living setting.	See Line 2.

Comments related to 12VAC30-122-430

2.	DDWAC	1. A- Strike "FIS waiver" Add "all waivers" 2. Strike C.1	1 and 2. DMAS is not able to make these changes at this time.
3.	VA Board for People with Disabilities	**Subdivision 1, The Board recommends striking "the FIS waiver" and adding "in all of the DD waivers."** Individuals and families receiving services through the BI or CL waiver could benefit from this service. There is no logical reason to only include it in the FIS waiver.	DMAS is not able to make these changes at this time.
4.	Karen Tefelski - vaACCSES	A- Strike "FIS waiver" Add "in all of the DD waivers". There is no reason that it is only included in the FIS waiver. Individuals and their families can benefit from this service. Strike C.1	DMAS is not able to make these changes at this time.

5.	B Huffman - VersAbility Resources	A- Strike “FIS waiver” Add “in all of the DD waivers”. There is no reason that it is only included in the FIS waiver. Individuals and their families can benefit from this service. Strike C.1	DMAS is not able to make these changes at this time.
6.	Citizen	A- Strike “FIS waiver” Add “in all of the DD waivers”. There is no reason that it is only included in the FIS waiver. Individuals and their families can benefit from this service	DMAS is not able to make these changes at this time.
7.	Citizen	12VAC30-122-430 - Individual and Family/Caregiver Training Service. • A- Strike “FIS waiver” Add “in all of the DD waivers”. There is no reason that it is only included in the FIS waiver. Individuals and their families can benefit from this service. • Strike C.1	DMAS is not able to make these changes at this time.
8.	Dominion Waiver/Koke	• A- Strike “FIS waiver” Add “in all of the DD waivers”. There is no reason that it is only included in the FIS waiver. Individuals and their families can benefit from this service. • Strike C.1	DMAS is not able to make these changes at this time.
9.	Wormley, Kerns, Collier, Lester, Hauley - VersAbility Rsc	A- Strike “FIS waiver” Add “in all of the DD waivers”. There is no reason that it is only included in the FIS waiver. Individuals and their families can benefit from this service. Strike C.1	DMAS is not able to make these changes at this time.
10.	Virginia Board for People with Disabilities	Subdivision C 1: The Board recommends striking this Subdivision, which states that this service is only available in the FIS waiver.	DMAS is not able to make these changes at this time.

Comments related to 12VAC30-122-440

2.	Citizen	1. This service is now available (Medicaid Memo Sept. 4, 2018). It should be included in the final DD Waiver regulations and out for public comment. 2. The name of this service needs to be consistent. Is it Employment and Community Transportation or Nonmedical Transportation Service. Needs to be consistent between DD Waiver renewals and regulations.	Edits made.
3.	Karen Tefelski - vaACCSES	This service is now available (Medicaid Memo Sept. 4, 2018). It should be included in the final DD Waiver regulations and out for public comment. The name of this service needs to be consistent. Is it Employment and Community Transportation or Nonmedical Transportation Service. Needs to be consistent between DD Waiver renewals and regulations.	Edits made.
4.	B Huffman - VersAbility Resources	This service is now available (Medicaid Memo Sept. 4, 2018). It should be included in the final DD Waiver regulations and out for public comment. The name of this service needs to be consistent. Is it Employment and Community Transportation or Nonmedical Transportation Service. Needs to be consistent between DD Waiver renewals and regulations.	Edits made.
5.	Citizen	12VAC30-122-440 - Nonmedical Transportation Service (Reserved). • This service is now available (Medicaid Memo Sept. 4, 2018). It should be included in the final DD Waiver regulations and out for public comment. • The name of this service needs to be consistent. Is it Employment and Community Transportation or Nonmedical Transportation Service. Needs to be consistent between DD Waiver renewals and regulations	Edits made.

6.	Dominion Waiver/Koke	• This service is now available (Medicaid Memo Sept. 4, 2018). It should be included in the final DD Waiver regulations and out for public comment. • The name of this service needs to be consistent. Is it Employment and Community Transportation or Nonmedical Transportation Service. Needs to be consistent between DD Waiver renewals and regulations.	Edits made.
7.	Wormley, Kerns, Collier, Lester, Hauley - VersAbility Rsc	This service is now available (Medicaid Memo Sept. 4, 2018). It should be included in the final DD Waiver regulations and out for public comment. The name of this service needs to be consistent. Is it Employment and Community Transportation or Nonmedical Transportation Service. Needs to be consistent between DD Waiver renewals and regulations.	Edits made.
8.	Virginia Board for People with Disabilities	This section is reserved; however nonmedical transportation is now an available service and the Board recommends that the regulations address this service.	Edits made.

Comments related to 12VAC30-122-450

2.	VA Board for People with Disabilities	**This section is reserved; however peer supports is a service currently in effect (although not being provided) and the Board recommends addressing it in the regulations.**	Edits made.
3.	Karen Tefelski - vaACCSES	This service is now available (Medicaid Memo September 4, 2018). It should be included in the final DD Waiver regulations and out for public comment.	Edits made.
4.	B Huffman - VersAbility Resources	This service is now available (Medicaid Memo September 4, 2018). It should be included in the final DD Waiver regulations and out for public comment.	Edits made.
5.	Citizen	Peer Support Service (reserved). • This service is now available (Medicaid Memo September 4, 2018). It should be included in the final DD Waiver regulations and out for public comment.	Edits made.
6.	Dominion Waiver/Koke	• This service is now available (Medicaid Memo September 4, 2018). It should be included in the final DD Waiver regulations and out for public comment.	Edits made.
7.	Wormley, Kerns, Collier, Lester, Hauley - VersAbility Rsc	This service is now available (Medicaid Memo September 4, 2018). It should be included in the final DD Waiver regulations and out for public comment.	Edits made.

Comments related to 12VAC30-122-460

2.	Lucy Beadnell, Virginia Ability Alliance	Proposed regs don't allow personal care to be billed in conjunction with skilled nursing. Challenge for those receiving both services. It is not reasonable to ask that an individual with Waiver having a nurse come for a brief nursing visit would be able to have their personal care attendant leave during that time and return once the nurse leaves, or to sit by without pay during the visit. The problem is compounded as personal care attendant is the person who will be able to provide private	A nursing provider can provide personal care as part of their

		personal care that the nurse may not be best suited to giving during the visit. **Suggest allowing some overlap of billing for times when skilled nurses are making brief visits and regularly scheduled personal care is still needed.**	service provision.
3.	Lucy Beadnell, Virginia Ability Alliance	Regs allow personal care attendants in combination with group or individual supported employment, unless individual is living in group home or sponsored residential situation. This loophole creates an unnecessary hurdle to accessing employment for people living in either group or sponsored residential situations.	Edits made.
4.	Lucy Beadnell, Virginia Ability Alliance	Regs should clarify that, for individuals needing personal care attendant with them while accessing community guide services, service overlap should be allowed as the community guide does not provide personal care supports. For similar reasons, community engagement should allow for the simultaneous provision of personal care services.	Community guide service has been amended to allow for the provision of ADLs as needed. Check with Donna on specific language. Add an allowable activity to community engagement for the provision of ADLs as needed.
5.	DDWAC	1. A.4- Change to “all waivers” 2. B.4.e. correct spelling of “activities” 3. C.7.a & b.- Strike all references to “Companion” and replace with “Personal Assistance”	DMAS is not able to make this change at this time. / Edits made. / Edits made.
6.	Dville/Pittvania CSB/S. Craddock	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.
7.	Citizen	12VAC30-122-460 - strike all references to "companion" and replace with "Personal Assistance" B.4.E - strike "actitivities" and replace with "activities"	Edits made.
8.	Harrison-Rock’ham CSB/ Slaughbaugh	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.
9.	RBHA/M Harrison	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.

10.	Citizen	1. A.3. – Add “Personal Assistance can be provided simultaneously with supported employment services and can be billed concurrently”. The provision currently states that an additional component of personal assistance services is to aid and supports to individuals in the work place, with the final sentence stating, “Work related personal assistance service shall not duplicate supported employment service.” The addition of the suggested sentence at the end of this section clarifies that both can be provided at the same time and that they are distinctly different services. 2. A.4- Change to “in all DD waivers”. As previously stated, it is unclear why this service is not available in the BI waiver. Individuals in the BI waiver are more likely individuals with physical developmental disabilities who may require personal assistance services in order to live independently in their homes. PA services can be critical to this population. 3. C.7.a & b.- Strike “Companion” Add “Personal Assistance”. This is a typographical error.	The regulations permit this. / 2. DMAS is not able to make this change at this time / 3. Edits made.
11.	Karen Tefelski - vaACCSES	A.3. – Add “Personal Assistance can be provided simultaneously with supported employment services and can be billed concurrently”. The provision currently states that an additional component of personal assistance services is to aid and supports to individuals in the work place, with the final sentence stating, “Work related personal assistance service shall not duplicate supported employment service.” The addition of the suggested sentence at the end of this section clarifies that both can be provided at the same time and that they are distinctly different services. A.4- Change to “in all DD waivers”. As previously stated, it is unclear why this service is not available in the BI waiver. Individuals in the BI waiver are more likely individuals with physical developmental disabilities who may require personal assistance services in order to live independently in their homes. PA services can be critical to this population. C.7.a & b.- Strike “Companion” Add “Personal Assistance”. This is a typographical error.	See Line 11.
12.	Beth Martin, The Choice Group	A.3. – Add “Personal Assistance can be provided simultaneously with supported employment services and can be billed concurrently”. The provision currently states that an additional component of personal assistance services is to aid and supports to individuals in the work place, with the final sentence stating, “Work related personal assistance service shall not duplicate supported employment service.” The addition of the suggested sentence at the end of this section clarifies that both can be provided at the same time and that they are distinctly different services.	The regulations permit this.
13.	B Huffman - VersAbility Resources	A.3. – Add “Personal Assistance can be provided simultaneously with supported employment services and can be billed concurrently”. The provision currently states that an additional component of personal assistance services is to aid and supports to individuals in the work place, with the final sentence stating, “Work related personal assistance service shall not duplicate supported employment service.” The addition of the suggested sentence at the end of this section clarifies that both can be provided at the same time and that they are distinctly different services. A.4- Change to “in all DD waivers”. As previously stated, it is unclear why this service is not available in the BI waiver. Individuals in the BI waiver are more likely individuals with physical developmental	See Line 11.

		disabilities who may require personal assistance services in order to live independently in their homes. PA services can be critical to this population. C.7.a & b.- Strike "Companion" Add "Personal Assistance". This is a typographical error.	
14.	C Skelly, DD Committee, Arlington CSB	**Concurrent Billing for Skilled Nursing, Private Duty Nursing, and Personal Care Attendant.** These are three different services that need to collaborate and work together in order to ensure the health of a client. The person who provides personal care should be present while a client is being seen and/or monitored by a nurse. The skilled nurse overseeing the work of a private duty nurse needs to be in the same place at the same time. These regulations don't make sense and can jeopardize care for our most fragile clients, forcing them into institutions (page 3 of the VAA letter).	Concurrent billing would be a duplication of services. Nurses are permitted to assist with personal care or personal care attendants can provide delegated care when the nurse is not present.
15.	C Skelly, DD Committee, Arlington CSB	**Concurrent Billing for Personal Care Attendants with Group or Individual Supported Employment.** The current regulations disallow billing for personal care attendants for supported employment if the person lives in a group home or sponsored residential situation. This regulation prevents individuals who are otherwise employable, from being able to receive group or individual supported employment due to their personal care needs. Olmstead requires support for integrated employment regardless of the level of disability, so this prohibition should be eliminated (p. 3 of the VAA letter).	The regulations permit this.

16.	Beatty/VA Alliance	1) The proposed Waiver regulations prohibit the same person from receiving both Private Duty Nursing and Skilled Nursing. This has been a concern for families whose loved ones using Waivers have significant nursing needs that require ongoing nursing care through PDN, but also significant skilled oversight that realistically only comes with a nursing case manager. If the regulations were to allow limited hours of Skilled Nursing for those people whose nursing needs are beyond what can reasonably be covered with the limited oversight funded in the Private Duty Nursing rate as demonstrated by history, it would prevent institutionalization for some of the most medically at-risk individuals in our system. 2) The proposed regulations do not allow personal care to be billed in conjunction with skilled nursing. For individuals who receive both services, this is a challenge. It is not reasonable to ask that an individual with Waiver having a nursing come for a brief nursing visit would be able to have their personal care attendant leave during that time and return once the nurse leaves, or to sit by without pay during the visit. The problem is compounded as personal care attendant is the person who will be able to provide private personal care that the nurse may not be best suited to giving during the visit. We suggest allowing some overlap of billing for times when skilled nurses are making brief visits and regularly scheduled personal care is still needed. 3) The Waiver regulations allow the use of personal care attendants in combination with group or individual supported employment, unless the individual is living in a group home or sponsored residential situation. This loophole creates an unnecessary hurdle to accessing employment for people living in either group or sponsored residential situations. 4) Regulations should clarify that, for individuals needing a personal care attendant with them while accessing community guide services, service overlap should be allowed as the community guide does not provide personal care supports. For similar reasons, community engagement should allow for the simultaneous provision of personal care services.	Skilled nurses provide PDN and any oversight is included in the responsibility and that rate for PDN if so needed by the individual/2. see above/3. fixed /4. addressed
17.	Citizen	12VAC30-122-460 - Personal assistance service. • A.3. – Add “Personal Assistance can be provided simultaneously with supported employment services and can be billed concurrently”. The provision currently states that an additional component of personal assistance services is to aid and supports to individuals in the work place, with the final sentence stating, “Work related personal assistance service shall not duplicate supported employment service.” The addition of the suggested sentence at the end of this section clarifies that both can be provided at the same time and that they are distinctly different services. • A.4- Change to “in all DD waivers”. As previously stated, it is unclear why this service is not available in the BI waiver. Individuals in the BI waiver are more likely individuals with physical developmental disabilities who may require personal assistance services in order to live independently in their homes. PA services can be critical to this population. • C.7.a & b.- Strike “Companion” Add “Personal Assistance”. This is a typographical error.	The regulations permit this. / DMAS is not able to make this change at this time. / Edits made.

18.	Dominion Waiver/Koke	• A.3. – Add "Personal Assistance can be provided simultaneously with supported employment services and can be billed concurrently". The provision currently states that an additional component of personal assistance services is to aid and supports to individuals in the work place, with the final sentence stating, "Work related personal assistance service shall not duplicate supported employment service." The addition of the suggested sentence at the end of this section clarifies that both can be provided at the same time and that they are distinctly different services. • A.4- Change to "in all DD waivers". As previously stated, it is unclear why this service is not available in the BI waiver. Individuals in the BI waiver are more likely individuals with physical developmental disabilities who may require personal assistance services in order to live independently in their homes. PA services can be critical to this population. • C.7.a & b.- Strike "Companion" Add "Personal Assistance". This is a typographical error.	See Line 11.
19.	Wormley, Kerns, Collier, Lester, Hauley -VersAbility Rsc	A.3. – Add "Personal Assistance can be provided simultaneously with supported employment services and can be billed concurrently". The provision currently states that an additional component of personal assistance services is to aid and supports to individuals in the work place, with the final sentence stating, "Work related personal assistance service shall not duplicate supported employment service." The addition of the suggested sentence at the end of this section clarifies that both can be provided at the same time and that they are distinctly different services. A.4- Change to "in all DD waivers". As previously stated, it is unclear why this service is not available in the BI waiver. Individuals in the BI waiver are more likely individuals with physical developmental disabilities who may require personal assistance services in order to live independently in their homes. PA services can be critical to this population. C.7.a & b.- Strike "Companion" Add "Personal Assistance". This is a typographical error.	See Line 11.
20.	Maureen Hollowell, VA Assoc of Centers for Independent Living	1) C.6. Add that skilled nursing services can be performed as allowed by 54-1-2901.A.31. which allows for health care tasks to be directed in limited circumstances based on the capability of the individual to direct the skilled service. 2) C.10. The personal assistance service should be permitted under the FIS or CL Waiver, if the specific task the individual under 21 needs to have performed is not covered by EPSDT.	1. Edits made. / 2. need to remove #10 when we change our amendment
21.	Virginia Board for People with Disabilities	Subdivision A 3: the Board recommends adding the following sentence at the end of this subdivision: "Personal assistance can be provided simultaneously with supported employment services and can be billed concurrently." The provision currently states that an additional component of personal assistance services is to aid and supports to individuals in the work place, with the final sentence stating, "Work related personal assistance service shall not duplicate supported employment service." The addition of the suggested sentence at the end of this section clarifies that both can be provided at the same time and that they are distinctly different services.	See Line 11.
22.	Virginia Board for People with Disabilities	Subdivision A 4: The Board recommends modifying as follows: "Personal assistance shall be covered in the FIS and CL waiver in all DD Waivers." As noted previously, it is unclear why this service is not available in the Building Independence (BI) waiver. Individuals in this waiver are more likely individuals with physical developmental disabilities who may require personal assistance services in order to live	See Line 11.

		independently in their homes. Personal assistance services can be critical to this population.	
23.	Virginia Board for People with Disabilities	Subdivisions C 7a & C 7b: The Board recommends striking the term “companion” and replacing it with “personal assistance.” This is a typographical error as this section covers personal assistance services.	See Line 11.
24.	Virginia Board for People with Disabilities	Subdivision C 10: The Board recommends that DMAS closely review all available data regarding the authorization and utilization of personal care since the requirement to provide these solely through EPSDT was put into place. The results of any study/review should be made public. While it appears that a solution may be at hand and the situation resolved shortly, the Board is concerned with the prohibition of personal assistance services to individuals under the age of 21 who are eligible for such services under the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT). There are continuing reports of parents being denied personal care services for their children despite significant needs. EPSDT provides medically necessary services and decisions are made based on medical necessity. Not all personal care services are necessarily medically necessary. The expectation that parents provide these services does not account for parents who work outside the household and need this essential support in order to keep their child at home. This is an issue under the CCC Plus waiver as well, where there are significant numbers of families complaining that personal care (and nursing) services are being denied or reduced.	DMAS does not have the ability to perform this study at this time.

Changes related to 12VAC30-122-470

K. Black-Hope House	B. Strike ‘when there is no one else in the home with the individual enrolled in the wavier who is competent or continuously available to call for help in an emergency’ and replace with ‘when the need is identified in the individual’s ISP and will support the individual living safely and independently in the least restrictive community setting’.	This service is designed for individuals when there is no one else available to assist.

Changes related to 12VAC30-122-480

2.	Lucy Beadnell, Virginia Ability Alliance	Prohibiting same person from receiving both Private Duty Nursing and Skilled Nursing. Concern for individuals in Waivers who have significant nursing needs that require ongoing nursing care through PDN, but also significant skilled oversight that only comes with a nursing case manager. **If the regulations were to allow limited hours of Skilled Nursing for those people whose nursing needs are beyond what can reasonably be covered with the limited oversight funded in the Private Duty Nursing rate as demonstrated by history, it would prevent institutionalization for some of the most medically at-risk individuals in our system**.	Skilled nursing and oversight are allowed in PDN. More information will be provided in the manual .

