COMMONWEALTH of VIRGINIA
Office of the Attorney General

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MEMORANDUM

TO: **BRIAN MCCORMICK**
Regulatory Supervisor
Department of Medical Assistance Services

FROM: **JENNIFER L. GOBBLE**
Assistant Attorney General

DATE: **August 14, 2014**

SUBJECT: **Emergency Regulations - Exceptional Rate of Reimbursement/ID Waiver**

I have reviewed the attached emergency regulations that would enable Medicaid providers of congregate residential support services to be reimbursed at a higher rate for rendering exceptional support services required by individuals enrolled in the ID Waiver that have complex medical and/or behavioral needs.

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

The authority for this emergency action is found in Virginia Code § 2.2-4011(B), which provides that emergency regulations may be adopted in "situations in which Virginia statutory law, the [Virginia] appropriation act, or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment . . .." The attached emergency regulations will enable the Director, in lieu of the Board of Medical Assistance Services, to comply with the directives set forth in the 2013 *Acts of Assembly*, Chapter 806, Item 307.BBBB.

Please be advised that under Virginia Code §2.2-4011(B), the Department must state in writing "the nature of the emergency and of the necessity for such action and may adopt the regulations." Pursuant to § 2.2-4012, such regulations shall become effective upon approval by the Governor and filing with the Registrar of Regulations. The Department's statement of the nature of the emergency and necessity for such action appears to have been accomplished in the "Agency Background Document." In addition, the emergency regulations shall be effective for

no more than 18 months. If the Department intends to continue regulating the subject matter governed by these emergency regulations beyond 18 months, it will be necessary to replace these emergency regulations with regulations duly promulgated under Article 2 of the APA. A Notice of Intended Regulatory Action relating to the proposed replacement regulations must be filed with the Registrar within 60 days of the effective date of the emergency regulations. The proposed regulations must be filed with the Registrar within 180 days after the effective date of the emergency regulations. Va. Code § 2.2-4011(C).

If you have any questions or need any additional information, please feel free to contact me at 786-4905.

cc: Kim F. Piner
Senior Assistant Attorney General

Emergency Text

Action:
Exceptional Rate for ID Waiver Individuals
Stage: Emergency/NOIRA
8/13/14 4:10 PM [latest]

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

Part IV
Intellectual Disability Waiver

Article 1
Definitions and General Requirements

12VAC30-120-1000. Definitions.

"AAIDD" means the American Association on Intellectual and Developmental Disabilities.

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

"Agency-directed model" means a model of service delivery where an agency is responsible for providing direct support staff, for maintaining individuals' records, and for scheduling the dates and times of the direct support staff's presence in the individuals' homes.

"ADA" means the American with Disabilities Act pursuant to 42 USC § 12101 et seq.

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

"Applicant" means a person (or his representative acting on his behalf) who has applied for or is in the process of applying for and is awaiting a determination of eligibility for admission to a home and community-based waiver or is on the waiver waiting list waiting for a slot to become available.

"Assistive technology" or "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, which enable individuals to increase their abilities to perform ADLs, or to perceive, control, or communicate with the environment in which they live, or that are necessary to the proper functioning of the specialized equipment.

"Barrier crime" means those crimes listed in §§ 32.1-162.9:1 and 63.2-1719 of the Code of Virginia.

"Behavioral health authority" or "BHA" means the local agency, established by a city or county under § 37.2-100 of the Code of Virginia that plans, provides, and evaluates mental health, intellectual disability (ID), and substance abuse services in the locality that it serves.

"Behavioral specialist" means a person who possesses any of the following credentials: (i) endorsement by the Partnership for People with Disabilities at Virginia Commonwealth University as a Positive Behavioral Supports Facilitator; (ii) board-certification as a Behavior Analyst (BCBA) or board-certification as an Associate Behavior Analyst (BCABA), or (iii) licensure by the Commonwealth as either a psychologist, a Licensed Professional Counselor (LPC), a Licensed Clinical Social Worker (LCSW), or a Psychiatric Clinical Nurse Specialist.