3.	Karen Tefelski - vaACCSES	Support the recommendation by the Virginia Board for People with Disabilities (VBPD) that DMAS undertake an intensive review of all available data regarding the authorization of private duty nursing since the requirement to provide this service solely through EPSDT was put into place in order to determine, on a systemic level, whether families are being adequately served. The results of any study/review should be made public. Families that receive significantly reduced hours of skilled or private duty nursing or both can end up in a position where they would have to choose institutional over home and community-based care This is inconsistent with he requirement of the DOJ Settlement Agreement and incongruent with the stated desire to improve care and keep children at home with their families.	Private Duty Nursing has been studied by DMAS and a General Assembly report is forthcoming.
4.	B Huffman - VersAbility Resources	Support the recommendation by the Virginia Board for People with Disabilities (VBPD) that DMAS undertake an intensive review of all available data regarding the authorization of private duty nursing since the requirement to provide this service solely through EPSDT was put into place in order to determine, on a systemic level, whether families are being adequately served. The results of any study/review should be made public. Families that receive significantly reduced hours of skilled or private duty nursing or both can end up in a position where they would have to choose institutional over home and community-based care This is inconsistent with he requirement of the DOJ Settlement Agreement and incongruent with the stated desire to improve care and keep children at home with their families.	See Line 3.
5.	C Skelly, DD Committee, Arlington CSB	**Concurrent Billing for Skilled Nursing, Private Duty Nursing, and Personal Care Attendant.** These are three different services that need to collaborate and work together in order to ensure the health of a client. The person who provides personal care should be present while a client is being seen and/or monitored by a nurse. The skilled nurse overseeing the work of a private duty nurse needs to be in the same place at the same time. These regulations don't make sense and can jeopardize care for our most fragile clients, forcing them into institutions (page 3 of the VAA letter).	Skilled nursing and oversight are allowed in PDN. More information will be provided in the manual. New #4 PDN is not meant to be delivered at the same time as personal care but may be approved by DBHDS.

6.	Beatty/VA Alliance	1) The proposed Waiver regulations prohibit the same person from receiving both Private Duty Nursing and Skilled Nursing. This has been a concern for families whose loved ones using Waivers have significant nursing needs that require ongoing nursing care through PDN, but also significant skilled oversight that realistically only comes with a nursing case manager. If the regulations were to allow limited hours of Skilled Nursing for those people whose nursing needs are beyond what can reasonably be covered with the limited oversight funded in the Private Duty Nursing rate as demonstrated by history, it would prevent institutionalization for some of the most medically at-risk individuals in our system. 2) The proposed regulations do not allow personal care to be billed in conjunction with skilled nursing. For individuals who receive both services, this is a challenge. It is not reasonable to ask that an individual with Waiver having a nursing come for a brief nursing visit would be able to have their personal care attendant leave during that time and return once the nurse leaves, or to sit by without pay during the visit. The problem is compounded as personal care attendant is the person who will be able to provide private personal care that the nurse may not be best suited to giving during the visit. We suggest allowing some overlap of billing for times when skilled nurses are making brief visits and regularly scheduled personal care is still needed. 3) The Waiver regulations allow the use of personal care attendants in combination with group or individual supported employment, unless the individual is living in a group home or sponsored residential situation. This loophole creates an unnecessary hurdle to accessing employment for people living in either group or sponsored residential situations. 4) Regulations should clarify that, for individuals needing a personal care attendant with them while accessing community guide services, service overlap should be allowed as the community guide does not provide personal care supports. For similar reasons, community engagement should allow for the simultaneous provision of personal care services.	1. Skilled nursing and oversight are allowed in PDN. More information will be provided in the manual. 2. DMAS will consider this comment. Skilled nursing is meant to be intermittent. Personal care is an ongoing service. 3. Edits made. 4. Language under Community Guide addresses this comment.
7.	Citizen	Private Duty Nursing Service. • Support the recommendation by the Virginia Board for People with Disabilities (VBPD) that DMAS undertake an intensive review of all available data regarding the authorization of private duty nursing since the requirement to provide this service solely through EPSDT was put into place in order to determine, on a systemic level, whether families are being adequately served. The results of any study/review should be made public. Families that receive significantly reduced hours of skilled or private duty nursing or both can end up in a position where they would have to choose institutional over home and community-based care This is inconsistent with he requirement of the DOJ Settlement Agreement and incongruent with the stated desire to improve care and keep children at home with their families.	See Line 3.
8.	Dominion Waiver/Koke	• Support the recommendation by the Virginia Board for People with Disabilities (VBPD) that DMAS undertake an intensive review of all available data regarding the authorization of private duty nursing since the requirement to provide this service solely through EPSDT was put into place in order to determine, on a systemic level, whether families are being adequately served. The results of any study/review should be made public. Families that receive significantly reduced hours of skilled or private duty nursing or both can end up in a position where they would have to choose institutional over home and community-based care. This is inconsistent with the requirement of the DOJ Settlement Agreement	See Line 3.

		and incongruent with the stated desire to improve care and keep children at home with their families.	
9.	Wormley, Kerns, Collier, Lester, Hauley - VersAbility Rsc	Support the recommendation by the Virginia Board for People with Disabilities (VBPD) that DMAS undertake an intensive review of all available data regarding the authorization of private duty nursing since the requirement to provide this service solely through EPSDT was put into place in order to determine, on a systemic level, whether families are being adequately served. The results of any study/review should be made public. Families that receive significantly reduced hours of skilled or private duty nursing or both can end up in a position where they would have to choose institutional over home and community-based care. This is inconsistent with the requirement of the DOJ Settlement Agreement and incongruent with the stated desire to improve care and keep children at home with their families.	See Line 3.
10.	Virginia Board for People with Disabilities	Subdivision C 3: The Board recommends DMAS undertake an intensive review of all available data regarding the authorization and utilization of private duty nursing since the requirement to provide this service solely through EPSDT was put into place in order to determine, on a systemic level, whether families are being adequately served. The results of any study/review should be made public. While it appears as though there may be a resolution to this issue shortly, the Board is concerned about significant numbers of families complaining about reductions in nursing hours for their children who now have to access this service under EPSDT. The Board does not have specific information that would denote whether these complaints relate to skilled or private duty nursing or both. Families who receive significantly reduced hours of this critical service can end up in the position where they would have to choose institutional over home- and community-based care. This is inconsistent with the requirement of the Commonwealth's Settlement Agreement with the Department of Justice and incongruent with the stated desire to improve care and keep children at home with their families.	See Line 3.

Comments related to 12VAC30-122-490

2.	Dville/Pittvania CSB/S. Craddock	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made
3.	Harrison-Rock'ham CSB/ Slaughbaugh	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made
4.	RBHA/M Harrison	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made

Comments related to 12 VAC30-122-500

2.	Lucy Beadnell, Virginia Ability Alliance	At least one CSB is offering families the option to receive Consumer Directed services without a Service Facilitator, if the family is willing to act in that role without pay. Regulations should clarify whether or not this is allowed, and in what circumstances.	This is already permitted.

3.	Parent of Two Adult Sons with Fragile X, Fairfax, VA	**Nix SFs, Regulate Service Providers, Day Programs** 1. Support Facilitators (SF). We have experienced their required involvement with our family for over 10 years now and I believe they are a complete waste of time, energy, money, and source of harassment. We have had many with various companies with their main focus always being to get their monthly visits done, as quickly as possible, so they can collect payment. I ask: Why was this role created? What are they intended to be doing? A complete disconnect exists between whatever this is and what they actually do. I believe each SF I have met believes the same thing too- that their role is chicanery, unnecessary; perhaps this explains their high turnover rate. Even the things they are required to do for us (approve hours/services, act as intermediary with fiscal agent) interfere with the quality of service we receive from our indispensable CSB Support Coordinators (SC). Our SCs complain that they are delayed in getting things done for our family because they have to wait for the SF to do their part, when they could do the same thing in much less time. I ask: how are SFs even qualified to assess the approval of more hours when it is the SCs who best know this and primarily make these recommendations? Support Facilitators do absolutely nothing to support our needs and need to be eliminated! The little that they are responsible for is best served by Support Coordinators. The funding expended for SFs needs to be rerouted for a better use;	In order to receive CD services, the family is not required to have a SF if a family member would like to perform that role as an unpaid facilitator.
4.	Maureen Hollowell, VA Assoc of Centers for Independent Living	Previous regulation required the use of a DMAS-95 Addendum to assist with determining if the individual could be the EOR. If this document is no longer required, a similar process should be established.	This was required under the DD waiver, but not under the ID waiver. This will be taken into consideration, and any changes will be included in the manual.
5.	Virginia Board for People with Disabilities	The Board recommends re-examining the role of the consumer-directed services facilitator to eliminate unnecessary duplication of functions and more clearly delineate the roles of services facilitators, support coordinators, and CCC Plus care coordinators. Service facilitators, support coordinators, and CCC Plus care coordinators are all responsible for monitoring waiver services. This can result in duplication of effort, diffusion of responsibility, confusion, and reduced individual ownership of responsibility. It can also unduly burden individuals who must accommodate multiple home visits and assessments. When various parties have overlapping roles, DMAS should either distinguish how each party's contribution to the overall role differs from the others' contributions or, if the contributions do not differ, consolidate the role under fewer parties. If the majority of the service facilitator's roles are also shared by other parties, which appears to be the case, DMAS should also consider transferring the remaining roles (such as training employers of record and reviewing timesheets) to the other parties and eliminating the service facilitator position. The cost of this service should be analyzed in relation to the benefit achieved for the funding agency and the consumer.	Further information will be provided in the manual.

6.	Virginia Board for People with Disabilities	Subdivisions B 3, B 4, and B 8: The Board recommends changes that would ensure that these subdivisions, which address face-to-face meetings between the individual and the service facilitator, be consistent with one another. Subdivision B 3 states that face-to-face meetings shall occur between the service facilitator and the individual at least every six months. However, Subdivisions B 4 and B 8 refer to quarterly routine visits. The Board recommends every six months per Subdivision B 3, unless the individual requires or requests more frequent contact.	Edits made.
7.	Virginia Board for People with Disabilities	Subdivision 500 C 1: The Board recommends modifying the last sentence of this subdivision to state, "The support coordinator shall document in the individual's record that the individual can serve as the EOR or if there is a need or desire for another person to serve as the EOR on behalf of the individual." Individuals who are capable of, but unwilling to, direct their own care should be allowed to designate an EOR if desired.	Edits made.

Comments related to 12VAC30-122-510

2.	Henrico Area MHDS	B. 4.a. Include a definition of fellowship	Definition added.
3.	The Arc of VA T. Milling	**Shared Living Support Services - 12VAC30-122-510**; This is a service that has had a difficult time getting off the ground, but it is an excellent service that could benefit some people. However, the administrative payment to the provider does not cover the services they are asked to provide in this definition. In the regulation is it unclear how often the provider is eligible for the flat fee noted. **The Arc of Virginia believes in the value of this service and recommends that the method for administrative fees be reconsidered. Similar to the Federal program Ticket to Work, an up-front small payment to a provider for beginning a case with someone, followed by subsequent lump payments upon evidence of the desired outcome, could incentivize providers to innovate. Additionally we recommend a minimum of $5,000 per year for the administrative fee.**	A funding mechanism has been identified at DBHDS for these services. Any funding increases would require General Assembly authorization.
4.	Henrico Area MHDS	Include a definition of fellowship	Definition added.
5.	H Denman/Arc of Harrisonburg	This is a service that has had a difficult time getting off the ground, but it is an excellent service that could benefit some people. However, the administrative payment to the provider does not cover the services they are asked to provide in this definition. In the regulation is it unclear how often the provider is eligible for the flat fee noted. The Arc of Harriosnburg and Rockingham believes in the value of this service and recommends that the method for administrative fees be reconsidered. Similar to the Federal program Ticket to Work, an up front small payment to a provider for beginning a case with someone, followed by subsequent lump payments upon evidence of the desired outcome, could incentivize providers to innovate. Additionally we recommend a minimum of $5,000 per year for the administrative fee.	A funding mechanism has been identified at DBHDS for these services. Any funding increases would require General Assembly authorization.

Comments related to 12VAC30-122-520

2.	VA Board for People with Disabilities	Subdivision B 4: The Board recommends DMAS undertake an intensive review of all available data regarding the authorization and utilization of skilled nursing since the requirement to provide this service solely through EPSDT was put into place in order to determine, on a systemic level, whether families are being adequately served. The results of any study/review should be made public. While it appears as though there may be a resolution to this issue shortly, the Board is concerned about significant numbers of families complaining about reductions in nursing hours for their children who now have to access this serve under EPSDT. The Board does not have specific information that would denote whether these complaints relate to skilled or private duty nursing or both. Families who receive significantly reduced hours of this critical service can end up in the position where they would have to choose institutional over home and-community-based care. This is inconsistent with the requirement of the Commonwealth's Settlement Agreement with the Department of Justice and incongruent with the stated desire to improve care and keep children at home with their families.	Private Duty Nursing has been studied by DMAS and a General Assembly report is forthcoming.
3.	Karen Tefelski - vaACCSES	Support the recommendation by the Virginia Board for People with Disabilities (VBPD) that DMAS undertake an intensive review of all available data regarding the authorization of private duty nursing since the requirement to provide this service solely through EPSDT was put into place in order to determine, on a systemic level, whether families are being adequately served. The results of any study/review should be made public. Families that receive significantly reduced hours of skilled or private duty nursing or both can end up in a position where they would have to choose institutional over home and community-based care This is inconsistent with he requirement of the DOJ Settlement Agreement and incongruent with the stated desire to improve care and keep children at home with their families.	See Line 2.
4.	B Huffman - VersAbility Resources	Support the recommendation by the Virginia Board for People with Disabilities (VBPD) that DMAS undertake an intensive review of all available data regarding the authorization of private duty nursing since the requirement to provide this service solely through EPSDT was put into place in order to determine, on a systemic level, whether families are being adequately served. The results of any study/review should be made public. Families that receive significantly reduced hours of skilled or private duty nursing or both can end up in a position where they would have to choose institutional over home and community-based care This is inconsistent with he requirement of the DOJ Settlement Agreement and incongruent with the stated desire to improve care and keep children at home with their families.	See Line 2.
5.	C Skelly, DD Committee, Arlington CSB	**Concurrent Billing for Skilled Nursing, Private Duty Nursing, and Personal Care Attendant.** These are three different services that need to collaborate and work together in order to ensure the health of a client. The person who provides personal care should be present while a client is being seen and/or monitored by a nurse. The skilled nurse overseeing the work of a private duty nurse needs to be in the same place at the same time. These regulations don't make sense and can jeopardize care for our most fragile clients, forcing them into institutions (page 3 of the VAA letter).	Concurrent billing would be a duplication of services. Nurses are permitted to assist with personal care or personal care attendants can provide delegated

			care when the nurse is not present.
6.	Beatty/VA Alliance	1) The proposed Waiver regulations prohibit the same person from receiving both Private Duty Nursing and Skilled Nursing. This has been a concern for families whose loved ones using Waivers have significant nursing needs that require ongoing nursing care through PDN, but also significant skilled oversight that realistically only comes with a nursing case manager. If the regulations were to allow limited hours of Skilled Nursing for those people whose nursing needs are beyond what can reasonably be covered with the limited oversight funded in the Private Duty Nursing rate as demonstrated by history, it would prevent institutionalization for some of the most medically at-risk individuals in our system. 2) The proposed regulations do not allow personal care to be billed in conjunction with skilled nursing. For individuals who receive both services, this is a challenge. It is not reasonable to ask that an individual with Waiver having a nursing come for a brief nursing visit would be able to have their personal care attendant leave during that time and return once the nurse leaves, or to sit by without pay during the visit. The problem is compounded as personal care attendant is the person who will be able to provide private personal care that the nurse may not be best suited to giving during the visit. We suggest allowing some overlap of billing for times when skilled nurses are making brief visits and regularly scheduled personal care is still needed. 3) The Waiver regulations allow the use of personal care attendants in combination with group or individual supported employment, unless the individual is living in a group home or sponsored residential situation. This loophole creates an unnecessary hurdle to accessing employment for people living in either group or sponsored residential situations. 4) Regulations should clarify that, for individuals needing a personal care attendant with them while accessing community guide services, service overlap should be allowed as the community guide does not provide personal care supports. For similar reasons, community engagement should allow for the simultaneous provision of personal care services.	1. Will be adding clarifying language. Skilled nursing and oversight are allowed in PDN. 2. Nursing provider can provide personal care as part of their service provision.
7.	Citizen	Skilled Nursing Service. • See comment above regarding Private Duty Nursing Service and support of the VBPD recommendation.	Concurrent billing would be a duplication of services. Nurses are permitted to assist with personal care or personal care attendants can provide delegated care when the nurse is not present.
8.	Dominion Waiver/Koke	• See comment above regarding Private Duty Nursing Service and support of the VBPD recommendation.	See Line 2.

9.	Wormley, Kerns, Collier, Lester, Hauley - VersAbility Rsc	Support the recommendation by the Virginia Board for People with Disabilities (VBPD) that DMAS undertake an intensive review of all available data regarding the authorization of private duty nursing since the requirement to provide this service solely through EPSDT was put into place in order to determine, on a systemic level, whether families are being adequately served. The results of any study/review should be made public. Families that receive significantly reduced hours of skilled or private duty nursing or both can end up in a position where they would have to choose institutional over home and community-based care This is inconsistent with he requirement of the DOJ Settlement Agreement and incongruent with the stated desire to improve care and keep children at home with their families.	See Line 2.

Comments related to 12VAC30-122-530

2.	DDWAC	1. E.1.c.- Strike “confirming the amount of the individual’s time in service and” 2. E.1.c.- End of second sentence strike “at least a daily note” add “in a progress note” This makes documentation consistent]	1 and 2: Edits made. Documentation requirements will be consistent with 12VAC30-122-120.
3.	Dville/Pittvania CSB/S. Craddock	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.
4.	Citizen	12VAC30-122-530 - E.1.c - strike "confirming the amount of the individual's time in service and" - as Sponsor Residential no longer bills hourly the current language is not consistent E.1.c. - end of second sentence strike "at least a daily note" add "in a progress note"	See Line 2.
5.	Harrison-Rock’ham CSB/ Slaughbaugh	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.
6.	Family Sharing/Farrell	E.1.c.- Strike “confirming the amount of the individual’s time in service and” E.1.c.- End of second sentence strike “at least a daily note” add “in a progress note” ·	See Line 2.
7.	Citizen	E.1.c.- Strike “confirming the amount of the individual’s time in service and” E.1.c.- End of second sentence strike “at least a daily note” add “in a progress note” ·	See Line 2.
8.	RBHA/M Harrison	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.
9.	Weatherspoon Wall Res, Inc.	1. E.1.c.- **Strike “confirming the amount of the individual’s time in service and**” [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] 2. E.1.c.- End of second sentence strike “at least a daily note” add “in a progress note” [This makes documentation consistent]	See Line 2.
10.	J Ciffizari Wall Res, In.	Same as Line 9.	See Line 2.
11.	Citizen	Same as Line 9.	See Line 2.

12.	A. May/Spons. Res GH Provider	**I Agree With Comments Posted By Wall Residences** 1. I agree with the comments posted by Wall Residences but want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] 2. E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2.
13.	Citizen	**I agree with the comments posted by Wall Residences** 1. I want to highlight that I support the Definition of Progress Note in Section 20. In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] 2. E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent] 3. I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2.
14.	D Carroll, WRAP Program Manager	I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2.
15.	J. Healey/Wall Res., Inc.	I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2.
16.	Citizen	I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2.
17.	Buford/Wall Residence, Inc.	I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2.

18.	Citizen	I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2.
19.	Citizen	I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2.
20.	Citizen	I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2.
21.	S. Johnson Wall Res., Inc	I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2.
22.	Citizen	I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2.
23.	K. Tyree Spons. Res. Prov	I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2.
24.	A Layman Wall Res., Prov.	I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2.
25.	Karen Tefelski - vaACCSES	E.1.c.- Strike "confirming the amount of the individual's time in service and" E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note". This makes documentation consistent as previously stated.	See Line 2.

26.	M. Ingram/Wall Res., Inc.	1. E.1.c.- **Strike "confirming the amount of the individual's time in service and"** [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] 2. E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2.
27.	R. Ledingham, Wall Res.	E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2.
28.	M. Rosenbaum, Wall Res	Same as Line 9.	See Line 2.
29.	Citizen-Wall Res.	In addition, I support the following changes to Section 530 Sponsored Residential E.1.c.- Strike "confirming the amount of the individual's time in service and" [This has already been removed from Group Home Services and needs to be removed from Sponsored now that we have moved to a daily rate and not one based on hours of service.] E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note" [This makes documentation consistent]	See Line 2.
30.	B Huffman - VersAbility Resources	E.1.c.- Strike "confirming the amount of the individual's time in service and" E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note". This makes documentation consistent as previously stated.	See Line 2.
31.	Citizen	Proposed regulations do not address having parents as the last resort for sponsored placement. It is currently addressed in the DMAS manual (briefly). It should have a clear definition of expectations and allowable activities in these regulations.	See 12VAC30-122-120 B.
32.	Citizen	Sponsored Residential Support Service. • E.1.c.- Strike "confirming the amount of the individual's time in service and" • E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note". This makes documentation consistent as previously stated.	See Line 2.
33.	Dominion Waiver/Koke	• E.1.c.- Strike "confirming the amount of the individual's time in service and" • E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note". This makes documentation consistent as previously stated.	See Line 2.
34.	Wormley, Kerns, Collier, Lester, Hauley -VersAbility Rsc	E.1.c.- Strike "confirming the amount of the individual's time in service and" E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note". This makes documentation consistent as previously stated.	See Line 2.
35.	Renon/Wall Res.	Same as Line 9.	See Line 2.
36.	Citizen	12VAC50-122-530. Sponsored residential section should address when it is allowable or if it is allowable for family members/guardians to serve as the sponsor. There is language regarding family as service provider under Consumer Directed services but not in this section.	See 12VAC30-122-120 B.

Comments related to 12VAC30-122-540

2.	Lucy Beadnell, Virginia Ability Alliance	Individuals best served with Supported Living service have difficulties in finding suitable option - often need housing voucher for affordability reasons. However, the regulations mandate Supported Living residences be provider owned/licensed, thus incompatible with housing vouchers. **We would like to see an adjustment made to allow the use of the two options together.**	If individuals use a housing voucher, they can get similar services through in-home supports or independent living supports.
3.	DDWAC	A- First sentence, match the definition in section 20	Edits made.
4.	Loudoun CSB L. Snider	Clarification on what constitutes "an apartment setting". Could this be a townhome or house with private entrances for multiple individuals?	Edits made.
5.	Dville/Pittvania CSB/S. Craddock	Clarification on what constitutes "an apartment setting". Could this be a townhome or house with private entrances for multiple individuals?	Edits made.
6.	Dville/Pittvania CSB/S. Craddock	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.
7.	Harrison-Rock'ham CSB/ Slaughbaugh	Clarification on what constitutes "an apartment setting". Could this be a townhome or house with private entrances for multiple individuals?	Edits made.
8.	Harrison-Rock'ham CSB/ Slaughbaugh	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference	Edits made.
9.	Blue Ridge Beh Healthcare A. Monti	Clarification on what constitutes "an apartment setting". Could this be a townhome or house with private entrances for multiple individuals?	Edits made.
10.	Blue Ridge Beh Healthcare A. Monti	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference	Edits made.
11.	RBHA/M Harrison	Clarification on what constitutes "an apartment setting". Could this be a townhome or house with private entrances for multiple individuals?	Edits made.
12.	RBHA/M Harrison	Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made.
13.	Collins and Collins, Inc. & Citizen	As a parent, I support the removal of the age cap for Autism health coverage. Noticed several references to the EDCD and Tech Waivers, which no longer exist. Clarification needed for what constitutes "apartment setting."	This comment is not related to this section. Edits made related to apartment setting.
14.	VA Board for People with Disabilities	**Subsection A: Consistent with comment #19 in 122-20, Definitions, the Board recommends deleting "an apartment setting", and changing to a service "taking place in the individual's own home."** Not all supported living residential settings are apartments.	Edits made.

15.	Karen Tefelski - vaACCSES	First sentence - match the definition in section 122-20 to be consistent. DELETE “an apartment setting” and changing to a service “taking place in the individual’s own home.” Not all supported living residential settings areapartments.	Edits made.
16.	K. Black-Hope House	A- First sentence, match the definition in section 20	Edits made.
17.	B Huffman - VersAbility Resources	First sentence - match the definition in section 122-20 to be consistent. DELETE “an apartment setting” and changing to a service “taking place in the individual’s own home.” Not all supported living residential settings areapartments.	Edits made.
18.	C Skelly, DD Committee, Arlington CSB	**Supported Living Services.** Olmstead requires that individuals should be allowed to live in the most integrated settings possible. In Arlington, we are increasingly seeing situations where individuals choose to live in their own apartments, using the Housing Choice Voucher or other rental assistance, with the support of licensed residential service providers. Therefore, requiring that a home be owned/operated by a licensed provider in order to receive these services constitutes a barrier to integrated, community-based living arrangements (page 4 of the VAA letter).	There are other services available to support an individual who is living in their own home.
19.	Citizen	12VAC30-122-540 - Supported Living Residential Service. • First sentence - match the definition in section 122-20 to be consistent. DELETE “an apartment setting” and changing to a service “taking place in the individual’s own home.” Not all supported living residential settings are apartments.	Edits made.
20.	Dominion Waiver/Koke	• First sentence - match the definition in section 122-20 to be consistent. DELETE “an apartment setting” and changing to a service “taking place in the individual’s own home.” Not all supported living residential settings are apartments.	Edits made.
21.	Wormley, Kerns, Collier, Lester, Hauley -VersAbility Rsc	First sentence - match the definition in section 122-20 to be consistent. DELETE “an apartment setting” and changing to a service “taking place in the individual’s own home.” Not all supported living residential settings areapartments.	Edits made.

Comments related to 12VAC30-122-550

2.	Gordon Walker, Fidura & Assoc	**Recommended Change #1: In Section C. 3.,** "telephone communication" should be deleted from the list of in-kind activities that cannot be billed. Reason for Change: Telephone communication is considered an allowable activity in B. i. **Recommended Change #2: In Section B.i.,** the phrase "or via video conferencing should be added at the end. Reason for Change**:** The would clarify that video conferencing is an allowable activity in the provision of Therapeutic Consultation services. Allowing video conferencing might increase the availability of Therapeutic Consultation services, especially in rural areas. **Recommend for Change #3: All of C.4** ("Therapeutic consultation shall not be billed solely for purposes of monitoring the individual") should be deleted. Reason for Change**:** Page 79 of the December 2018 DOJ Monitor's report states "... of those who did have BSPs, half were not supervised by qualified behavior clinicians." The current language in the regulations suggests that monitoring of an ongoing Behavioral	Recommendation #1 - C3 - Telephone communication - adding "unrelated to a therapeutic outcome" to be consistent with B i. Recommendation #2 - B i - secure telemedicine connection in full accordance with DMAS policy. Recommendation #3 - "unrelated to

		Support Plan (BSP) is not an allowable activity. In fact, ongoing monitoring (that is, supervision by a qualified clinician) of an individual's progress is essential if the plan is to be successful. The language in C.4. suggests that this monitoring is not permitted.	a therapeutic outcomes"
3.	Hansel Union Consulting, PLLC	Reclassify PBS Facilitators and Certified Rec Therapist to billing code 97139. - Remove telephone calls from non-billable activity. - Permit video chat and conferencing - helps provide svs to rural area/underserved pops and in urban areas where travel time is barrier between services. - Allow Certified Occupational Therapy Assistants, COTA's certified by the Commonwealth, to work under the supervision of Occupational therapist. COTA could be billed at 97530 and OT's will use code 97139. - Therapeutic consultation should be allowed under all Wavier programs, including ICF/ID. - Make all documentation billable activity. - All therapeutic consultants should receive a 5% raise to be comparable to the commercial industry. - Standardization of documentation, either in written forms or EMR. - Expand therapy services to include psychiatry and nurse practitioner for medication management. Allow Positive Behavior Support Facilitators, PBSF to have a Positive Behavior Support Assistant, PBSA mirroring the BCBA protocol.	Telephone calls and video conferencing have been addressed in Line 2. Other comments have been taken into consideration.
4.	Citizen	**I propose that tele practice platforms be incorporated into Therapeutic Consultation services to aid in providing more services to the rural and urban areas where distance and time spent traveling impedes service delivery.** Tele practice can be used safely and HIPAA compliant with the appropriate platforms, especially in caregiver training, assessments and observations.	Telephone calls and video conferencing have been addressed in Line 2.
5.	DDWAC	1. B.2.i - Support Dr. Walker's comments 2. C.3- Strike "written preparation and telephone communication"	See Line 2
6.	Citizen	12VAC30-122-550 - delete after the word *service* "taking place in an apartment setting" and change to "taking place in an individual's own home" - this stays consistent as "own home" is also defined and there is not reason to dictate what type of living arrangement a person should live in to receive a service.	No references to apartment setting in this section. Edits made in Section 540.
7.	Family Sharing/Farrell	B.2.i - Support Dr. Walker's comments; and C.3- Strike "written preparation and telephone communication"	See Line 2
8.	Citizen	B.2.i - Support Dr. Walker's comments C.3- Strike "written preparation and telephone communication"	See Line 2

9.	Christy Evanko, BCBA, LBA	A. Service description. Therapeutic consultation service means professional consultation provided by members of psychology, social work, rehabilitation engineering, behavioral analysis/consultation, speech-language pathology therapy, occupational therapy, psychiatry, psychiatric clinical nursing, therapeutic recreation, or physical therapy disciplines that are designed to assist individuals, parents, guardians, family members, and any other providers of support services with implementing the individual support plan. This service shall provide assessments, development of a therapeutic consultation support plan, and teaching in any of these designated specialty areas to assist family members, caregivers, and other providers in supporting the individual enrolled in the waiver. The individual's therapeutic consultation service support plan shall clearly reflect the individual's needs, as documented in the assessment information, for specialized consultation provided to family/caregivers and providers. Therapeutic consultation service shall be covered in the FIS and CL waivers. **Comment:** When behavior precedes analysis, it should be "behavior" rather than "behavioral" A therapeutic consultation service support plan is the report of recommendations resulting from a therapeutic consultation that is developed by the professional consultant after he spends time with the individual to determine the individual's needs in his area of expertise.	Edits made
10.	Christy Evanko, BCBA, LBA	1. Comment: When behavior precedes analysis, it should be "behavior" rather than "behavioral" 2. B2i - Suggest adding "by video" 3. Comment: The unit of service should be 15 minutes rather than one hour. This would invite less confusion on what to do if the service was provided for less or more than one hour. If service unit remains one hour, it is paramount that the rounding rules are specifically spelled out for providers. 4. Comment: services is spelled incorrectly 5. Comment: This statement contradicts B2i above. Suggest removing "telephone communication" 6. Comment: In Virginia, BCBAs and BCaBAs are licensed and the regulations should reflect that. Suggest: "Behavior consultation shall only be provided by (i) a licensed behavior analyst or licensed assistant behavior analyst . . ." Board Certified Behavior Analyst ® and Board Certified Assistant Behavior Analyst ® are copyrighted terms and must be listed correctly and with the registration mark if used. (see www.bacb.com for information). 7. Comment: The SIS assessment is not unique to this service and it is redundant to include it in the individual's therapeutic consultation record. It also does not tend to inform the treatment plan. It would be accessible through the case manager. In addition, therapeutic consultation providers may not be invited to the SIS or may not treat the client at the time when the SIS is being administered as it is only administered tri-annually. 8. Comment: Suggest adding more guidelines for the support plan to set standards and protect the waiver recipient. Each profession should have different guidelines for the plan. Behavior Consultation Plans should include the following at a minimum: Target behaviors and definitions; includes both behaviors targeted for reduction and replacement behaviors; Results of functional assessment, including function, type of assessment, dates, location, who participated, etc.;	1. See Line 9. 2. See Line 2. 3. See Line 11. 4. Edits made. 5. See Line 2. 6. Edits made. 7. The consultant should have a copy of the assessment in their record. 8. Changes have been to the Behavior Consultation Plan requirements. 9. Quarterly reports - changes have been made / BI - Those individuals who are living on their own are not expected to need extensive therapeutic consultation.

		Behavioral objectives; Baseline data (could be from assessment) Data collection methods; Clear description of treatment methods for behavior reduction and skill acquisition including antecedent and consequence procedures/protocols for each target behavior ; Functional reinforcer is identified for each behavior targeted for reduction; Possible reinforcers (results from preference assessment) and schedule of reinforcement for replacement behaviors; Generalization and maintenance strategies Medical contraindication; Crisis management (what to do when individual is not responding to the behavior plan and is a danger to self and/or others); Criteria for discharge; Benefits and risks associated with treatment and for not receiving treatment; Signatures indicating consent from team members and from individual/legal guardian 9. Comment: The quarterly reports are actually due three months after the person-centered planning meeting, regardless of when consultation service began. Suggest: "If the consultation service extends three months or longer, written quarterly reviews that are completed by the provider using the quarterly schedule based on when the person-centered planning meeting is due, and forwarded . . . " or something that lets providers know that they need to follow the same schedule. 10. Final Comment: Therapeutic Consultation, especially behavioral therapeutic consultation, should be an available service for the Building Independence waiver as well.	
11.	Citizen	**Regarding Therapeutic Consultation -** The unit of service for Therapeutic Consultation should be 15 minutes rather than one hour. This would mimic the current permanent codes used for billing of autism and behavioral health services. Therapeutic Consultation, especially behavioral therapeutic consultation, should be available across all three waivers.	DMAS is not able to make this change at this time.
12.	Tiffanie Johnson BCBA, LBA-RCG Behavioral Health Network	Same as Line 10.	See Line 10.
13.	Faison Center R. Ernest	Same as Line 10.	See Line 10.
14.	Faison Center A. Warman	Same as Line 10.	See Line 10.
15.	Michelle Witt, BCBA, LBA	Same as Line 10.	See Line 10.
16.	Weatherspoon Wall Res, Inc.	C.3- Strike "written preparation and telephone communication"	See Line 2

17.	J Ciffizari Wall Res, In.	Same as Line 16.	See Line 2.
18.	Citizen	Same as Line 16.	See Line 2.
19.	Karen Tefelski - vaACCSES	Support Dr. Walker's comments C.3- Strike "written preparation and telephone communication" D (1) Recommend adding Registered Behavior Technicians (RBT) to list of people that may provide direct support under the supervision of Board Certified Behavior Analyst. (RBT's would not provide consultation, rather direct support).	See Line 2. / This is not a direct care service but a consultative service and requires a higher level of education.
20.	M. Ingram/Wall Res., Inc.	C.3- Strike "written preparation and telephone communication"	See Line 2
21.	R. Ledingham, Wall Res.	C.3- Strike "written preparation and telephone communication"	See Line 2
22.	M. Rosenbaum, Wall Res	Same as Line 16.	See Line 2.
23.	K. Black-Hope House	C.3- Strike "written preparation and telephone communication"	See Line 2
24.	J Creech/Pos. Beh. Consults	Same as Line 10.	See Line 10.
25.	Beth Martin, The Choice Group	**D (1):** Recommendation **-** Consider adding Registered Behavior Technician's (RBT) to list of people that may provide direct support under the supervision of Board Certified Behavior Analyst. (RBT's would not provide consultation, rather direct support). C.3- Strike "written preparation and telephone communication"	This is not a direct care service but a consultative service and requires a higher level of education.
26.	B Huffman - VersAbility Resources	Same as Line 19.	See Line 19.
27.	D. Creech	Same as Line 10.	See Line 10.
28.	VABA/Pub Policy Workgroup	In general, and throughout, when behavior precedes analysis, it should be "behavior" rather than "behavioral" 1. We support the adding of telephone consultation to allowable activities and suggest that HIPAA-compliant video consultation be added as well. However, later in the service limits, telephone consultation should be removed from the list of in-kind services. 2. For therapeutic consultation, the unit of service should be 15 minutes rather than one hour. This would invite less confusion on what to do if the service was provided for less or more than one hour. If service unit remains one hour, it is paramount that the rounding rules are specifically spelled out for providers. 3. Behavior analysts are listed incorrectly in the description of who should provide behavior consultation. In Virginia, BCBAs and BCaBAs are licensed and the regulations should reflect that. Board Certified Behavior Analyst ® and Board Certified Assistant Behavior Analyst ® are copyrighted terms and must be listed correctly and with the registration mark if used. 4. The SIS should not be included in the documentation necessary	"Behavior" - Edits made / 1. Phone consultation - see Line 2 / 2. Unit length - see Line 25 / 3. Edits made. / 4. The consultant should have a copy of the assessment in their record. / 5. Changes have been to the Behavior Consultation Plan requirements. / Quarterly reports - changes have

		for the individual's record. The SIS assessment does not tend to inform the treatment plan and would be accessible through the case manager. In addition, therapeutic consultation providers may not be invited to the SIS or may not treat the client at the time when the SIS is being administered as it is only administered tri-annually. 5. There should be more guidelines for the support plan to set standards and protect the waiver recipient. Each profession should have different guidelines for the plan. Behavior Consultation Plans should include the following at a minimum: - Target behaviors and definitions; includes both behaviors targeted for reduction and replacement behaviors - Results of functional assessment, including function, type of assessment, dates, location, who participated, etc. - Behavioral objectives - Baseline data (could be from assessment) - Data collection methods - Clear description of treatment methods for behavior reduction and skill acquisition including antecedent and consequence procedures/protocols for each target behavior - Functional reinforcer is identified for each behavior targeted for reduction - Possible reinforcers (results from preference assessment) and schedule of reinforcement for replacement behaviors - Generalization and maintenance strategies - Medical contraindication - Crisis management (what to do when individual is not responding to the behavior plan and is a danger to self and/or others) - Criteria for discharge - Benefits and risks associated with treatment and for not receiving treatment - Signatures indicating consent from team members and from individual/legal guardian - The quarterly reports are actually due three months after the person-centered planning meeting, regardless of when consultation service began. The portion on the writing of the quarterly report should be written more clearly to let providers know that they need to follow the same schedule. In addition, all quarterly reports must include data in the form of charts, graphs, or other measures that show that the plan is effective, or if ineffective, how the provider plans to change the service to make it effective. - Finally, Therapeutic Consultation, especially behavioral therapeutic consultation, should be an available service for the Building Independence waiver as well.	been made / BI - Those individuals who are living on their own are not expected to need extensive therapeutic consultation.
29.	VA Int. Of Aut/L Haskins	"Therapeutic consultation" means professional consultation provided by members of psychology, social work, rehabilitation engineering, behavioral analysis, speech therapy, occupational therapy, psychiatry, psychiatric clinical nursing, therapeutic recreation, physical therapy, or behavior consultation disciplines that are designed to assist individuals, parents, family members, and any other providers of support services with implementing the individual support plan. **Comment:** When behavior precedes analysis, it should be "behavior" rather than "behavioral"	Edits made