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

"Case management" means the assessing and planning of services; linking the individual to services and supports identified in the Individual Support Plan; assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources; coordinating services and service planning with other agencies and providers involved with the individual; enhancing community integration; making collateral contacts to promote the implementation of the Individual Support Plan and community integration; monitoring to

assess ongoing progress and ensuring services are delivered; and education and counseling that guides the individual and develops a supportive relationship that promotes the Individual Support Plan.

"Case manager" means the person who provides case management services on behalf of the community services board or behavioral health authority, as either an employee or a contractor, possessing a combination of (ID) work experience and relevant education that indicates that the individual possesses the knowledge, skills, and abilities as established by DMAS in 12VAC30-50-450.

"Community services board" or "CSB" means the local agency, established by a city or county or combination of counties or cities under Chapter 5 (§ 37.2-500 et seq.) of Title 37.2 of the Code of Virginia, that plans, provides, and evaluates mental health, ID, and substance abuse services in the jurisdiction or jurisdictions it serves.

"Companion" means a person who provides companion services for compensation by DMAS.

"Companion services" means nonmedical care, support, and socialization provided to an adult (ages 18 years and over). The provision of companion services does not entail routine hands-on care. It is provided in accordance with a therapeutic outcome in the Individual Support Plan and is not purely diversional in nature.

"Complex behavioral needs" means conditions requiring exceptional supports in order to respond to the individual's significant safety risk to self or others and documented by the Supports Intensity Scale (SIS) Virginia Supplemental Risk Assessment form (2010) as defined in 12 VAC 30-120-1012.

"Complex medical needs" means conditions requiring exceptional supports in order to respond to the individual's significant health or medical needs requiring frequent hands on care and medical oversight and documented by the Supports Intensity Scale (SIS) Virginia Supplemental Risk Assessment form (2010) as defined in 12 VAC 30-120-1012.

"Comprehensive assessment" means the gathering of relevant social, psychological, medical, and level of care information by the case manager and is used as a basis for the development of the Individual Support Plan.

"Congregate residential support" or "CRS" means those supports in which the residential support services provider renders primary care (room, board, general supervision) and residential support services to the individual in the form of continuous (up to 24 hours per day) services performed by paid staff who shall be physically present in the home. These supports may be provided individually or simultaneously to more than one individual living in that home, depending on the required support. These supports are typically provided to an individual living (i) in a group home, (ii) in the home of the ID Waiver services provider (such as adult foster care or sponsored residential), or (iii) in an apartment or other home setting.

"Consumer-directed model" means a model of service delivery for which the individual or the individual's employer of record, as appropriate, is responsible for hiring, training, supervising, and firing of the person or persons who render the direct support or services reimbursed by DMAS.

"Crisis stabilization" means direct intervention to individuals with ID who are experiencing serious psychiatric or behavioral challenges that jeopardize their current community living situation, by providing temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement. This service shall be designed to stabilize the individual and strengthen the current living situation so the individual can be supported in the community during and beyond the crisis period.

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

"DBHDS staff" means persons employed by or contracted with DBHDS.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means persons employed by or contracted with DMAS.

"DRS" means the Department of Rehabilitative Services.

"Day support" means services that promote skill building and provide supports (assistance) and safety supports for the acquisition, retention, or improvement of self-help, socialization, and adaptive skills, which typically take place outside the home in which the individual resides. Day support services shall focus on enabling the individual to attain or maintain his highest potential level of functioning.

"Developmental risk" means the presence before, during, or after an individual's birth, of conditions typically identified as related to the occurrence of a developmental disability and for which no specific developmental disability is identifiable through existing diagnostic and evaluative criteria.

"Direct marketing" means either (i) conducting directly or indirectly door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; (ii) mailing directly; (iii) paying "finders' fees"; (iv) offering financial incentives, rewards, gifts, or special opportunities to eligible individuals and the individual's family/caregivers, as appropriate, as inducements to use the providers' services; (v) continuous, periodic marketing activities to the same prospective individual and the individual's family/caregiver, as appropriate - for example, monthly, quarterly, or annual giveaways as inducements to use the providers' services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of the providers' services or other benefits as a means of influencing the individual's and the individual's family/caregivers, as appropriate, use of the providers' services.