30.	VA Int. Of Aut/L Haskins	**Therapeutic consultation service:** A. Service description. Therapeutic consultation service means professional consultation provided by members of psychology, social work, rehabilitation engineering, behavioral analysis/consultation, speech-language pathology therapy, occupational therapy, psychiatry, psychiatric clinical nursing, therapeutic recreation, or physical therapy disciplines that are designed to assist individuals, parents, guardians, family members, and any other providers of support services with implementing the individual support plan. This service shall provide assessments, development of a therapeutic consultation support plan, and teaching in any of these designated specialty areas to assist family members, caregivers, and other providers in supporting the individual enrolled in the waiver. The individual's therapeutic consultation service support plan shall clearly reflect the individual's needs, as documented in the assessment information, for specialized consultation provided to family/caregivers and providers. Therapeutic consultation service shall be covered in the FIS and CL waivers. **Comment: When behavior precedes analysis, it should be “behavior” rather than “behavioral”**	Edits made
31.	VA Int. Of Aut/L Haskins	A therapeutic consultation service support plan is the report of recommendations resulting from a therapeutic consultation that is developed by the professional consultant after he spends time with the individual to determine the individual's needs in his area of expertise. B. Criteria and allowable activities. 1. To qualify for therapeutic consultation service, the individual shall have a documented need for consultation. Documented need shall indicate that the ISP cannot be implemented effectively and efficiently without such consultation as provided by this covered service and approved through service authorization. The need for this service shall be based on the individual's ISP and shall be provided to an individual for whom specialized consultation is clinically necessary. Therapeutic consultation serviceay 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 ISP. 2. Allowable activities for this service shall include: a. Interviewing the individual, family members, caregivers, and relevant others to identify issues to be addressed and desired outcomes of consultation; b. Observing the individual in daily activities and natural environments and observing and assessing the current interventions, support strategies, or assistive devices being used with the individual; c. Assessing the individual's need for an assistive device for a modification or adjustment of an assistive device, or both, in the environment or service, including reviewing documentation and evaluating the efficacy of assistive devices and interventions identified in the therapeutic consultation plan; d. Developing data collection mechanisms and collecting baseline data as appropriate for the type of consultation service provided; e. Designing a written therapeutic consultation plan detailing the interventions, environmental adaptations, and support strategies to address the identified issues and desired outcomes, including recommendations related to specific devices, technology, or adaptation of other training programs or activities. The plan may recommend training relevant persons to better support the individual	1. Telehealth is being considered for this service. C 1. The unit of service cannot be changed at this time.

		simply by observing the individual's environment, daily routines, and personal interactions; f. Demonstrating (i) specialized, therapeutic interventions; (ii) individualized supports; or (iii) assistive devices; g. Training family/caregivers and other relevant persons to assist the individual in using an assistive device; to implement specialized, therapeutic interventions; or to adjust currently utilized support techniques; h. Intervening directly, by behavioral consultants, with the individual and demonstrating to family/caregivers or staff such interventions. Such intervention modalities shall relate to the individual's identified behavioral needs as detailed in established specific goals and procedures set out in the ISP; and i. Consulting related to person centered therapeutic outcomes, in person or over the phone. **Comment:** Suggest adding "by HIPAA compliant video conferencing" C. Service units and limits. 1. The unit of service shall be one hour. **Comment**: The unit of service should be 15 minutes rather than one hour. This would invite less confusion on what to do if the service was provided for less or more than one hour. If service unit remains one hour, it is paramount that the rounding rules are specifically spelled out for providers. 2. The services shall be explicitly detailed in the plan for supports. Comment: services is spelled incorrectly 3. Travel time, written preparation, and telephone communication shall be considered as in-kind expenses within therapeutic consultation service and shall not be reimbursed as separate items. Comment: This statement contradicts B2i above. Suggest removing "telephone communication" 4. Therapeutic consultation shall not be billed solely for purposes of monitoring the individual. 5. Only behavioral consultation in the therapeutic consultation service may be offered in the absence of any other waiver service. 6. Other than behavioral consultation, therapeutic consultation service 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. Behavior consultation may include direct behavioral interventions and demonstration of such interventions to family members or staff.	
32.	VA Int. Of Aut/L Haskins	Comment: The SIS assessment is not unique to this service and it is redundant to include it in the individual's therapeutic consultation record. It would be accessible through the case manager. In addition, therapeutic consultation providers may not be invited to the SIS or may not treat the client at the time when the SIS is being administered as it is only administered tri-annually. Comment: The quarterly reports are actually due three months after the person-centered planning meeting. Suggest: "If the consultation service extends three months or longer, written quarterly reviews that are completed by the provider using the quarterly schedule based on when the person-centered planning meeting is due, and forwarded . . . " or something that lets providers know that they need to follow the same schedule. f. All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator, DMAS, and DBHDS. g. Written progress note documentation of contacts made with the individual's family/caregiver, physicians, providers, and all professionals concerning the individual. h. A contemporaneously signed and dated final disposition summary that is forwarded to the support coordinator within 30 days following the	See Line 10.

		end of this service and that includes: (1) Strategies utilized; (2) Objectives met; (3) Unresolved issues; and (4) Consultant recommendations. 2. Provider documentation shall support all claims submitted for DMAS reimbursement. Claims for payment that are not supported by supporting documentation shall be subject to recovery by DMAS or its designee as a result of utilization reviews or audits.	
33.	T Long, NOVA Instructional Consult, LLC	**Remove statement regarding Functional Analysis of Behavior from Provider Participation Requirements** 1. The unit for Therapeutic Consultation for Behavior should be 15 minutes in order to allow flexibility for providers and clients and to account for the various activities.2. Consultation via phone and video conferencing should be allowed as billable charges in order to allow for remote participation, training, and fading of consultative services. 3. For Therapeutic Consultation, page 16 of the Provider Participation Requirements includes the statement: *"11. Therapeutic Consultation – in addition to any license, certification, or endorsement, must also possess at least one year of documented work experience in developmental disabilities services, performing functional analysis of behavior, developing behavior support strategies, developing written behavior support plans, and training caregivers in the implementation of behavior support interventions."* First, this is listed an additional line item after all of the other provider requirements (including OT, SLP, Psych, Therapeutic Recreation, etc...) and not specifically tied to Behavior Consultation. Professions other than Licensed Behavior Analysts won't have experience with the functional analysis of behavior, developing behavior support plans etc..... so if this is included (although it is unnecessary and could be omitted), it should be as an addition to only the Behavior Consultation Provider Participation Requirements section. Second, it is rare that a professional providing therapeutic consultation for behavior would actually conduct a functional analysis of behavior. This includes manipulating variables in a controlled setting and the needed factors aren't typically available in home and community based settings. A functional behavior assessment includes interviews, observations, scales, record reviews, etc.... as outlined in the activities for therapeutic consultation, but there is a distinct difference between a functional behavior assessment and a functional analysis. The reference to functional analysis should be removed from this statement as many licensed behavior analysts may not have experience with a functional analysis of behavior, and that is not necessary in order to provide therapeutic consultation for behavior. Additionally, a Positive Behavior Support Facilitator would never have experience in the functional analysis of behavior, so they would be excluded from eligibility to provide therapeutic consultation for behavior, even though they are previously listed as an eligible provider.	1. Unit of service cannot be changed. 2. Telemedicine is being considered. 3. -- Parts 1 and 2: DMAS is not able to make this change at this time.
34.	Citizen	Therapeutic Consultation Service. • B.2.i - Support Dr. Walker's comments • C.3- Strike "written preparation and telephone communication" • D (1) Recommend adding Registered Behavior Technicians (RBT) to list of people that may provide direct support	See Line 2 and Line 25.

		under the supervision of Board Certified Behavior Analyst. (RBT's would not provide consultation, rather direct support).	
35.	Dominion Waiver/Koke	• B.2.i - Support Dr. Walker's comments • C.3- Strike "written preparation and telephone communication" • D (1) Recommend adding Registered Behavior Technicians (RBT) to list of people that may provide direct support under the supervision of Board Certified Behavior Analyst. (RBT's would not provide consultation, rather direct support).	See Line 2 and Line 25.
36.	Wormley, Kerns, Collier, Lester, Hauley -VersAbility Rsc	Same as Line 35.	See Line 2 and Line 25.
37.	Renon/Wall Res.	Same as Line 16.	See Line 2.
38.	Citizen	1) In general, we support and endorse the comments of vaACCSES and those of Virginia Association for Behavior Analysis, Public Policy Workgroup. In specific to add, 2) 12VAC30-122-550 - Therapeutic Consultation Service. 3) C.3- Strike "written preparation and telephone communication" 4) D (1) Recommend adding Registered Behavior Technicians (RBT) to list of people that may provide direct support under the supervision of Board Certified Behavior Analyst. (RBT's would not provide consultation, rather direct support).	See Line 2 and Line 25.
39.	M.S. BCBA Perry Olson, ABA Today (abatoday.net)	1) I support the comments made by the Virginia Ability Alliance. I would like to make a comment based on my experience as a Medicaid ABA provider (in another state) that works very well. Our company is based in Virginia and I would like to see Virginia adopt a similar model. I suggest that the tiered model used by private insurance companies and other state Medicaid programs replace the sole BCBA provider model currently in use in Virginia. 2) In a tiered model, clients receive ABA services from a team of RBT's (Registered Behavior Technicians) under the direct supervision of a BCBA (Board Certified Behavior Analyst). The cost of an RBT is much less than that of a BCBA. The BCBA will be responsible for the close ongoing supervision of RBTs. This may be cost-effective and allow for more direct services for our clients. We would be happy to sit down and discuss the tiered model in more detail at any time!	DMAS is not able to make a change to the tiered model at this time.

Comments related to 12VAC30-122-570

2.	Citizen	1. B.4. – Add (e) at the end of the lettered list which adds "Phone, media and in-person contacts with a Job Coach" as an allowable/billable activity. There may be times when a workplace assistant may need to consult with the individual's job coach in order to meet the needs of the individual and to ensure consistency of strategies to support the individual to be successful in the workplace. 2. D.3. – Providers of Workplace Assistance that are CARF accredited employment vendors of DARS satisfy staff competency requirements for Workplace Assistance Services.	1. This will be clarified in the manual. 2. DMAS has considered this request but is not able to make this change at this time.
3.	VA Board for People with Disabilities	**Subdivision B 4: The Board recommends adding an "e" at the end of the lettered list which adds phone, media, and in-person contacts with a job coach as allowable/billable activities.** There may be instances in which the workplace assistant may need to consult with	This will be clarified in the manual.

		the individual's job coach in order to best meet the individual's needs and to ensure consistency of strategies designed to support the individual to be successful in the workplace.	
4.	Karen Tefelski - vaACCSES	B.4. – Add (e) at the end of the lettered list which adds "Phone, media and in-person contacts with a Job Coach" as an allowable/billable activity. There may be times when a workplace assistant may need to consult with the individual's job coach in order to meet the needs of the individual and to ensure consistency of strategies to support the individual to be successful in the workplace. D.3. – Providers of Workplace Assistance that are CARF accredited employment vendors of DARS satisfy staff competency requirements for Workplace Assistance Services. Recommend that Workplace Assistance Services be added to the BI Waiver as individuals on this Waiver may have health and/or safety monitoring needs in a place of employment.	See Line 2.
5.	B Huffman - VersAbility Resources	Same as Line 4.	See Line 2.
6.	Citizen	Workplace Assistance Service (12VAC30-122-570). • B.4. – Add (e) at the end of the lettered list which adds "Phone, media and in-person contacts with a Job Coach" as an allowable/billable activity. There may be times when a workplace assistant may need to consult with the individual's job coach in order to meet the needs of the individual and to ensure consistency of strategies to support the individual to be successful in the workplace. • D.3. – Providers of Workplace Assistance that are CARF accredited employment vendors of DARS satisfy staff competency requirements for Workplace Assistance Services. • Recommend that Workplace Assistance Services be added to the BI Waiver as individuals on this Waiver may have health and/or safety monitoring needs in a place of employment.	1. This will be clarified in the manual. 2. See line 2. 3. Individuals in the BI waiver typically do not require this level of support to maintain employment.
7.	Dominion Waiver/Koke	• B.4. – Add (e) at the end of the lettered list which adds "Phone, media and in-person contacts with a Job Coach" as an allowable/billable activity. There may be times when a workplace assistant may need to consult with the individual's job coach in order to meet the needs of the individual and to ensure consistency of strategies to support the individual to be successful in the workplace. • D.3. – Providers of Workplace Assistance that are CARF accredited employment vendors of DARS satisfy staff competency requirements for Workplace Assistance Services. • Recommend that Workplace Assistance Services be added to the BI Waiver as individuals on this Waiver may have health and/or safety monitoring needs in a place of employment.	1. This will be clarified in the manual. 2. DMAS has considered this request but is not able to make this change at this time.
8.	Wormley, Kerns, Collier, Lester, Hauley - VersAbility Rsc	Same as Line 4.	See Line 2.

General Comments

2.	Citizen	The Waiver indicates no more transportation options - Roanoke VA sparse.Need to ensure Waiver is equal for every one. My understanding was that one of the purposes of combining DD with ID was to make sure everyone had the same access to all available services. Not true statement. The DD population needs to have more living in the community options and more public transportation options so that we are not restricted at 8:15pm to go out in the community.	This concern will be forwarded to DMAS Transportation staff.
3.	Citizen	I strongly support comments on waiver made by the Virginia Ability Alliance.	DMAS provided a response to these specific comments.
4.	Citizen	I fully support the Virginia Ability Alliance (VAA) comments and suggestions.	DMAS provided a response to these specific comments.
5.	Citizen	I fully support and agree with all the comments made by the Virginia Ability Alliance regarding the changes to the Virginia Disability waiver regulations. The DMAS-62 form is a very cursory form that is I'll equipped to properly assess a disabled individual's need for personal attendant care services. Without waiver assistance for my child's care, we will not be able to continue as a two-person working household, which is absolutely necessary. The personal attendant care hours are essential to ensure we can provide attention and care to our other child, as well. I am deeply afraid of the implications of the Waiver changes on my son's future when I am no longer able to care for him. I again echo all of the comments made by the Virginia Ability Alliance.	DMAS provided a response to these specific comments.
6.	Harrison-Rockingham CSB/J Malone	There are several references to the EDCD and/or Tech Waiver, which no longer exist	These regulations are in process and are not yet final. The references will be updated once the regulations are final.
7.	Henrico Area MHDS	Suggest not having different requirements for DD CM versus ID CM.	There are two different State Plan Amendments.
8.	Family Sharing	Type over this text and enter your comments here. You are limited to approximately 3000. *Such documentation shall be written on the date of service delivery.* Strike or change to as soon as practicable but no longer than one week after the service. This is in keeping with the definition of Progress Note from this chapter.	Edits made.
9.	Family Sharing/Jarret	Strike or change to as soon as practicable but no longer than one week after the service. This is in keeping with the definition of Progress Note from this chapter.	Edits made.

10.	Citizen	Positive Behavior supports - Strike the definition entirely and use the definition from the American Association for Positive Behavior Supports Service Authorizations - delete "medically" Supported living residential- delete following a service “taking place in an apartment setting”; add following operated by a DBHDS-licensed provider, “taking place in an individual’s own home”	DMAS will consider this as a possible future change. / Edits made. / Edits made.
11.	Citizen	Support for Comments made by the Virginia Ability Alliance - I am writing to support the comment letter sent to you by the Virginia Abilities Alliance. As the parent of a young adult with an intellectual disability I am concerned about long waiting lists for services, as will as the lack of waiver funding. My husband and I are in our late fifties and are very concerned that our daughter will not receive an appropriate housing placement until after our deaths. As pointed out in the letter, that outcome would be extremely stressful for our daughter. Our desire is to see her placed in a supportive living environment while we are stil able to assist with the transition and help her to achieve her optium level of independence and functioning. I believe that is every parents wish.	We empathize with your situation, and we are grateful to you for expressing it to us. Unfortunately, we have a limited amount of funding allocated by the General Assembly for waiver slots. With a shortage of resources for waiver services, this process attempts to allocate those limited services fairly. The waiting list focuses on individual criteria rather than age. If the caregiver develops a serious illness or upon their death, the individual may be considered for an emergency slot.
12.	Citizen	I support the comments submitted by the Virginia Ability Alliance. In particular, I ask that you allow for a spend down for people with DD waivers . People with the DD Waivers do not have the option to “spend down” income over the Waiver income cap on medical expenses to demonstrate eligibility for Waiver. The net result is that people with either high earned or unearned income are ineligible for the DD Waivers, though they are eligible for the CCC Plus Waiver that does have a “spend down” option. As we see the generation of baby boomers retiring and SSDI payments to adult children reaching and exceeding the limits of financial eligibility for Waiver, it would be wise to amend the DD	Spend-down - DMAS is not able to make this change at this time.

		Waiver Regulations to allow a "spend down" option similar to that allowed under the CCC Plus Waiver. Additionally, regulations should protect eligibility for anyone who is put over the monthly income cap as a result of SSDI received from parents. This benefit cannot be refused or reduced, despite the wishes of the person with a disability, yet it can have the effect of making them ineligible for crucial services they cannot afford to fund with their own incomes.	
13.	Citizen	Our 48 year-old son has been on the Developmental Disability waiver **wait list** for well over 20 years (and still waiting). We **strongly** endorse the comments of the Virginia Ability Alliance regarding the current waiver process. We have seen some improvement over the years, but not nearly enough to address the needs of many individuals throughout the Commonwealth. We are seriously nearing the point of our son being left with no support system as we age beyond the ability to continue meeting all of his needs!! We, too, are becoming incapacitated with age-related medical issues that require a lot of our time and energy. Please, please take the comments and recommendations seriously - lives depend upon it!!. Thank you for the difficult and complex that it takes to improve the system	We empathize with your situation, and we are grateful to you for expressing it to us. Unfortunately, we have a limited amount of funding allocated by the General Assembly for waiver slots. With a shortage of resources for waiver services, this process attempts to allocate those limited services fairly. The waiting list focuses on individual criteria rather than age. If the caregiver develops a serious illness or upon their death, the individual may be considered for an emergency slot.
14.	Family Sharing	...Such documentation shall be written on the date of service delivery. Strike or change to as soon as practicable but no longer than one week after the service. This is in keeping with the definition of Progress Note from this chapter.	Edits made.
15.	Family Sharing	Strike or change to as soon as practicable but no longer than one week after the service. This is in keeping with the definition of Progress Note from this chapter.	Edits made.
16.	VA Kadpa	Inputs on Three Waivers redesign (ID, DD, AND DS) I support comment made by Virginia Ability Alliance.	Thank you for your comment.
17.	VA Kadpa	inputs on 3 wavers redesign.I support comments made by virginia ability alliance.	Thank you for your comment.

18.	VA Kadpa	I support comments made by virginia ability alliance.	Thank you for your comment.
19.	VA Kadpa	1.I support the comments made by Virginia Ability Aliance.	Thank you for your comment.
20.	VA Kadpa	Inputs on three waivers redesign (ID,DD,DS I support the comments made by Virginia Ability Aliance.	Thank you for your comment.
21.	VA Kadpa	I support comments by Virginia Ability Alliance. Please do not decrease the CCC+ waiver hours.	See Line 22.
22.	VA Kadpa	1.I support comment made by Virginia Ability Alliance. 2.To support families in caring for their chlidren while they are on waiting list, do not continue decrease CCC Pluse waivers hours.	Personal care hours under the CCC Plus Waiver have been addressed in policy changes.
23.	VA Kadpa	I support comments by Virginia ability alliance. To support the familys in caring for their children while they are on waiting list ,do not continue to decrease CCC plus waiver hours.	See Line 22.
24.	VA Kadpa	1. I support the **comments made by Virginia Ability Alliance**. 2. To support the families in caring for their children while they are on the waiting list, do not continue to decrease CCC Plus Waiver hours.	See Line 22.
25.	VA Kadpa	I support comments made by the Virginia Ability Alliance. Don't reduce the CCC plus Waiver time.	See Line 22.
26.	VA Kadpa	I support the comments made by VA Ability Allance. I also don't want to reduce the CCC PLUS WAIVER TIMES	See Line 22.
27.	VA Kadpa	I support comment made by Virginia Ablitiy Alliance	Thank you for your comment.
28.	Citizen	*20-A-10-d ...Such documentation shall be written on the date of service delivery.* *Strike or change to as soon as practicable but no longer than one week after the service. This is in keeping with the definition of Progress Note from this chapter.*	Edits made.
29.	Citizen	I support the comments made by Virginia Ability Alliance. CCC Plus waiver should not decrease service hours.	See Line 22.
30.	Citizen	Thank you for opening a public comment period. We would like the regulation/requirement on back up caregiver to be rescinded. If that is not possible we propose it read: backup caregiver means the secondary person Or Agency who will assume the role of providing direct care to and support the waiver individual in instances of emergencies and in the absence of the primary caregiver who is unable to care for the individual. Such secondary person shall perform the duties needed by the waiver individual and shall be trained in the skilled needs and technologies required by the waivered individual. With that proposal we are adding agency can be backup and are deleting without compensation. I have a 28 year old son who wears pull ups,still needs to be wiped, and has bitten my finger off.(literally) He has a history of biting. I have needed stitches on my face, surgery to close the finger stub, mrsa treatment from a bite etc..... It is difficult to find people who want to deal with this. The second request I have is that the managed care groups for Medicaid be required to give a written reason for denial when they issue a denial of claim. Thank you again for	Having a provider as the backup plan is not prohibited by the regulation.

		your willingness to listen. We do appreciate the waiver and our people and psychiatrist at Racsb. :)	
31.	VA Kadpa	I support comments made by the Virginia Ability Alliance. Don't reduce the CCCPlus waiver time.	See Line 22.
32.	VA Kadpa	Three waivers redesigned - I support comments made by the Virginia Ability Alliance. Don't reduce the CCC Plus waiver time.	See Line 22.
33.	VA Kadpa	Three waivers redesigned - I support comments made by the Virginia Ability Alliance. Don't reduce the CCC Plus waiver time.	See Line 22.
34.	VA Ability Alliance	In virginia known to worst service state in the country for DD,DDS. I would like to express fully support for New waver regulation 2-21-19	Thank you for your comment.
35.	VA Ability Alliance	I support comments made by the Virginia Ability Alliance. Do not recuce the CCCPlus waiver time. Thank you.	See Line 22.
36.	VA Ability Alliance	I support comments made by the Virginia Ability Alliance. Do not reduce the CCCPlus waiver time. Thank you.	See Line 22.
37.	VA Ability Alliance	I support the **comments made by Virginia Ability Alliance**. To support the families in caring for their children while they are on the waiting list, do not continue to decrease CCC Plus Waiver hours.	See Line 22.
38.	VA Ability Alliance	I support the comments made by the Virginia Ability Alliance. To support the families in caring for their children while they are on the waiting list, do not continue to decrease CCC Plus Waiver hours.	See Line 22.
39.	VA Ability Alliance	I support the comments made by the Virginia Ability Alliance. To support the families in caring for their children while they are on the waiting list, do not continue to decrease CCC Plus Waiver hours.	See Line 22.
40.	VA Ability Alliance	I support the comments made by the Virginia Ability Alliance. To support the families in caring for their children while they are on the waiting list, do not continue to decrease CCC Plus Waiver hours.	See Line 22.
41.	VA Ability Alliance	Same as Line 22.	See Line 22.
42.	VA Ability Alliance	Same as Line 22.	See Line 22.
43.	VA Ability Alliance	Same as Line 22.	See Line 22.
44.	VA Ability Alliance	Same as Line 22.	See Line 22.
45.	VA Ability Alliance	Same as Line 22	See Line 22.
46.	VA Ability Alliance	Same as Line 22	See Line 22.
47.	VA Ability Alliance	Same as Line 22	See Line 22.
48.	VA Ability Alliance	Same as Line 22	See Line 22.

49.	VA Ability Alliance	Same as Line 22	See Line 22.
50.	VA Ability Alliance	Same as Line 22	See Line 22.
51.	VA Ability Alliance	Same as Line 22	See Line 22.
52.	VA Ability Alliance	Same as Line 22	See Line 22.
53.	VA Ability Alliance	Same as Line 22	See Line 22.
54.	VA Ability Alliance	Please do not reduce the CCC Plus waiver hours for our kids.	See Line 22.
55.	VA Ability Alliance	Inputs on Three waivers redesign - I support the comments made by Virginia Ability Alliance. To support the families in caring for their children while they are on the waiting list, do not continue to decrease CCC Plus Waiver hours.	See Line 22.
56.	Virginia Ability Alliance	I support the comments made by the Virginia Ability Alliance. To support the families in caring for their children while they are on the waiting list, do not continue to decrease CCC Plus Waiver hours.	See Line 22.
57.	VA DADPA	Concerns with DD Waiver Proposed Regulations - Three waivers redesigned - I support comments made by the Virginia Ability Alliance. Don't reduce the CCC plus waiver time.	See Line 22.
58.	Virginia Ability Alliance	I support comments made by the virginia ability alliance. Do not reduce the cccplus waiver time.	See Line 22.
59.	Citizen	I support that Removing age cap on Autism health coverage	This comment is unrelated to these regulations.
60.	KADPA	Same as Line 22	See Line 22.
61.	Virginia Ability Alliance	I support comment by the Virginia Ability Alliance. Do not reduce the CCCPlus waiver time. Thank you	See Line 22.
62.	Virginia Ability Alliance	New wavior legulation	No response - possible input error.
63.	VA Kadpa Citizen	**CCC plus time -** I support comments made by V A A. Don't reduce the CCC plus waiver time.	See Line 22.
64.	VA Kadpa Citizen	Inputs on three waivers redesign(ID, DD and DS)	No response - possible input error.
65.	VA Kadpa Citizen	Three waivers redesigned - I support comments made by the Virginia Ability Alliance. Don't reduce the CCC Plus waiver time. Thank you.	See Line 22.
66.	VA Kadpa Citizen	Three waivers redesigned - I support comments made by the Virginia Ability Alliance. Don't reduce the CCC Plus waiver time. Thank you.	See Line 22.
67.	Virginia Ability Alliance - Citizen	Three waiver - I support comments made by the Virginia ability alliance. Please don't reduce the CC Plus waiver time.	See Line 22.
68.	Virginia Ability Alliance - Citizen	Three waivers redesigned - I support comments made by Virginia Ability Alliance. Don’t reduce the ccc plus waiver time. Thanks.	See Line 22.

69.	VA Kadpa Citizen	Three waivers redesigned	No response - possible input error.
70.	VA Kadpa Citizen	Inputs on three waiver redesign	No response - possible input error.
71.	VA Kadpa Citizen	I support comment made by the Virginia ability alliance.do not reduce the ccc plus waiver time.	See Line 22.
72.	VA Kadpa Citizen	**Three Waivers redesigned -** I support comments made by the Virginia Ability Alliance. Don't reduce the CCC plus Waiver time. Thank You.	See Line 22.
73.	VA Kadpa Citizen	I support comments made by the Virginia ability alliance.do not reduce the ccc plus waiver time.	See Line 22.
74.	VA Kadpa Citizen	**Three Waivers Redesigned -** I Support Comments made by the Virginia Ability Alliance. Don't reduce the CCC plus Waiver time.	See Line 22.
75.	George Mason University Citizen	I support comments made by the Virginia ability alliance.do not reduce the ccc plus waiver time.	See Line 22.
76.	VA Kadpa Citizen	**Three Waivers Redesigned -** I Support Comments made by the Virginia Ability Alliance. Don't reduce the CCC plus Waiver time.	See Line 22.
77.	VA Ability Alliance Citizen	**Inputs on Three Waivers Redesign (ID, DD, and DS)** 1. I support the **comments made by Virginia Ability Alliance**. 2. To support the families in caring for their children while they are on the waiting list, do not continue to decrease CCC Plus Waiver hours.	See Line 22.
78.	VA Kadpa Citizen	Three waivers redesigned	No response - possible input error.
79.	VA Kadpa Citizen	**Three waivers redesigned;** I support comments made by the Virginia Ability Alliance. Don't reduce CCC Plus waiver time.	See Line 22.
80.	VA Kadpa Citizen	**Three waivers redesigned** Three waivers redesigned	No response - possible input error.
81.	VA Kadpa Citizen	**Three waivers redesigned** Three waivers redesigned	No response - possible input error.
82.	Parent of Two Adult Sons with Fragile X, Fairfax, VA	*2. Quality of Service Providers*. The quality of care, level of expertise, and knowledge that group homes/facilities provide are grossly inadequate, neglectful, and abusive. My sons have consistently experienced *many* of the following in *every* group home they have lived: teeth not brushed/excessively bleeding gums; burns in their mouths; nails long and dirty; unshaven for weeks/months; smelling from not bathing; shirts, pants, underwear, socks, and shoes on backwards; inappropriate, wrong size, another person's clothing; zippers on winter coats broken, not fixed; evidence/reports of excessive hunger/not being fed; kept inside all the time, not taken out in the community; having *new* problematic behaviors uncharacteristic for them; theft of their personal property; embezzlement by, mismanagement of group home personnel; staff under the influence of (illegal) drugs; in other words, the Wild, Wild West! Not only is it extremely disturbing to observe these things, but it is even more so to think about what I do not and cannot see. My sons, and many like them, are <u>VULNERABLE</u> individuals who need every possible means	We empathize with your situation, and we are grateful to you for expressing it to us. Unfortunately, we have a limited amount of funding allocated by the General Assembly for waiver slots. With a shortage of resources for waiver services, this process

		used to ensure their safety and *dignity as humans*. As a society, we need to ensure that they are protected and provided for appropriately and that funds provided for this are utilized effectively. My sons are mentally 3 and 12 years old; *would we allow children of this chronological age to be cared for by the private sector at this disturbingly low level and lack of oversight?* I see the problem with this as inherent to allowing the private sector to provide these services *and* to lack of oversight of these private providers .I think that local CSBs should be administering these services because they are in the position to provide the highest level and quality of care, oversight, consistency, stability, security, and to recruit and retain higher quality staff by offering higher wages, benefits, quality of employment. Many CSB Support Coordinators have told me the best managed group homes/facilities are those run by the County governments. Loudoun County is one that is particularly praised. Not only is this the solution to this problem, *it is the right thing to do*. A cost analysis of this proposal may even show that it is economically feasible;	attempts to allocate those limited services fairly. The waiting list focuses on individual criteria rather than age. Please contact your CSB and encourage them to provide this service.
83.	Parent of Two Adult Sons with Fragile X, Fairfax, VA	*4. Day Programs*. Both of my sons cannot get accepted to a day program (all privately owned and run) because of their behaviors and have been stuck "at home" full-time since aging out of school one and two years ago, respectively. My second son has minor behavioral issues (occasionally curses, tears up/throws paper when upset). Yet, because of a lack of programs and their ability to reject anyone for any reason, my sons have been languishing. This has led to mental health problems (depression, frustration) and in turn more unwanted behaviors- *a vicious cycle*. I was pleased to read the Virginia Ability Alliance's comment that Personal Assistants need to be funded/allowed to accompany those who need them to participate in the community. This would improve my sons' ability and opportunity participate in available private sector day support programs if they could have a caregiver with them. With this not being funded, my sons are stuck "at home", 24/7, until I take them out. 5. Need for Streamlined Processes. It is a full-time job coordinating the care of my sons and is often daunting, yet I am diligent in my advocacy as no one else is going to do what is needed. But I am also an aging parent with health issues, cannot continue to do this indefinitely. I think the stress of having to deal daily not only with the challenges of my sons' disability, but more so the lack of adequate supports we've needed and not gotten over the years: the endless paperwork, evaluations, interventions, visits, often to prove my sons are still disabled when their condition is not going to change, barring a miracle, is nothing short of harassment; and the endless searching for quality service providers, having to constantly monitor them, find new ones when those fail, never being able to rest, assured that my sons are healthy and happy	Funding is not available for Personal Assistants for individuals who are in day programs.

84.	Citizen	Benefits Planning, Community Guide, Non-medical Transportation/Employment & Community Transportation Services, Peer Support Services are not included in the proposed regulations but are current available waiver services. A Medicaid Memo was published September 4, 2018 for Community Guide, including Community Housing Guide, Peer Mentor Supports and Benefits Planning Services. Sufficient time has elapsed to include these services in the final DD Waiver regulations for consistency in waiver implementation. We recognize that including them at this stage is a substantive change. However, to continue on without regulatory authority is unacceptable. All waiver services should be included for the purposes of public review and comment. DMAS and DBHDS should create the option for a single agency to have one Plan for Supports per individual regardless of the number of services provided to an individual in order to streamline documentation and reduce the number of quarterly reports required. This was a unanimous recommendation of the DBHDS's own Provider Issues Resolution Workgroup (PIRW) in its report published August 2018. Support the allowance of employment services organizations (ESOs) to be providers of Peer Mentor Supports, Employment & Community Transportation Services and Community Guide services. Support the consistent use of "progress notes" as defined in the DD Waiver regulations versus the use of "daily note" references. We support the definition of "progress notes" as defined in 12VAC30-122-20 "Definitions" for consistency. "Progress notes" means individual-specific written documentation that (i) contains unique differences specific to the individual's circumstances and the supports provided, and the individual's responses to such supports; (ii) is signed and dated by the person who rendered the supports; and (iii) is written and signed and dated as soon as is practicable but no longer than one week after the referenced service." Support changing the 10-day requirement to a 15-day requirement for service providers to submit quarterly reports.	These services will be added to the final stage. Add progress note answer.
85.	Citizen	1. Virginia should develop and implement a central provider audit tool to decrease multiple requests of providers for the same information across reviewers. This tool should bring together the various monitoring entities and result in collaboration and consistency in interpretation across agencies and reviewers eliminating redundancy in documentation requests. This includes reviews by DBHDS subcontractors, human rights, licensing and Medicaid regulations and interpretations by contractors, specialists, and quality management and provider integrity. 2. Provide for the opportunity for deemed provider status for providers that hold a national accreditation (CARF) or specific certification to reduce the frequency of reviews. This would reduce both state government and provider time and money.	The agencies are reviewing for compliance with different sets of regulations. The agencies continue to try to streamline audit processes. Add CARF issue.

86.	Citizen	Recently, service care hours for attendant who cares for our son Joshua was drastically reduced from 60 to less than 30. Joshua has a seizure condition and due to brain damaged caused by it at early age, he is unable to talk, walk, move about or care for himself in anyway. Because of this he is completely dependent and needs constant care for all his needs. Both my wife and I work full time to make ends meet but without the service care hours that Is needed we will not be able to do so. Joshua is 12 years old and we are grateful that he has gotten the care he has needed thru Medicaid so far, I truly believe his health and well-being has improved through the years although it may be hard to judge. Please re-evaluate decreasing service care hours so that Josh can continue to make his progress.	Individual response. Personal Care Hours - CCC Plus repsonse
87.	Karen Tefelski - vaACCSES	1. Benefits Planning, Community Guide, Non-medical Transportation/Employment & Community Transportation Services, Peer Support Services are not included in the proposed regulations but are current available waiver services. A Medicaid Memo was published September 4, 2018 for Community Guide, including Community Housing Guide, Peer Mentor Supports and Benefits Planning Services. Sufficient time has elapsed to include these services in the final DD Waiver regulations for consistency in waiver implementation. We recognize that including them at this stage is a substantive change. However, to continue on without regulatory authority is unacceptable. All waiver services should be included for the purposes of public review and comment. 2. DMAS and DBHDS should create the option for a single agency to have one Plan for Supports per individual regardless of the number of services provided to an individual in order to streamline documentation and reduce the number of quarterly reports required. This was a unanimous recommendation of the DBHDS's own Provider Issues Resolution Workgroup (PIRW) in its report published August 2018. 3. Support the allowance of employment services organizations (ESOs) to be providers of Peer Mentor Supports, Employment & Community Transportation Services and Community Guide services.	1. See Line 86. 2. This comment is under review and is being considered. 3. See above.
88.	Karen Tefelski - vaACCSES	Same as Line 105	
89.	Pov. Law Firm/J. Hanken	General comment – These regulations should include the 90 day time limit for final DMAS action on appeals.	This comment has been forwarded to the Appeals Division.

90.	B Martin - CHOICE Group	Benefits Planning, Community Guide, Non-medical Transportation/Employment & Community Transportation Services, Peer Support Services are not included in the proposed regulations but are current available waiver services. A Medicaid Memo was published September 4, 2018 for Community Guide, including Community Housing Guide, Peer Mentor Supports and Benefits Planning Services. Sufficient time has elapsed to include these services in the final DD Waiver regulations for consistency in waiver implementation. We recognize that including them at this stage is a substantive change. However, to continue on without regulatory authority is unacceptable. All waiver services should be included for the purposes of public review and comment. DMAS and DBHDS should create the option for a single agency to have one Plan for Supports per individual regardless of the number of services provided to an individual in order to streamline documentation and reduce the number of quarterly reports required. This was a unanimous recommendation of the DBHDS's own Provider Issues Resolution Workgroup (PIRW) in its report published August 2018. Support the allowance of employment services organizations (ESOs) to be providers of Peer Mentor Supports, Employment & Community Transportation Services and Community Guide services. Support the consistent use of "progress notes" as defined in the DD Waiver regulations versus the use of "daily note" references.	These services will be added to the final stage. / This comment is under review and is being considered. / These terms have different meanings. DMAS will review the references to these terms in the regulations.
91.	B Martin - CHOICE Group	Community Coaching (122-310.E.2), Community Engagement (122-320.E.2), Group Day (122-380.D.5.), Group Residential (122-390.D.5), Crisis Support Services (122-350.E.2) and Center-Based Crisis Support Services (122-300.E.2) all have additional burdensome requirements under Service Documentation or Provider requirements that state that there must be written supervision notes for each DSP, signed by the supervisor and included semi-annual documentation of individual's satisfaction by the supervisor. (Center-based Crisis Supports does not include the semi-annual requirement.) Semi-Annual supervisory documentation of an individual's "Satisfaction with service provision" or "observation of satisfaction" is also required. This is duplicative of the initial and annual thereafter required documentation of proficiency of staff competencies included under 122-180.Not to mention, much more stringent. Why some services and not others? Consistency between the services does not exist. Group Day requires documentation of "observation of satisfaction". The requirement of semi-annual notes in the DSP supervision note regarding "satisfaction of the individual" or "observation of satisfaction of the individual" is not consistent with the already required individualized documentation. If anyone should be documenting an "individual's satisfaction with service provision" or "observation of satisfaction" – it should be the support coordinator/case manager during their regular visits. Someone other than the provider should be evaluating whether an individual is satisfied with the service they are receiving from the provider. It's like the proverbial "rooster guarding the hen house". The support coordinator/case manager is the more appropriate person and, if required, it should be required for all waiver	See Line 105.

		services and not just some services. The requirement of proscribed supervisory notes on a regular semi-annual basis is another added administrative burden layered on top of the annual DSP staff competency requirement which was added after the waiver rates were set. Both cumbersome documentation requirements are not included in any rate. Virginia should develop and implement a central provider audit tool to decrease multiple requests of providers for the same information across reviewers. This tool should bring together the various monitoring entities and result in collaboration and consistency in interpretation across agencies and reviewers eliminating redundancy in documentation requests. This includes reviews by DBHDS subcontractors, human rights, licensing and Medicaid regulations and interpretations by contractors, specialists, quality management and provider integrity. Provide for the opportunity for deemed provider status for providers that hold a national accreditation (CARF) or specific certification to reduce the frequency of reviews. This would reduce both state government and provider time and money.	
92.	J Creech/Pos. Beh. Consults	Recommendations: Behavior Support Plan must be written within 6 months of start date. There is currently no guidance re: when a behavior support plan should be written. Ideally, it is written within 3 months; however, 6 months leaves room for extenuating circumstances, such as hospitalizations. Providers must have a documented contact with the individual being supported OR support team a minimum of 1x every 6 months. Again, ideally, providers would have at least monthly contact. There is no current recommendations regarding how often a provider should have contact with the individual or their support team. Six months leaves room for extenuating circumstances such as lengthy hospitalizations, cancellations, etc. Comments on Therapeutic Consultation (Behavioral Consultation): "Therapeutic consultation" means professional consultation provided by members of psychology, social work, rehabilitation engineering, behavioral analysis, speech therapy, occupational therapy, psychiatry, psychiatric clinical nursing, therapeutic recreation, physical therapy, or behavior consultation disciplines that are designed to assist individuals, parents, family members, and any other providers of support services with implementing the individual support plan. When behavior precedes analysis, it should be “behavior” rather than “behavioral”	Edits have been made to the Therapeutic Consultation section.
93.	H Denman/Arc of Harrisonburg	I agree with the comments posted by The Arc of Virginia & I agree with the comments made by John Malone, HR-CSB	Thank you for your comment.
94.	Community Concepts, Inc.	Such documentation shall be written on the date of service delivery. Strike or change to as soon as practicable but no longer than one week after the service. This is in keeping with the definition of Progress Note from this chapter.	Progress notes
95.	Kathy Adams, Parents of Autistic Children of NOVA	The Board of Directors of Parents of Autistic Children of Northern Virginia supports the DD waiver regulation comments made by the Virginia Ability Alliance.	Thank you for your comment.