"Employer of record" or "EOR" means the person who performs the functions of the employer in the consumer directed model. The EOR may be the individual enrolled in the waiver, or a family member, caregiver or another person, as appropriate, when the individual is unable to perform the employer functions.

"Enroll" means that the individual has been determined by the case manager to meet the level of functioning requirements for the ID Waiver and DBHDS has verified the availability of an ID Waiver slot for that individual. Financial eligibility determinations and enrollment in Medicaid are set out in 12VAC30-120-1010.

"Entrepreneurial model" means a small business employing a shift of eight or fewer individuals who have disabilities and usually involves interactions with the public and coworkers who do not have disabilities.

"Environmental modifications" or "EM" means physical adaptations to a primary place of residence, primary vehicle, or work site (when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act) that are necessary to ensure the individual's health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards. Such EM shall be of direct medical or remedial benefit to the individual.

"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by DMAS for children under the age of 21 according to federal guidelines (that prescribe preventive and treatment services for Medicaid eligible children) as defined in 12VAC30-50-130.

"Exceptional reimbursement rate" or "Exceptional rate" means a rate of reimbursement for congregate residential supports (CRS) paid to providers who qualify to receive the exceptional rate set out in 12 VAC 30-120-1062.

"Exceptional supports" or "Exceptional support services" means a qualifying level of supports, as more fully described in 12 VAC 30-120-1012, that are medically necessary for individuals with complex medical or behavioral needs, or both, to safely reside in a community setting. The need for exceptional supports is demonstrated when the funding required to meet the individual's needs has been expended on a consistent basis by providers in the past 90 days for medical or behavioral supports, or both, over and above the current maximum allowable CRS rate in order to support the individual in a manner that assures his health and safety.

"Exceptional Supports and Reimbursement Rate Review Committee" or "review committee" means DBHDS staff, including a trained SIS® specialist approved by DBHDS, a behavior specialist, a Registered Nurse, and a masters level social worker, and other staff as may be otherwise constituted by DBHDS, who will evaluate and make a determination about applications for the congregate residential support services and exceptional CRS reimbursement rate for compliance with regulatory requirements.

"Fiscal employer/agent" means a state agency or other entity as determined by DMAS to meet the requirements of 42 CFR 441.484 and the Virginia Public Procurement Act (Chapter 43 (§ 2.2-4300 et seq.) of Title 2.2 of the Code of Virginia).

"Freedom of choice" means the right afforded an individual who is determined to require a level of care specified in a waiver to choose (i) either institutional or home and community-based services provided there are available CMS-allocated and state-funded slots; (ii) providers of services; and (iii) waiver services as may be limited by medical necessity.

"Health planning region" or "HPR" means the federally designated geographical area within which health care needs assessment and planning takes place, and within which health care resource development is reviewed.

"Health, safety, and welfare standard" means that an individual's right to receive a waiver service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria and a written individual plan for supports, and that services can be safely provided in the community.

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

"IDOLS" means Intellectual Disability Online System.

"In-home residential support services" means support provided in a private residence by a DBHDS-licensed residential provider to an individual enrolled in the waiver to include: (i) skill building and supports and safety supports to enable individuals to maintain or improve their health; (ii) developing skills in daily living; (iii) safely using community resources; (iv) being included in the life of the community and home; (v) developing relationships; and (vi) participating as citizens of the community. In-home residential support services shall not replace the primary care provided to the individual by his family and caregiver but shall be supplemental to it.

"Incremental step down provisions" means procedures normally found in plans for supports in which an individual's supports are gradually altered or reduced based upon progress towards meeting the goals of the individual's behavior plan.

"Individual" means the person receiving the services or evaluations established in these regulations.

"Individual Support Plan" or "ISP"means a comprehensive plan that sets out the supports and actions to be taken during the year by each service provider, as detailed in the provider's Plan for Supports, to achieve desired outcomes. The Individual Support Plan shall be developed by the individual enrolled in the waiver, the individual's family/caregiver, as appropriate, other service providers such as the case manager, and other interested parties chosen by the individual, and shall contain essential information, what is important to the individual on a day-to-day basis and in the future, and what is important for the individual to be healthy and safe as reflected in the Plan for Supports. The Individual Support Plan is known as the Consumer Service Plan in the Day Support Waiver.

"Instrumental activities of daily living" or "IADLs" means tasks such as meal preparation, shopping, housekeeping, laundry, and money management.

"Intellectual disability" or "ID" means a disability as defined by the American Association on Intellectual and Developmental Disabilities (AAIDD) in the Intellectual Disability: Definition, Classification, and Systems of Supports (11th edition, 2010).

~~"ICF/ID"~~ "ICF/IID" means a facility or distinct part of a facility certified by the Virginia Department of Health as meeting the federal certification regulations for an Intermediate Care Facility for ~~the Intellectually Disabled~~ Individuals with Intellectual Disability and persons with related conditions and that addresses the total needs of the residents, which include physical, intellectual, social, emotional, and habilitation providing active treatment as defined in 42 CFR 435.1010 and 42 CFR 483.440.

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

"Medicaid Long-Term Care Communication Form" or "DMAS-225" means the form used by the case manager to report information about changes in an individual's situation.

"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 and in accordance with Medicaid policy.

"Parent" or "parents" means a person or persons who is or are biologically or naturally related, a foster parent, or an adoptive parent to the individual enrolled in the waiver.

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

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

"Person-centered planning" means a fundamental process that focuses on the needs and preferences of the individual to create an Individual Support Plan that shall contain essential information, a personal profile, and desired outcomes of the individual to be accomplished through waiver services and included in the providers' Plans for Supports.

"Personal assistance services" means assistance with ADLs, IADLs, access to the community, self-administration of medication or other medical needs, and the monitoring of health status and physical condition.

"Personal assistant" means a person who provides personal assistance services.

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

"Personal profile" means a point-in-time synopsis of what an individual enrolled in the waiver wants to maintain, change, or improve in his life and shall be completed by the individual and another person, such as his case manager or family/caregiver, chosen by the individual to help him plan before the annual planning meeting where it is discussed and finalized.

"Plan for Supports" means each service provider's plan for supporting the individual enrolled in the waiver in achieving his desired outcomes and facilitating the individual's health and safety. The Plan for Supports is one component of the Individual Support Plan. The Plan for Supports is referred to as an Individual Service Plan in the Day Support and Individual and Family with Developmental Disability Services (IFDDS) Waivers.

"Prevocational services" means services aimed at preparing an individual enrolled in the waiver for paid or unpaid employment. The services do not include activities that are specifically job-task oriented but focus on concepts such as accepting supervision, attendance at work, task completion, problem solving, and safety. Compensation for the individual, if provided, shall be less than 50% of the minimum wage.

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

"Qualified mental retardation professional" or "QMRP" for the purposes of the ID Waiver means the same as defined at 12VAC35-105-20.

"Qualifying individual" means an individual who has received a service authorization from DMAS or its service authorization contractor to receive exceptional supports.

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

"Residential support services" means support provided in the individual's home by a DBHDS-licensed residential provider or a VDSS-approved provider of adult foster care services. This service is one in which skill-building, supports, and safety supports are routinely provided to enable individuals to maintain or improve their health, to develop skills in daily living and safely use community resources, to be included in the community and home, to develop relationships, and to participate as citizens in the community.

"Respite services" means services provided to individuals who are unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those unpaid persons normally providing the care.

"Risk assessment" means an assessment that is completed by the case manager to determine areas of high risk of danger to the individual or others based on the individual's serious medical or behavioral factors. The required risk assessment for the ID Waiver shall be found in the state-designated assessment form which may be supplemented with other information. The risk assessment shall be used to plan risk mitigating supports for the individual in the Individual Support Plan.

"Safety supports" means specialized assistance that is required to assure the health and welfare of an individual.

"Service authorization" means the process of approving by either DMAS or its designated service authorization contractor, for the purpose of DMAS' reimbursement, the service for the individual before it is rendered.

"Service authorization for exceptional supports" means the process of approving an individual, by either DMAS or its designated service authorization contractor, for the purpose of receiving exceptional supports. Service authorization shall be obtained before exceptional supports to the individual are rendered.

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

"Services facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual or the individual's family/caregiver, or EOR, as appropriate, by collaborating with the case manager to ensure the development and monitoring of the CD Services Plan for Supports, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed companion, personal assistance, and respite services.