		Kathy Adams, Scott Campbell, Susan Edgerton, Brianne Russell-Morris, www.poac-nova.org	
96.	Citizen	I support the DD waiver regulation comments made by Virginia Ability Alliance.	Thank you for your comment.
97.	Kelly Reichard, Stand Up, Inc	1. DMAS and DBHDS should create the option for a single agency to have one Plan for Supports per individual regardless of the number of services provided to an individual in order to streamline documentation and reduce the number of quarterly reports required. This was a unanimous recommendation of the DBHDS's own Provider Issues Resolution Workgroup (PIRW) in its report published August 2018. 2. Support the allowance of employment services organizations (ESOs) to be providers of Peer Mentor Supports, Employment & Community Transportation Services and Community Guide services. 3. Support the consistent use of "progress notes" as defined in the DD Waiver regulations versus the use of "daily note" references. We support the definition of "progress notes" as defined in 12VAC30-122-20 "Definitions" for consistency. "Progress notes" means individual-specific written documentation that (i) contains unique differences specific to the individual's circumstances and the supports provided, and the individual's responses to such supports; (ii) is signed and dated by the person who rendered the supports; and (iii) is written and signed and dated as soon as is practicable but no longer than one week after the referenced service." 4. A.10.d- Strike "Such documentation shall be written on the date of service delivery." This is not in keeping with the definition of Progress Note in 122-20 and as referenced earlier in comments. 5. Support changing the 10-day requirement to a 15-day requirement for service providers to submit quarterly reports. 6. C. (3) - Group and individual supported employment service shall take place in nonresidential settings separate from the individual's home. Recommendation: Change wording to allow for services, which may occur in an individual's home, such as job development or for individuals that work or telework from their home. 7. C.4. – Strike "service" after employment. Strike "in combination w/other day service or residential service" and Change to "concurrently w/other waiver services for purposes of job discovery". Should read as follows: "For time limited and service authorized periods (not to exceed 24 hours) individual supported employment service may be provided in combination w/concurrently w/other waiver services for purposes of job discovery." 8. E.1.c. – Sentence needs to be reworked. "Documentation confirming the individual's time in service" is for Group Supported Employment (GSE) only. "Daily note" is only applicable to GSE as well. Strike "daily note" and insert "progress note" to be consistent with other sections and definition of "progress note" in Section 122-20. 9. E.1.f. - Sentence needs to be reworked. Should read "Documentation that indicates the date, type of service rendered,	1. Plan for Supports. 2.ESOs 3. Progress notes. 4. Progress notes. 5. DMAS is not able to make this change at this time. 6. Ask Heather. 7. DMAS is not able to make this change at this time. 8. Edits made. 9. The attendance log activity refers to the job coach. 10. Make change.

		and the number of hours provided, including specific timeframe. An attendance log or similar document shall be maintained for Group Supported Employment". An attendance log or similar document is not required for ISE since the individual is competitively employed. 10. E.1.i. – After group, Insert "for Group Supported Employment".	
98.	Self Advocate	Problems with fiscal agent, DentaQuest, etc 1. In Jan i got the FIS Waiver and my DSS failed to put in my medicaid renewal correctly resulting in my attendants not getting paid for three months. As type this, they still have not been paid. 2. With the switch to FIS Waiver also came a fiscal agent switch to CDCN. CDCN lost background checks, online timesheet glitches, ETC. 3. My letter I mailed to DentaQuest: - I writing to place a complaint with DentaQuest. I've had an extremely difficult time getting my teeth cleaned under the adult dental coverage plan. I understand two cleanings a year are covered under my MCO, which is Healthkeepers Plus. - Each of the offices listed below were referred by DentaQuest / Healthkeepers Plus. - February 5, 2018 - Julie Ball (757) 427-1600 1515 Lynnhaven Pkwy, Virginia Beach - My partner of 21 years took a day off from work to take me to the dental appointment because I cannot drive. When going into the office, there are two visible steps inside. I use a heavy power chair; steps create a barrier. Why is an inaccessible dental office listed on DentaQuest? Result: Did not get my teeth cleaned. - September 21, 2018 - Debra A Davis (757) 464-0723 4600 Westgrove Ct, Virginia Beach - This dentist cleaned my teeth on March 26, 2018. For my next scheduled cleaning, I called the office and discovered they did not accept my MCO as they did previously. Result: Did not get my teeth cleaned. - February 15, 2019 - Kool Smiles (757) 769-8911 4239 Holland Road, Virginia Beach - I went to their office and filled out the paperwork only to find out they wanted me to pay $110 for a cleaning. They informed me that they only accept PPOs, not MCOs or HMOs. Result: Did not get my teeth cleaned. - I would like to see the dental provider list updated regularly with accurate information on ADA compliant offices to prevent this from happening again to me or anyone else.	Please continue to work with your case manager to resolve these issues.
99.	C Skelly, DD Committee, Arlington CSB	On behalf of the Developmental Disabilities (DD) Committee of the Arlington Community Services Board, I am writing to support the extensive comments and recommendations of the Virginia Abilities Alliance (VAA) regarding the current Medicaid Waiver structure, and to highlight specific areas of concern.	Thank you for your comment.

100.	Citizen	support the VAA Comments on DD Waiver Regulations & adding caregiver age to Priority One List I support the VAA Comments on DD Waiver Regulations listed below. I also fully support the the consideration of a caregivers age to be added back in to be added to the Priority One Waiting List. As a mother of a 36 year old lovely daughter with Autism, I have experienced first hand the difficulties she experienced in transitions through her life. Changes have required discussions way in advance at times, social stories, pictures, and planning ways to decrease negative behaviors that result as The Arc of Northern Virginia and other disability advocacy organizations in Northern Virginia routinely meet to share information and concerns. This coalition of organizations is named The Virginia Ability Alliance, and we focus on ensuring all people with disabilities are living a full life in their homes and communities. Our organizations collectively serve many thousands of Northern Virginians with developmental disabilities (DD) and their loved ones. On a frequent basis, we all field inquiries about Medicaid Waivers and the cadre of DD service options in Virginia. These contacts with families have helped us learn a tremendous amount about how the previous regulations for the Waivers and the current emergency regulations have impacted the ability of people with disabilities to access critical services and supports. The new regulations and Waiver system are a significant improvement from the previous system. Having seen the new regulations in use since fall 2016 has given us the opportunity to find ways in which they could be further improved. The comments below are representative of our joint concerns with the current regulations and, where appropriate, include proposed remedies to the issues cited. We look forward to working closely with DBHDS at every opportunity to assist in having needed adjustments made to the DD Waiver Regulations. The DD Waivers Waiting List Though the funding for DD Waivers is beyond the control of DBHDS, the long and continuously growing waiting list to access the DD Waiver is a foremost concern of our organizations. We would support any consideration of a contract that would not allow a waiting list for basic care services. For individuals on the waiting list, we have growing concerns about the age of the primary caregiver(s) not being considered in assessing waiting list priority. Since the new regulations have been in effect, we have seen rapidly growing panic from aging caregivers who no longer qualify for the Priority One waiting list due to age. It creates tremendous stress for the caregivers and loved ones. We have done ourselves a disservice in planning as it is obvious that caregivers in advanced age, no matter how healthy, are going to reach a point in the near future when help is critical. The removal of this eligibility for Priority One reduces the odds that the person with a disability will be able to access services before their caregiver dies. This is setting up the person with a disability for a series of rapid crises, as they lose parents, navigate the service system, and, in many cases, move to access services they need. We propose that the age of the caregiver again be considered as a factor in determining eligibility for Priority One of the waiting list. The terminology used in association with the Priority tiers is confusing and misleading. To explain these categories in terms	Age of primary caregiver - There is a shortage resources for waiver services, and this process attempts to allocate those limited services fairly. The waiting list focuses on individual criteria rather than age. / Priority tiers - DMAS will take this comment into consideration. / Medical team and nursing hours - the medical team completes the form and their input is considered. / Appeal of SIS scores - SIS scores are not appealable but there is a process for reassessment to request a review when an individual's needs change such that current SIS no longer reflects current tx / Overlap of PDN and skilled nursing - Skilled nurses can provide either service, and can supervise in PDN. DMAS is not able to make changes at this time. / Overlap of personal care and community

		of years someone could be expected to wait for services furthers the notion that our system will always have multiple years of wait time for assistance. It frames our future in a negative light and is disrespectful to people who are eligible for assistance immediately, but who have been failed by our state's continuous failure to budget appropriately. Additionally, the usage of years of wait time confuses families who often feel it is a guaranteed maximum waiting time. For individuals who need to transfer from one Waiver to another Waiver offering a higher level of services, urgency of need should be taken into account. Though anyone in this situation is in need, there are people on that list who have emergency needs (e.g., death of all caregivers or behavioral crises) and people who need a higher level of service but may be able to wait a short period of time (e.g., parent who is struggling to lift them and perform needed personal care at home). A system to assess that urgency and award reserve Waiver slots accordingly would be a better solution. If no one is currently on the reserve list at a given CSB when a slot becomes available, that slot should be made available to the person highest on the Priority One waiting list. Assessment for services The DMAS-62 form that scores someone's medical needs and eligibility for hours of nursing care under the DD Waiver system does not include all possible medical needs. Some people with complex and unusual needs are not able to get nursing hours their care team recommends, as the needs are not reflected on the form. The regulations should clarify that the advice of the providing medical team should be taken into account in determining nursing hours. There is heavy reliance upon the Supports Intensity Scale (SIS) in determining service availability, with all indications that such reliance will increase in the future. Like all assessments, it is imperfect in seeing the full picture of someone's life. Because specialists (e.g., medical and behavioral providers) have invaluable insights into the support needs of individuals they serve, their written statements should be taken into account, along with SIS responses, to determine final SIS scores. SIS scores should be able to be appealed when the SIS fails to take into account critical care information not captured in the assessment. Waiver and Service Eligibility People with the DD Waivers do not have the option to "spend down" income over the Waiver income cap on medical expenses to demonstrate eligibility for Waiver. The net result is that people with either high earned or unearned income are ineligible for the DD Waivers. As we see the generation of baby boomers retiring and SSDI payments to adult children reaching and exceeding the limits of financial eligibility, it would be wise to amend the DD Waiver Regulations to allow a "spend down" option similar to that allowed under the CCC Plus Waiver. Additionally, regulations should protect eligibility for anyone who is put over the monthly income cap as a result of SSDI received from parents. This benefit cannot be refused, despite the wishes of the person with a disability, yet it can have the effect of making them ineligible for crucial services they cannot afford. Service Conflicts The proposed Waiver regulations prohibit the same person from receiving both Private Duty Nursing and Skilled Nursing. This has been a concern for families whose loved ones using Waivers	guide - edits made. / Overlap of personal care and community engagement - personal assistance is a component of community engagement. / Family homes that are unsafe - current regulations address this concern because these issues are considered. / EM uses narrow - Edits made. / Supported living residences must be provider owned-licensed - Edits made. Also, If individuals use a housing voucher, they can get similar services through in-home supports or independent living supports. / Customized rates - DMAS wis not able to make changes at this time. / Parents as paid caregivers - DMAS is not able to make changes at this time. / Accessing DD waivers out of state - Edits made. / CD personal care out of state - DMAS is not

		have significant nursing needs that require ongoing nursing care through PDN, but also significant skilled oversight that realistically only comes with a nursing case manager. If the regulations were to allow limited hours of Skilled Nursing for those people whose nursing needs are beyond what can reasonably be covered with the limited oversight funded in the Private Duty Nursing rate as demonstrated by history, it would prevent institutionalization for some of the most medically at-risk individuals in our system. The proposed regulations do not allow personal care to be billed in conjunction with skilled nursing. For individuals who receive both services, this is a challenge. It is not reasonable to ask that an individual with Waiver having a nursing come for a brief nursing visit would be able to have their personal care attendant leave during that time and return once the nurse leaves, or to sit by without pay during the visit. The problem is compounded as personal care attendant is the person who will be able to provide private personal care that the nurse may not be best suited to giving during the visit. We suggest allowing some overlap of billing for times when skilled nurses are making brief visits and regularly scheduled personal care is still needed. The Waiver regulations allow the use of personal care attendants in combination with group or individual supported employment, unless the individual is living in a group home or sponsored residential situation. This loophole creates an unnecessary hurdle to accessing employment for people living in either group or sponsored residential situations. Regulations should clarify that, for individuals needing a personal care attendant with them while accessing community guide services, service overlap should be allowed as the community guide does not provide personal care supports. For similar reasons, community engagement should allow for the simultaneous provision of personal care services. Service Definitions and Regulations The eligibility for center-based crisis and community-based crisis services mandates a history of involvement with psychiatric hospitalization, incarceration, a loss of residential or day placement, or behavior at risk of jeopardizing “placement.” The terminology about a “jeopardized placement” does not clearly reflect risks to individuals living in family homes, which is not “placement” in the general usage of the term. The regulations should be amended to clarify that individuals living in family homes with behaviors making those living environments unsafe are eligible. The allowable usages of Environmental Modifications are quite narrow, not taking allowing changes needed for safety, including items like keypads on doors to prevent individuals from eloping. These and other safety-based modifications are critical to allowing many individuals to access their communities and safely live at home. Individuals who are best served with the Supported Living service are experiencing difficulties in finding a suitable option as they often need a housing voucher for affordability reasons. However, the regulations mandate Supported Living residences be provider owned/licensed, thus incompatible with housing vouchers. We would like to see an adjustment made to allow the use of the two options together. The current regulations only allow customized rates in group day and residential services.	able to make this change at this time. / BI waiver - personal care and crisis support - DMAS is not able to make this change at this time. / AT vendors and markup - The current process allows vendors to charge and bill for usual and customary charges associated with the product. The provider's charge for Assistive Technology may include a charge for the product, and other charges associated with procuring the product. Additional guidance will be provided in the Manual. / 24 hours of job discovery - this is 24 hours over the course of time, not one day. / Different case mgmt for different IQs - this is due to the fact that there are two state plans that were reviewed and approved by CMS. / Privately contracted support coordinators -

		Individuals with comparable needs, but using more integrated services (e.g., employment, in-home private duty nursing) cannot access customized rates and have challenges getting the services they need. Customized rates should be available for any service that cannot be provided with the base rate due to the exceptional needs of the individual. At a minimum, this should include all employment and nursing services. The regulations disallow parents of a minor children from being paid caregivers. Since residential services are only available to adults, this regulatory hurdle complicates efforts to get children out of nursing homes and Intermediate Care Facilities (ICF) and increases the chances other children will access these institutional settings in the future. In our personal experience, many of the kids at the Iliff Nursing Home for children are there because the families were well informed about Waivers. Many of those families have a very low household income and/or limited-English proficiency, making navigating the many complexities of the Waiver infinitely harder. Allowing these families to be paid to take care of their children at home would open up options for many of those children to be discharged. The reality of hiring care attendants for people with complex needs is that families will struggle to identify adequate staff and there will be gaps in service. This makes it impossible for families with all working parents and inflexible jobs to support children with complex needs at home. This can be remedied if children can have paid parent caregivers. Justification should be provided demonstrating this need, with automatic eligibility for children in or at risk of nursing home or ICF placement. Current rules and regulations prohibit lawful current Virginia residents from accessing DD Waiver services while they are living outside of Virginia, as is the case for Foreign Service families, military families, and students with disabilities attending school in another state. These families have the option to stay on the waiting list while they are out of the area, but do not have the ability to accept services if offered as they do not have the option to choose where they are stationed (and in the case of college students, often do not have the option of attending simply any college or university). We support an adjustment to the regulations to allow people to use consumer directed personal care services when living outside of Virginia as long as they maintain Virginia residence, while using technology-based options for "face to face visits." They would allow Service Facilitators and Support Coordinators to have visits and inspect the home environment. The BI Waiver does not allow for Personal Care Attendants or crisis support services. Additionally, many "Tier 1" individuals receive the BI Waiver and are then only eligible for up to 10 weekly hours of Independent Living Services. These limits can prevent individuals who would otherwise thrive with this Waiver from accepting it. The use of limited Personal Care hours and crisis support services would make this Waiver a realistic option and increase independent living. Under the regulations, Assistive Technology vendors cannot add a markup to purchases. The result is that it became incredibly difficult to find AT vendors, let alone a choice of vendors. Allowing the 30% mark-up to be reinstated would help	CSBs offer qualified privately contracted support coordinators when they are available. / Child at least six years old - edits made. / Conflict of interest - case management and services are administratively separate. DMAS is not able to make this change at this time. / 10 day grace period - this will be discussed in the manual. / Either immediate transfer or technology-based visits - there are case management transfer protocols in place. DMAS is not able to make changes at this time. / Without reimbursement 2 days per month - DMAS is not able to change the rate methodology at this time.