"Significant change" means, but shall not be limited to, a change in an individual's condition that is expected to last longer than 30 calendar days but shall not include short-term changes that resolve with or without intervention, a short-term acute illness or episodic event, or a well-established, predictive, cyclical pattern of clinical signs and symptoms associated with a previously diagnosed condition where an appropriate course of treatment is in progress.

"Skilled nursing services" means both skilled and hands-on care, as rendered by either a licensed RN or LPN, of either a supportive or health-related nature and may include, but shall not be limited to, all skilled nursing care as ordered by the attending physician and documented on the Plan for Supports, assistance with ADLs, administration of medications or other medical needs, and monitoring of the health status and physical condition of the individual enrolled in the waiver.

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

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

"Supports" means paid and nonpaid assistance that promotes the accomplishment of an individual's desired outcomes. There shall be three types of supports: (i) routine supports that assist the individual in daily activities; (ii) skill building supports that help the individual gain new abilities; and (iii) safety supports that are required to assure the individual's health and safety.

"Supported employment" means paid supports provided in work settings in which persons without disabilities are typically employed. Paid supports include skill-building supports related to paid employment, ongoing or intermittent routine supports, and safety supports to enable an individual with ID to maintain paid employment.

"Support plan" means the report of recommendations resulting from a therapeutic consultation.

"Supports Intensity Scale®" or "SIS®"means a tool, developed by the American Association on Intellectual and Developmental Disabilities (AAIDD), that measures the intensity of an individual's support needs for the purpose of assessment, planning, and aligning resources to enhance personal independence and productivity.

"Therapeutic consultation" means covered services designed to assist the individual and the individual's family/caregiver, as appropriate, with assessments, plan design, and teaching for the purpose of assisting the individual enrolled in the waiver.

"Transition services" means set-up expenses as defined in 12VAC30-120-2010.

"VDSS" means the Virginia Department of Social Services.

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

12VAC30-120-1012. Individuals enrolled in the ID waiver who are receiving congregate residential support services and require exceptional levels of supports.

A. Exceptional supports shall be available for individuals who:

1. are currently enrolled or are qualified to enroll in the ID waiver, and

2. are currently receiving or qualify to receive congregate residential support, and

3. have complex medical or behavioral needs, or both, and who require additional staffing support or professional services enhancements (i.e., the involvement of medical or behavioral professionals).

B. In addition to the requirements in subsection A above, in order for an individual to qualify for the receipt of exceptional supports, the individuals shall either:

1. Currently reside in an institution, such as a training center or a nursing facility, and be unable to transition to integrated community settings because they cannot access sufficient community waiver supports due to their complex medical or behavioral needs, or both. In addition to meeting the requirements of this section, in order to qualify for exceptional support, case managers for an individual who is currently residing in a training center or nursing facility shall document in their service authorization request to DMAS or its service authorization contractor that, based on supports required by the individual in the last 90 days, while he resided in a training center or nursing facility, the individual is unable to transition to the community. This inability to transition shall be due to the anticipated need for services that cannot be provided, within the maximum allowable CRS rate, upon discharge into the community,

or

2. Currently reside in the community and their medical or behavioral needs, or both, present an imminent risk of institutionalization and an exceptional level of congregate residential supports are required to maintain these individuals in the community. In addition to meeting the requirements set out below, in order to qualify for exceptional supports, individuals currently residing in the community shall provide, as a part of the service authorization request, documented evidence for the 90 days immediately prior to the exceptional supports request that one or more of the following has occurred:

a. Funding has been expended on a consistent basis by providers in the past 90 days for medical or behavioral supports, or both, over and above the current maximum allowable CRS rate in order to assure the health and safety of the individual;

b. The residential services plan for supports has been approved and authorized by DMAS or its service authorization contractor for the maximum number of hours of support, as in 24 hours per day seven days a week, yet the individual still remains at imminent risk of institutionalization;

c. The staff to individual ratio has increased in order to properly support the individual (e.g., the individual requires a 2:1 staff to individual ratio for some or all of the time) OR

d. Available alternative community options have been explored and utilized but the individual still remains at imminent risk of institutionalization.

C. In addition to the requirements in subsections A and B above, in order to qualify for exceptional supports individuals shall have the following numbered assessment values on the most recently completed Supports Intensity Scale ® (SIS) Virginia Supplemental Risk Assessment form (2010) as follows:

1. The individual requires frequent hands on staff involvement to address critical health and medical needs (#1a) and the individual has medical care plans in place that are documented in the ISP process (#1c);

2. The individual has been found guilty of a crime or crimes related to severe community safety risk to others through the criminal justice system (#2a) (*e.g.*, convicted of actual or attempted assault or injury to others, property destruction due to fire setting or arson, or sexual aggression) and the individual's severe community safety risk to others requires a specially controlled home environment, direct supervision at home or direct supervision in the community, or both, (#2b) and the individual has documented restrictions in place related to these risks through a legal requirement or order (#2c);

3. The individual has not been found guilty of crime related to a severe community safety risk to others (such as actual or attempted assault or injury to others, property destruction due to fire setting or arson, or sexual aggression) but displays the same severe community safety risk as a person found guilty through the criminal justice system (#3a) and the individual's severe community safety risk to others requires a specially controlled home environment, direct supervision at home or direct supervision in the community, or both (#3b) and the individual has documented restrictions in place related to these risks within the ISP process (#3c); OR

4. The individual engages in self-directed destructiveness related to self-injury, pica (eating non-food substances), or suicide attempts, or all of these, with the intent to harm self (#4a), the individual's severe risk of

injury to self currently requires direct supervision during all waking hours (#4b) and the individual has prevention and intervention plans in place that are documented within the ISP process (#4c); AND

5. The individual demonstrates a score of 2 (extensive support needed) on any two items in the AAIDD Supports Intensity Scale ®(version 2011) in EITHER:

a. Section #3a Exceptional Medical and Behavioral Support Needs**:** Medical Supports Needed except for item #11 (seizure management) or item 15 (therapy services) OR

b. Section #3b Exceptional Medical and Behavioral Support Needs**:** Behavioral Supports Needed except for item #12 (maintenance of mental health treatments).

D. The entire SIS® submitted as documentation in support of the individual's service authorization request for exceptional supports shall have been completed no more than six months prior to submission of the exceptional rate service authorization request.

E. The individual s case manager shall submit a service authorization request for exceptional supports to DMAS or its service authorization contractor, who shall make the final determination as to whether the individual qualifies for exceptional supports. If the service authorization request fails to demonstrate that the individual s support needs meet the criteria described in this section, service authorization shall be denied. Individuals may appeal the denial of a service authorization request for exceptional supports in accordance with the DMAS client appeal regulations, 12VAC30-110-10 through 12VAC30-110-370.

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

12VAC30-120-1062. Exceptional rate congregate residential supports provider requirements.

In addition to the general provider requirements set out in 12VAC30-120-1040, in order to qualify for exceptional rate reimbursement providers shall meet the following requirements.

A. Providers shall receive the exceptional rate only for exceptional supports provided to qualifying individuals. Providers shall not contest the determination that a given individual is not eligible for exceptional support services.

B. Providers requesting approval to provide and receive reimbursement for exceptional supports shall have a DBHDS license in good standing per 12VAC35-105. Neither provisional nor conditional licenses shall qualify a provider for the receipt of the exceptional rate. Providers shall demonstrate in writing on the exceptional rate application that they can meet the support needs of a specified qualifying individual through qualified staff trained to provide the extensive supports required by the qualified individual s exceptional support needs. Providers may qualify for exceptional rate reimbursement only when the CRS provider s staff (either employed or contracted) directly performs the support activity or activities required by a qualifying individual.

C. Providers shall work with local case managers in order to file their application for exceptional rate reimbursement. Provider requests for the exceptional rate shall be set out on the DBHDS-designated exceptional rate application and shall be directed to the CSB case manager for the qualifying individual requesting services from the provider. The qualifying individual's case manager shall consult with the DBHDS staff if the individual is currently residing in a training center. Case managers shall work directly with those qualifying individuals who are residing in the community. The case manager shall refer the provider's exceptional rate application to the DBHDS review committee, which shall make a determination on the application within ten business days.