		in service availability. The regulations do not allow more than 24 hours of billing overlap for job discovery while someone is accessing a day service. It can take much more than 24 hours to find the correct job and work with an employer on job prep, such as customized employment. This minimum should be increased to further remove barriers to employment. Support Coordination and Service Facilitation Despite many efforts to move our system to one where people with developmental disabilities and intellectual disabilities are treated equally, there continues to be a divide in relation to Support Coordination. Prohibiting people from accessing the full range of Support Coordinators because of their IQ does not make sense, nor is it fair or equitable. We would like to see the regulations for Support Coordination to be identical for all people eligible for the DD Waivers, including the option for privately contracted Support Coordinators. The eligibility criteria listed to receive Support Coordination and other services for individuals with developmental disabilities states the child must be at least six years old. Given that the state has adopted the federal definition of developmental disability, which has no age minimum, the regulations should be adjusted to remove any age minimums for service access. Under the proposed regulations, Community Service Boards (CSBs) are allowed to operate as service providers, even in cases when families have no choice but to select a CSB Support Coordinator. There is a clear conflict of interest if the person responsible for helping to evaluate and select service providers is also a provider. Recognizing that some areas have a dearth of service providers, we suggest a phase out period during which CSBs should step away from the direct provision of DD Waiver services and/or a move that would prohibit CSB Support Coordination if the CSB was also the Service Coordinator. Early presentations on the redesign stated that a 10 day grace period would be offered for in-person visits, including Support Coordinators and Service Facilitators. That grace period is critical. There are times when a family experiences an emergency, weather intervenes, or a Support Coordinator must manage a crisis and a visit must be rescheduled. The 10 day grace period allows for those visits to be rescheduled without undue stress and burden on individuals and their support team. The grace period should only be used as needed and should include written justification for its usage. Currently, if an individual moves from one CSB to another part of the state and begins to receive Support Coordination from their new CSB, their original Support Coordinator must continue to provide face to face visits until the individual stabilizes. Given the size of the state, in some cases this means Support Coordinators are spending more than a full day a month driving to do a single visit, sometimes for months on end. Additionally, for an individual moving a significant distance, a Support Coordination who is based near their old home cannot be available in person for crises and will be without a known network of support providers. The regulations should be adjusted to allow EITHER an immediate transfer from one Support Coordinator to another when an individual moves more than 100 miles (or equivalent distance in time) OR technology-based visits until such transfer	

		can occur. At least one CSB is offering families the option to receive Consumer Directed services without a Service Facilitator, if the family is willing to act in that role without pay. Regulations should clarify whether or not this is allowed, and in what circumstances. Miscellaneous Page 25 of the proposed regulations uses the term "Elder or Disabled with Consumer Direction Waiver" and "Technology Assisted Waiver" instead of using the terminology for the new Commonwealth Coordinated Care Plus Waiver. Though we understand the rationale behind allowing providers of certain residential services to bill for 344 days per year and receive 365 days worth of funding, it has created significant barriers for providers. Providers must guess at the beginning of the plan year when vacations or out-of-home time will happen, as it is not consistently planned a full year in advance, so they can balance out planning and billing. Otherwise, they risk getting to the end of the year and finding they cannot bill for three weeks of the final month of the plan year. This is a real hardship, especially for Sponsored Residential providers who often serve one individual and receive Waiver reimbursement as their sole source of income. Instead, allowing providers to go without reimbursement for up to two days per month and recoup that income at the end of the plan year based upon days actually spent out of the home would help level off the income dips and offer some safeguards. As Waiver prohibits individuals from billing more than a year after a service is received and sometimes denials for insignificant reasons occur, a policy to allow this option with a grace period for the billing would be an appropriate solution. Closing The task of redesigning the DD Waivers, writing and editing new regulations, and overseeing our DD service system is massive and daunting. We are truly grateful for the staff dedicated to working hard to make things run smoothly and ensure people with disabilities can access needed services. We hope these suggestions are seriously considered and implemented. We look forward to being part of the collaborative team that continues to improve services for individuals with developmental disabilities in Virginia.	

101.	Johnston/Vector Industries	**1.** Benefits Planning, Community Guide, Non-medical Transportation/Employment & Community Transportation Services, Peer Support Services are not included in the proposed regulations but are current available waiver services. A Medicaid Memo was published September 4, 2018 for Community Guide, including Community Housing Guide, Peer Mentor Supports and Benefits Planning Services. Sufficient time has elapsed to include these services in the final DD Waiver regulations for consistency in waiver implementation. We recognize that including them at this stage is a substantive change. However, to continue on without regulatory authority is unacceptable. All waiver services should be included for the purposes of public review and comment. **2.** DMAS and DBHDS should create the option for a single agency to have one Plan for Supports per individual regardless of the number of services provided to an individual in order to streamline documentation and reduce the number of quarterly reports required. This was a unanimous recommendation of the DBHDS's own Provider Issues Resolution Workgroup (PIRW) in its report published August 2018. **3.** Support the allowance of employment services organizations (ESOs) to be providers of Peer Mentor Supports, Employment & Community Transportation Services and Community Guide services. **4.** Support the consistent use of "progress notes" as defined in the DD Waiver regulations versus **5.** The use of "daily note" references. We support the definition of "progress notes" as defined in 12VAC30-122-20 "Definitions" for consistency. "Progress notes" means individual-specific written documentation that (i) contains unique differences specific to the individual's circumstances and the supports provided, and the individual's responses to such supports; (ii) is signed and dated by the person who rendered the supports; and (iii) is written and signed and dated as soon as is practicable but no longer than one week after the referenced service." **6**. Support changing the 10-day requirement to a 15-day requirement for service providers to submit quarterly reports. **7.** Semi-Annual Supervisory Notes for DSPs including "individual's satisfaction with service provision". Requirement should be eliminated or changed per comments below: **8.** CommunityCoaching(122-310.E.2),CommunityEngagement(122-320.E.2),GroupDay (122-380.D.5.), Group Residential (122-390.D.5), Crisis Support Services (122-350.E.2) and Center-Based Crisis Support Services (122-300.E.2) all have additional burdensome requirements under Service Documentation or Provider requirements that state that there must be written supervision notes for each DSP, signed by the supervisor and included semi-annual documentation of individual's satisfaction by the supervisor. (Center-based Crisis Supports does not include the semi-annual requirement.) Semi-Annual supervisory documentation of an individual's "Satisfaction with service provision" or "observation of satisfaction" is also required. **9.** This is duplicative of the initial and annual thereafter required documentation of proficiency of staff competencies included under 122-180. Not to mention, much more stringent. Why some services and not others? Consistency between the services does not exist. Group Day requires documentation of "observation of	1. Edits made. / 2. DMAS is not able to make this change at this time. / 3. See response in 12VAC30-122-400, line 2. / 4. Edits made. / 5. Edits made. / 6. DMAS is not able to make this change at this time. / 7. Edits have been made to include this in section 12VAC30-122-120 for all services. / 8. Edits have been made to include this in section 12VAC30-122-120 for all services. Edits made regarding individual's satisfaction. / 9. Edits have been made to include this in section 12VAC30-122-120 for all services. / 10. DMAS will take this into consideration. / 11. DMAS is not able to make this change at this time. / 12. DMAS is not able to make this change at this time. / 13. Edits made. / 14. Edits made.

		satisfaction". The requirement of semi-annual notes in the DSP supervision note regarding "satisfaction of the individual" or "observation of satisfaction of the individual" is not consistent with the already required individualized documentation. If any one should be documenting an "individual's satisfaction with service provision" or "observation of satisfaction" – it should be the support coordinator/case manager during their regular visits. Someone other than the provider should be evaluating whether an individual is satisfied with the service they are receiving from the provider. It's like the proverbial "rooster guarding the hen house". The support coordinator/case manager is the more appropriate person and, if required, it should be required for all waiver services and not just some services. The requirement of proscribed supervisory notes on a regular semi-annual basis is another added administrative burden layered on top of the annual DSP staff competency requirement which was added after the waiver rates were set. Both cumbersome documentation requirements are not included in any rate. **10.** Recommend that DMAS and DBHDS actively work with CMS to develop and seek approval of a checklist to substitute for "progress notes" (narrative daily notes) - the demands of which detract from providers' resources to effectively support individuals. **11.** Virginia should develop and implement a central provider audit tool to decrease multiple requests of providers for the same information across reviewers. This tool should bring together the various monitoring entities and result in collaboration and consistency in interpretation across agencies and reviewers eliminating redundancy in documentation requests. This includes reviews by DBHDS subcontractors, human rights, licensing and Medicaid regulations and interpretations by contractors, specialists, quality management and provider integrity. **12.** Provide for the opportunity for deemed provider status for providers that hold a national accreditation (CARF) or specific certification to reduce the frequency of reviews. This would reduce both state government and provider time and money. 12VAC30-50-490. Support Coordination/case management for individuals with developmental disabilities, including autism. **13.** Eliminate the term "autism" in the section header. Autism/Autism Spectrum Disorders (ASD) are included in the term developmental disability. **14.** Eliminate the limitation of case management to individuals who are six years of age and older and who are on the waiting list or receiving services. Since we have moved to a DD Waiver system that does not differentiate based on diagnosis, there should not be an age restriction to the receipt of case management services. This is a remnant from the old IFDDS waiver where children under six were all served through the ID waiver. If individuals under the age of six are not in the target group, then it is unclear how they would gain a slot on the DD Waiver wait list or receive a DD waiver.	
102.	Kasia Grzelkowski, VersAbility Resources	Same as Line 105	See Line 105.

103.	Terry Twigg, VersAbility Resources	Same as Line 105	See Line 105.
104.	Jennifer Campbell, VersAbility Resources	Same as Line 105	See Line 105.
105.	Citizen	General Comments • Benefits Planning, Community Guide, Non-medical Transportation/Employment & Community Transportation Services, Peer Support Services are not included in the proposed regulations but are current available waiver services. A Medicaid Memo was published September 4, 2018 for Community Guide, including Community Housing Guide, Peer Mentor Supports and Benefits Planning Services. Sufficient time has elapsed to include these services in the final DD Waiver regulations for consistency in waiver implementation. We recognize that including them at this stage is a substantive change. However, to continue on without regulatory authority is unacceptable. All waiver services should be included for the purposes of public review and comment. • DMAS and DBHDS should create the option for a single agency to have one Plan for Supports per individual regardless of the number of services provided to an individual in order to streamline documentation and reduce the number of quarterly reports required. This was a unanimous recommendation of the DBHDS's own Provider Issues Resolution Workgroup (PIRW) in its report published August 2018.	See Line 105.
106.	Citizen	Support changing the 10-day requirement to a 15-day requirement for service providers to submit quarterly reports. • Semi-Annual Supervisory Notes for DSPs including "individual's satisfaction with service provision". Requirement should be eliminated or changed per comments below: o Community Coaching (122-310.E.2), Community Engagement (122-320.E.2), Group Day (122-380.D.5.), Group Residential (122-390.D.5), Crisis Support Services (122-350.E.2) and Center-Based Crisis Support Services (122-300.E.2) all have additional burdensome requirements under Service Documentation or Provider requirements that state that there must be written supervision notes for each DSP, signed by the supervisor and included semi-annual documentation of individual's satisfaction by the supervisor. (Center-based Crisis Supports does not include the semi-annual requirement.) Semi-Annual supervisory documentation of an individual's "Satisfaction with service provision" or "observation of satisfaction" is also required. ? This is duplicative of the initial and annual thereafter required documentation of proficiency of staff competencies included under 122-180. Not to mention, much more stringent. ? Why some services and not others? ? Consistency between the services does not exist. Group Day requires documentation of "observation of satisfaction". ? The requirement of semi-annual notes in the DSP supervision note regarding "satisfaction of the individual" or "observation of satisfaction of the individual" is not consistent with the already required individualized documentation. ? If any one should be documenting an "individual's satisfaction with service provision" or "observation of	See Line 105.

		satisfaction" – it should be the support coordinator/case manager during their regular visits. Someone other than the provider should be evaluating whether an individual is satisfied with the service they are receiving from the provider. It's like the proverbial "rooster guarding the hen house". The support coordinator/case manager is the more appropriate person and, if required, it should be required for all waiver services and not just some services. ? The requirement of proscribed supervisory notes on a regular semi-annual basis is another added administrative burden layered on top of the annual DSP staff competency requirement which was added after the waiver rates were set. Both cumbersome documentation requirements are not included in any rate. • Recommend that DMAS and DBHDS actively work with CMS to develop and seek approval of a checklist to substitute for "progress notes" (narrative daily notes) - the demands of which detract from providers' resources to effectively support individuals.	
107.	citizen	I support comments made by the Virginia Ability Alliance. Don't reduce the CCCPlus waiver time. Thank you.	See Line 22.
108.	citizen	I support support comments made by Virginia Ability Alliances. Don't reduce CCC plus waiver time.	See Line 22.
109.	Citizen	I support comments made by the Virginia Ability Alliance. Don't reduce the CCCPlus waiver time. Thank you	See Line 22.
110.	Citizen	I support comments made by the Virginia Ability Alliance Don't reduce the ccc plus Waiver time	See Line 22.
111.	Eun Jin Seo, KADPA	I support comments made by the Virginia Ability Alliance. Don't reduce the CCC Plus waiver time.	See Line 22.
112.	Citizen	I support comments made by the Virginia Ability Alliance. Don't reduce the CCC Plus waiver time.	See Line 22.
113.	Dominion Waiver/Koke	Recommend Spend-down for all Long-Term Care waiver categories. This language is already in the CCC+ waiver. This language should be moved to all categories.	Spend-down - DMAS is not able to make this change at this time.
114.	Citizen	I support comments made by the Virginia Ability Alliance. Don't reduce the CCPlus waiver time.	See Line 22.
115.	Citizen	I support comments made by the Virginia Ability Alliance. Don't reduce the CCC Plus waiver time.	See Line 22.
116.	Citizen	I support comments made by the Va Ability Alliance.. Don't reduce tue CCCPlus waiver time. Thank you	See Line 22.
117.	Citizen	I support comments made by the Va Ability Alliance.. Don't reduce tue CCCPlus waiver time. Thank you	See Line 22.
118.	Citizen	I support comments made by the Va Ability Alliance.. Don't reduce tue CCCPlus waiver time. Thank you	See Line 22.
119.	Citizen	I support comments made by the Virginia Ability Alliance. Don't reduce the CCC Plus waiver time.	See Line 22.
120.	Citizen	I support comments made by the Virginia Ability Alliance. Don't reduce the CCC Plus waiver time.	See Line 22.
121.	Citizen	I support comments made by the Virginia Ability Alliance. Don't reduce the CCC Plus waiver time.	See Line 22.
122.	Citizen	I support comments made by the Virginia Ability Alliance. Don't reduce the CCC Plus waiver time.	See Line 22.
123.	Citizen/KADPA	I support comments made by Virginia Ability Alliance. Please don't reduce the CCC plus waiver time. Thank you.	See Line 22.

124.	Citizen/KADPA	I support comments made by Virginia Ability Alliance. Please don't reduce the CCC plus waiver time. Thank you.	See Line 22.
125.	Citizen/KADPA	I support comments made by Virginia Ability Alliance. Please don't reduce the CCC plus waiver time. Thank you.	See Line 22.
126.	Frontier Health K Honeycutt	Same as Line 105	See Line 105.
127.	Wormley, Kerns, Collier, Lester, Hauley - VersAbility Rsc	Same as Line 105	See Line 105.
128.	Citizen	Same as Line 105	See Line 105.
129.	C. McElroy, WorkSource Enterprises, Charlottesville	Same as Line 105	See Line 105.

Other comments

2.	Lucy Beadnell, Virginia Ability Alliance	Support Coordination divide. Prohibiting people from accessing the full range of Support Coordinators because of their IQ does not make sense, nor is it fair or equitable. Would like to see regulations for Support Coordination be identical for all people eligible for the DD Waivers, including option for privately contracted Support Coordinators.	There are two different state plan amendments for these case management .
3.	Citizen	1. In Jan i got the FIS Waiver and my DSS failed to put in my Medicaid renewal correctly resulting in my attendants not getting paid for three months. With the switch to FIS Waiver also came a fiscal agent switch to CDCN. CDCN lost background checks, online timesheet glitches, ETC. 2. DentaQuest problems: I writing to place a complaint with DentaQuest. I've had an extremely difficult time getting my teeth cleaned under the adult dental coverage plan. I understand two cleanings a year are covered under my MCO, which is Healthkeepers Plus. - Each of the offices listed below were referred by DentaQuest / Healthkeepers Plus. - February 5, 2018 - Julie Ball (757) 427-1600 1515 Lynnhaven Pkwy, Virginia Beach - My partner of 21 years took a day off from work to take me to the dental appointment because I cannot drive. When going into the office, there are two visible steps inside. I use a heavy power chair; steps create a barrier. Why is an inaccessible dental office listed on DentaQuest? Result: Did not get my teeth cleaned. - September 21, 2018 - Debra A Davis (757) 464-0723 4600 Westgrove Ct, Virginia Beach - This dentist cleaned my teeth on March 26, 2018. For my next scheduled cleaning, I called the office and discovered they did not accept my MCO as they did previously. Result: Did not get my teeth cleaned. - February 15, 2019 - Kool Smiles (757) 769-8911 4239 Holland Road, Virginia Beach - I went to their office and filled out the paperwork only to find out they wanted me to pay $110 for a cleaning. They informed me that they only accept	Your concerns were forwarded to the individuals at DMAS who monitor the DentaQuest contract so that your issues can be reviewed and addressed.

		PPOs, not MCOs or HMOs. Result: Did not get my teeth cleaned. - I would like to see the dental provider list updated regularly with accurate information on ADA compliant offices to prevent this from happening again to me or anyone else.	
4.	Citizen	I am the parent of a 20 year old with autism who is currently receiving waiver services in Fairfax County, and I support the comments submitted 3/7/19 by the Virginia Ability Alliance. Thank you.	Thank you for your comment.
5.	Citizen	I am the parent of a young woman who is priority one on the wait list. I support the comments of the Virginia Ability Alliance and emphasize the need for Virginia to change any language that assumes a wait list forever. We are a better people than that.	Thank you for your comment.
6.	Citizen	As a parent of a 19 year old special needs child, I appreciate the redesigned waiver, however, the waitlist for the DD waiver is incredibly discouraging. The timelines suggested only rise hopes that lead to disappointment. I agree fully with the comments of the Virginia Ability Alliance. Thank you for working hard for our special kids and their families.	Thank you for your comment.
7.	Blue Ridge Beh Healthcare A. Monti	12VAC30-122-290 E.2 Reference to 12VAC35-105 seems to miss part of the licensing regulation reference. 12VAC30-122-310 E.2 Reference to 12VAC35-105 seems to miss part of the licensing regulation reference. 12VAC30-122-320 E.2 Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made
8.	Blue Ridge Beh Healthcare A. Monti	12VAC30-122-380 D.5 Reference to 12VAC35-105 seems to miss part of the licensing regulation reference. 12VAC30-122-390 D.5 Reference to 12VAC35-105 seems to miss part of the licensing regulation reference. 12VAC30-122-410 D.4 Reference to 12VAC35-105 seems to miss part of the licensing regulation reference. 12VAC30-122-420 D.5 Reference to 12VAC35-105 seems to miss part of the licensing regulation reference. 12VAC30-122-460 D.4.b Reference to 12VAC35-105 seems to miss part of the licensing regulation reference. 12VAC30-122-490 D.4.b Reference to 12VAC35-105 seems to miss part of the licensing regulation reference. 12VAC30-122-530 D.5 Reference to 12VAC35-105 seems to miss part of the licensing regulation reference.	Edits made

9.	Virginia Ability Citizen	**Dear Human of Virginia**, First of all, I wholeheartedly agree with all of the comments made by the Virginia Ability Alliance. Secondly, I write to you as a desperate parent of a severely autistic non-verbal child, who is looking at decades of exhaustive living conditions ahead of me, living with and protecting my autistic son. I have learned recently that the state is now handing out fewer and fewer Community Living (CL) waivers, and is instead assigning increasing numbers of Family and Individual Service (FIS) waivers. However, FAMILIES LIKE MINE NEED MORE OF THE FORMER, AND LESS OF THE LATTER. To get a better sense of the level of disability we are dealing with, I ask you to please take a moment and read this piece I wrote that was recently published in the Washington Post. We are activist parents. We have fought for better school placements for our son and we have created a non-profit to address that employs people with intellectual and developmental disabilities. We fully embrace the idea that families in our position must do everything possible to help themselves and create our own opportunities for the children that we brought into this world. However, we cannot keep up this battle indefinitely. At some point, no matter how hard we work to keep our son safe, fed, and educated, we need help. We cannot maintain the energy needed to support our son until the very day that we die. We need help long before we ourselves are gone. Clearly, we will fight til we can't fight anymore. But the Commonwealth absolutely must step in sooner and with more Community Living waivers than it is currently offering to desperate families like ours.While we are willing to develop our own group home living situations for severely disabled people like our son, we simply cannot afford to pay for him to live in such a place by paying out of our own pocket. And by the time he hopefully receives his CL waiver, he may be in his 50s, and I will be in my 80s. It is unimaginable to think of how "the system" will struggle to transition a severely autistic ~55 year old man into a group home situation, after living his whole life in one home. These transitions absolutely need to happen earlier in his life and in ours. Families like ours should not be left on our own for so many decades. It's simply untenable for countless reasons.We have made all necessary arrangements to plan ahead for the care of our son, but we are only two people with the same clocks ticking on our lives as everyone else is offered on this Earth. We need help from the Commonwealth to ensure that our son has a stable living situation (via the Community Living waiver) LONG before we are too old to care for him. And we implore you to increase the number of CL waivers. The FIS waivers are simply not enough for citizens whose disabilities are profound.	We empathize with your situation, and we are grateful to you for expressing it to us. Unfortunately, we have a limited amount of funding allocated by the General Assembly for waiver slots. With a shortage resources for waiver services, the waitlist process attempts to allocate those limited services fairly. The waiting list focuses on individual criteria rather than age.
10.	VAIL/G. Brunk	says “Individual and Family Developmental Disabilities Support Waiver”. This is not the correct title any longer. And what is it referring to as there is no further text after this title.	Edits made.
11.	K. Black-Hope House	Benefits Planning, Community Guide, Non-medical Transportation, Peer Support are not included; we recognize that including them at this stage is a substantive change,	Edits made.

		however, to continue on without regulatory authority is unacceptable. Likewise, requiring providers to comply with provider manuals that are not available is unacceptable.	
12.	Anonymous	The state should consider a cap on personal care service and companion under CD and agency directed to be consistent with other Medicaid services .	There is a cap on companion services. DMAS can not implement a cap on personal care at this time.
13.	Beatty/VA Alliance	I support the VAA Comments on DD Waiver Regulations & adding caregiver age to Priority One List. I support the VAA Comments on DD Waiver Regulations listed below. I also fully support the consideration of a caregiver's age to be added back in to be added to the Priority One Waiting List. As a mother of a 36 year old lovely daughter with Autism, I have experienced first-hand the difficulties she experienced in transitions through her life. Changes have required discussions way in advance at times, social stories, pictures, and planning ways to decrease negative behaviors. The comments below are representative of our joint concerns with the current regulations and, where appropriate, include proposed remedies to the issues cited. We look forward to working closely with DBHDS at every opportunity to assist in having needed adjustments made to the DD Waiver Regulations.	With a shortage resources for waiver services, the waitlist process attempts to allocate those limited services fairly. The waiting list focuses on individual criteria rather than age.
14.	Citizen	**Benefits Planning, Community Guide, Non-medical Transportation/Employment & Community Transportation Services, Peer Support Services** are not included in the proposed regulations but are current available waiver services. All waiver services should be included for the purposes of public review and comment.	Edits made.
15.	Citizen	**I support the comments made by the Virginia Ability Alliance.** Support comments made by Virginia Ability Alliance and 2 areas to emphasize based on experience 1. Specifically, the first paragraph under "Service Conflicts" on page 3 accurately describes the need to receive both Private Duty Nursing (PDN) and Skilled Nursing. Most of the Private Duty Nurses who cared for a family member where at best adequate for the best days. Only 5 nurses out of over 100 I oriented in 6 years were good enough for the worst days. Without Skilled Nursing, a family member, who was not a trained medical professional, had to intervene consistently to ensure proper medical care was administered. 2. Additionally, the paragraph on page 4 addressing customized rates accurately describes the need for better pay for PDN. The customized rate would help companies mitigate the problem described above by providing more nurses good enough for the worst days without the need for Skilled Nursing. In the final 2 years of trying to care for the family member in the home with 24 hours/day, 7 days/week PDN provided by the waiver, only 3 weeks out of the 104 were completely staffed. The customized rate would help companies recruit and retain more nurses so shifts could be filled.	We empathize with your situation, and we are grateful to you for expressing it to us. Private Duty Nursing has been studied by DMAS and a General Assembly report is forthcoming.

		The VA waiver system failed my family member. The results were institutionalization at greater expense to the VA taxpayer and a less inclusive environment for the individual far from the family.	
16.	Citizen	I am the parent of a 22 year-old female with ID and Autism. It's an embarrassment how the state of Virginia provides support (really lack of support) for individuals with neurological disabilities. The long and continuously growing waiting list to access the DD Waiver is a major concern for my family. We would support any consideration on an 1115c Waiver, or other federal contract, that would not allow a waiting list for basic care services.	We empathize with your situation, and we are grateful to you for expressing it to us. Unfortunately, we have a limited amount of funding allocated by the General Assembly for waiver slots. With a shortage resources for waiver services, the waitlist process attempts to allocate those limited services fairly. The waiting list focuses on individual criteria rather than age.
17.	Citizen	Concur with Virginia Ability Alliance Comments. I fully support the comments made by Virginia Ability Alliance. There is real need for the DD waiver in particular to be made more accessible. I don't know what we would do without the CCC+ waiver, and so many have to struggle without it and without the DD waiver they qualify for. Anything you can do to help is appreciated.	Thank you for your comment.
18.	Citizen	Support the allowance of employment services organizations (ESOs) to be providers of Peer Mentor Supports, Employment & Community Transportation Services and Community Guide services. • Support the consistent use of “progress notes” as defined in the DD Waiver regulations versus • the use of “daily note” references. We support the definition of “progress notes” as defined in 12VAC30-122-20 “Definitions” for consistency	See response in 12VAC30-122-400, line 2.
19.	Citizen	“Progress notes” means individual-specific written documentation that (i) contains unique differences specific to the individual’s circumstances and the supports provided, and the individual’s responses to such supports; (ii) is signed and dated by the person who rendered the supports; and (iii) is written and signed and dated as soon as is practicable but no longer than one week after the referenced service.”	Edits made.

20.	Citizen	Virginia should develop and implement a central provider audit tool to decrease multiple requests of providers for the same information across reviewers. This tool should bring together the various monitoring entities and result in collaboration and consistency in interpretation across agencies and reviewers eliminating redundancy in documentation requests. This includes reviews by DBHDS subcontractors, human rights, licensing and Medicaid regulations and interpretations by contractors, specialists, quality management and provider integrity.	DMAS is not able to make this change at this time.
21.	Citizen	I support the comments made by the Virginia Ability Alliance.	Thank you for your comment.
22.	C Lightner-Collins, Thrive Skilled Pediatric Care	Re: Medicaid Memo. The issues that I have when trying to get auth is the Part V which is basically our 485. To me a year long 485 should be sufficient. The next biggest issue is having to break down our PDN hours between RN and LPN. When I have addressed this issue in the past the answer I get is we follow DMAS guidelines. Well that is not correct. DMAS nor our MCO/HMO's make us break those hours down. We request RN/LPN hours for the same amount each week for both. This makes it easier when I have an LPN and RN working on the same case. If someone is on vacation then the other can fill in. Currently there is no way to make this easy with DD Waiver. Then the hours don't get filled. The only person who suffers for this is the patient and the parents not getting coverage. Is there a way to fix this? Can we please follow DMAS and our MCO's guidelines in reference to RN/LPN hours? Thank you for your attention to this issue.	There is a different rate for RN vs LPN - to be paid appropriately, providers need to document and report hours.
23.	T Gilreath, Thrive Skilled Pediatric Care	Private Duty Nursing Authorizations - Medicaid Guidelines - This is in referrence to the released Medicaid Memo. The issues that I have when requesting authorization for private duty nursing is that I have both RNs and LPNs working in the home. Other EPSDT authorizations grant auth for a specific number of hours to be used by the RN or LPN. This way, if a nurse can cover a shift or if the parent is late and a nurse stays past her scheduled hours, we are able to bill for these services without disturbing the rest of the schedule. With the nursing shortage in Virginia, we need this flexibility in finding coverage. Also, if we find a nurse to add to the case, they often are not able to wait while we obtain the additional hours and they end up finding another position with another company in the meantime. Our nurses are also now asked to complete a Part V. There has been very little direction on how to complete this form and they are basically reiterating what is submitted in the year long plan of care. Why is the plan of care not suffiicient? Thank you.	See Line 22.

	citizen	I work for a pediatric home health company and when we have to submit for auth for DD waiver we have been running into many problems. First the Part V is really more tailored to the Care attendants and not nursing. Everything we put into the Part V can be found in the year long 485 we submit, which should be sufficient enough. We have also had an issue with the RN/LPN auth and having to break down the hours of when we use either one and give a justification for why they have both or just an RN. Sometimes we have an RN in the home because that is what we could find the child and I don't feel it should be up to you what type of nurse is ok to place in a home for a child. Also no other insurance, including DMAS which is what we were told DD waiver is supposed to be following, requires that we break down the hours between RN and LPN. We get the full amount of hours for either or. This is helpful if the RN is out for whatever reason because then we can just place an LPN if available. With DD waiver this is not an option and so the child ends up without coverage, which really isn't fair to the child or family. We have also had issues with submitting the schedules since we can't see what the attendant care company submitted and sometimes that means we submit for the same hours due to our nurses having flexible shifts and the care attendant covering when the nurse can't. In the past we would submit the general schedule that our nurse works and put a comment in that it varies and when nursing coverage is not available then care attendant is used. We have also had issues with being told different things as to what the SA's want to see on each form we submit which results in multiple changes and fixes that then result in us not having auth for months at a time for our patients which can then interrupt their nursing services as well. We also have an issue with increasing hours when needed which then results in us losing nursing coverage for the patient because the nurse goes elsewhere. Other Insurance companies give us a pool of hours to use and DD waiver only gives us what we currently use even if the child qualifies for way more. The DD waiver process has just become overall very frustrating and time consuming which really just ends up hurting the patient and families.	See Line 22.
24.	Jan Williams, ServiceSource	Virginia should develop and implement a central provider audit tool to decrease multiple requests of providers for the same information across reviewers. This tool should bring together the various monitoring entities and result in collaboration and consistency in interpretation across agencies and reviewers eliminating redundancy in documentation requests. This includes reviews by DBHDS subcontractors, human rights, licensing and Medicaid regulations and interpretations by contractors, specialists, and quality management and provider integrity. Provide for the opportunity for deemed provider status for providers that hold a national accreditation (CARF) or specific certification to reduce the frequency of reviews. This would reduce both state government and provider time and money.	DMAS is not able to make this change at this time.

25.	Dennis Brown, Consultant	I fully agree with the comments submitted by both ServiceSource and vaACCSES on specific regulatory language and concerns. I want to additionally comment on the urgent need for DMAS and DBHDS to refocus on older individuals and their family caregivers., both in terms of the wait list and as older individuals become service recipients.	With a shortage resources for waiver services, the waitlist process attempts to allocate those limited services fairly. The waiting list focuses on individual criteria rather than age.
26.	Citizen	For the greater good	No response - possible input error.
27.	Citizen	I support comments made by the Virginia Ability Alliance	Thank you for your comment.
28.	Citizen	Three wavers redegined	Thank you for your comment.
29.	Citizen	1. I support the comments made by Virginia Ability Alliance. Specifically relevant to my family situation is the waiver wait list - though the funding for DD Waivers is beyond the control of DBHDS, the long and continuously growing waiting list to access the DD Waiver is a foremost concern. We would support any consideration on an 1115c Waiver, or other federal contract, that would not allow a waiting list for basic care services. 2. It is disheartening that many other states offer far more support to disabled Americans than Virginia does. Now is the time for change!	We empathize with your situation, and we are grateful to you for expressing it to us. Unfortunately, we have a limited amount of funding allocated by the General Assembly for waiver slots. With a shortage of resources for waiver services, this process attempts to allocate those limited services fairly. The waiting list focuses on individual criteria rather than age.
30.	Citizen	12VAC30-50-450 F1b1 should acknowledge that the CSB can provide choice of Support Coordinators as available. There are many factors in determining SC availability such as specialized duties and caseload size. There also needs to be considered that individuals may choose to select (or remain with) a CSB that is geographically too far to effectively provide Support Coordination.	Edits made.

31.	Crum/ServiceSource	Virginia should develop and implement a central provider audit tool to decrease multiple requests of providers for the same information across reviewers. This tool should bring together the various monitoring entities and result in collaboration and consistency in interpretation across agencies and reviewers eliminating redundancy in documentation requests. This includes reviews by DBHDS subcontractors, human rights, licensing and Medicaid regulations and interpretations by contractors, specialists, quality management and provider integrity. Provide for the opportunity for deemed provider status for providers that hold a national accreditation (CARF) or specific certification to reduce the frequency of reviews. This would reduce both state government and provider time and money.	DMAS is not able to make these changes at this time.
32.	Donald Kelly, L'Arche	* DMAS and DBHDS should create the option for a single agency to have one Plan for Supports per individual regardless of the number of services provided to an individual in order to streamline documentation and reduce the number of quarterly reports required. This was a unanimous recommendation of the DBHDS's own Provider Issues Resolution Workgroup (PIRW) in its report published August 2018.* Virginia should develop and implement a central provider audit tool to decrease multiple requests of providers for the same information across reviewers. This tool should bring together the various monitoring entities and result in collaboration and consistency in interpretation across agencies and reviewers eliminating redundancy in documentation requests. This includes reviews by DBHDS subcontractors, human rights, licensing and Medicaid regulations and interpretations by contractors, specialists, quality management and provider integrity.	DMAS is not able to make these changes at this time.
33.	Fairfax/Falls Ch CSB	12VAC-30-122-20 & 12VAC-30-122-30B references regulations that are either repealed or no longer in effect e.g. reference to Elderly and Disabled Wavier and Technology Assisted Wavier that no longer exist.	Edits made.

34.	Citizen	1) I support John Malone of the Harrisonburg Rockingham CSB and other CSB commenters in their concerns and recommendations. 2) I share the concerns in the 3/27/19 post of Groff – Bedford adult day care; however, feel the recommendation is extremely unwise as it would inadvertently have a significant impact on a large number of individuals served who do not have these medical issues, unfairly impact supervisory individuals who have achieved the functional equivalency status through multiple years of demonstrating dedication and all of the required knowledge, skills and abilities necessary to perform the supervisory function well – rather the state should include the functional equivalency acceptance in the definition of QDDP and/or grandfather in current functional equivalents the way they did with CSB's and moved to a higher standard going forward. 3) On the comment regarding the day as the sole unit for residential reimbursement, one colleague suggested that a possible reason for the current approach was because some residential providers may encourage individuals not to engage in employment or outside day support for additional reimbursement and this runs counter to the State's goal of increasing involvement in employment/outside day supports. Preemptively, because the state does not provide an opportunity for rejoinder it's important to point out that these issues should not be considered an answer to the criticisms nor adequate rationale for continuing the current system: 1st – the financial incentive for residential providers to encourage individuals to not attend an outside day program is greatly reduced when compared to the existing financial incentive to push them out the door, because the residential provider would have to provide staff and supports during the time the individual is there; whereas now a residential provider collects the money with no offsetting cost; 2nd – periodic supports are not suggested in the recommendations and if no periodic support reimbursement or available residential providers would have no incentive to encourage individuals to remain home on a given day if they were enrolled in an outside program; 3rd – solely residential providers could not prevent individuals from signing up for a day program outside the home is this is a decision made between the individual and the support coordinator – once the individual indicated to the support coordinator they desired a day placement it can be set up and arranged independent of the wishes of the residential provider; 4th – a better system of checks and balances would be in place to prevent the rights abuses which are occurring now, as the day support staff would have an incentive to have the individual attend day support (and thus protect their jobs) which could serve as a counterweight to any financial incentive for the solely residential provider; 5th – the State's goal of increasing involvement in employment/outside day support should not be accomplished through abuse of individual CMS final rule rights, no matter how laudable the state may feel these goals are state abuse of individual rights should not be permitted in their pursuit.	1. Thank you for your comment. 2. Thank you for your comment. 3. Rate methodology has been approved by CMS and will not be changed at this time.

35.	Kelsey DeWispelaere, CRi	Virginia should develop and implement a central provider audit tool to decrease multiple requests of providers for the same information across reviewers. This tool should bring together the various monitoring entities and result in collaboration and consistency in interpretation across agencies and reviewers eliminating redundancy in documentation requests. This includes reviews by DBHDS subcontractors, human rights, licensing and Medicaid regulations and interpretations by contractors, specialists, quality management and provider integrity.	DMAS is not able to make this change at this time.
36.	Citizen	1) Virginia should develop and implement a central provider audit tool to decrease multiple requests of providers for the same information across reviewers. This tool should bring together the various monitoring entities and result in collaboration and consistency in interpretation across agencies and reviewers eliminating redundancy in documentation requests. This includes reviews by DBHDS subcontractors, human rights, licensing and Medicaid regulations and interpretations by contractors, specialists, quality management and provider integrity. 2) Provide for the opportunity for deemed provider status for providers that hold a national accreditation (CARF) or specific certification to reduce the frequency of reviews. This would reduce both state government and provider time and money.	DMAS is not able to make this change at this time.
37.	DeAnne Mullins, LCSW	While narrative documentaiton that speaks to progress and outcomes as well as activities worked on is important it can be very time instensive as well: Recommend that DMAS and DBHDS actively work with CMS to develop and seek approval of a checklist to substitute for "progress notes" (narrative daily notes) - the demands of which detract from providers' resources to effectively support individuals	DMAS is not able to make this change at this time.
38.	Julie Dwyer-Allen, BCBA/CRi	1) Virginia should develop and implement a central provider audit tool to decrease multiple requests of providers for the same information across reviewers. This tool should bring together the various monitoring entities and result in collaboration and consistency in interpretation across agencies and reviewers eliminating redundancy in documentation requests. This includes reviews by DBHDS subcontractors, human rights, licensing and Medicaid regulations and interpretations by contractors, specialists, quality management and provider integrity. 2) Provide for the opportunity for deemed provider status for providers that hold a national accreditation (CARF) or specific certification to reduce the frequency of reviews. This would reduce both state government and provider time and money.	DMAS is not able to make this change at this time.
39.	Citizen	I am the parent of a 17 year old with autism who is currently receiving waiver services in Prince William County, and I support the comments submitted 3/7/19 by the Virginia Ability Alliance. Thank you.	Thank you for your comment.
40.	Citizen	concur with comments of Virginia Ability Alliance	Thank you for your comment.

41.	VAIL/G. Brunk	states "no costs for evaluations or assessments that may be required by either DMAS or DBHDS shall be borne by the individual." We understand that some CSBs may be attempting to charge for providing VIDES assessments. How will DMAS and DBHDS ensure that this is not occurring? Is this regulation only pertinent to individuals enrolled in the waiver? Or will DMAS cover the expense of a psychological or other assessment required to qualify for waiver or the waitlist?	DMAS provides oversight by peforming program integrity and quality management reviews and through complaints about provider practices.