1. The review committee shall deny an exceptional rate application if it determines either:

(i) That a provider has not demonstrated that it can safely meet the exceptional support needs of the qualifying individual,

(ii) That the provider s active protocols for the delivery of exceptional supports to the qualifying individual are not sufficient,

(iii) That the provider fails to meet the requirements of this section, or

(iv) That the application otherwise fails to support the payment of the exceptional rate.

2. If the review committee denies an exceptional rate application, it shall notify the provider in writing of such denial and the reason or reasons for the denial.

D. Providers requesting the exceptional reimbursement rate shall describe the exceptional supports they have the capacity to provide to a qualifying individual on the exceptional rate application. Providers shall ensure that their exceptional reimbursement rate application has been approved by DBHDS prior to submitting any claims for this exceptional rate. Payment at the exceptional reimbursement rate shall be made to the CRS provider effective the date of DBHDS approval of the provider s exceptional rate application and upon completion of the service authorization process for the individual, whichever comes later. Providers may appeal the denial of a request for the exceptional rate in accordance with the DMAS provider appeal regulations, 12VAC30-20-500 through 12VAC30-20-560.

E. Requirements for providers currently providing exceptional supports to qualifying individuals.

1. Providers, who have been approved to receive the exceptional rate and are currently supporting qualifying individuals, shall document in each of the qualifying individuals' plans for supports how that provider will respond to the individuals' specific exceptional needs. Providers shall update the plans for supports as necessary to reflect the current status of these individuals. Providers shall address each of the individuals' complex medical and behavioral support needs through specific and documented protocols that may include, for example, (i) employing additional staff to support the individual, (ii) securing additional professional support enhancements, or both, beyond those planned supports reimbursed through the maximum allowable CRS rate. Providers shall document in a qualifying individual s record that the costs of such additional supports exceeds those covered by the standard CRS rate.

2. CRS providers, delivering exceptional rate supports for qualifying individuals due to their medical support needs, shall employ or contract with a Registered Nurse (RN) for the delivery of exceptional supports. The RN shall be licensed in the Commonwealth or hold multi-state licensure privilege pursuant to § 54.1-3000 et. seq. of the *Code of Virginia* and shall have a minimum of two years of related clinical experience. This related clinical experience may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, nursing facility or an ICF/IID. The RN shall administer or delegate in accordance with 18VAC90-20-430 through 18VAC90-20-460, the required complex medical supports.

a. All staff who will be supporting a qualifying individual shall receive individual-specific training regarding the individual's medical condition or conditions, medications (including training about side effects), risk factors, safety practices, procedures that staff are permitted to perform under nurse delegation and any other training the RN deems necessary to enable the individual to be safely supported in the community. The provider shall arrange for the training to be provided by qualified professionals and document the training in their record.

b. The RN shall also monitor the staff including, but not limited to, observing staff performing the needed complex medical supports.

3. Providers providing exceptional supports for qualifying individuals due to their behavior support needs shall consult with a qualified behavioral specialist. This qualified behavior specialist shall develop a behavior plan based upon the qualifying individual s needs and train the provider's staff in its implementation consistent with the requirements defined in 12VAC30-120-1060. Both the behavior plan and staff receipt of training shall be documented in the provider s record.

4. Providers who will be supporting a qualifying individual with complex behavioral issues shall have training policies and procedures in place and demonstrate that staff has received appropriate training including, but not limited to, positive support strategies, in order to support an individual with mental illness, behavioral challenges, or both.

a. All staff who will be supporting qualifying individuals shall be identified on the exceptional rate application with a written description of the staff's abilities to meet the needs of qualifying individuals and the training received related to such needs.

b. Providers shall ensure that the physical environment of the home is appropriate to accommodate the needs of qualifying individuals with respect to the behavioral and medical challenges typical to this population.

5. Providers shall have on file crisis stabilization plans for all qualifying individuals with complex behavioral needs. These plans shall provide direct interventions that avert emergency psychiatric hospitalizations or institutional placement and include appropriate admission to crisis response services that are provided in the Commonwealth. These plans shall be approved by DBHDS and reviewed by the review committee as set out in 12VAC30-120-1062.

6. The provider's and the case manager's records shall also contain the following for each qualifying individuals to whom they are providing services:

a. The active protocol, for qualifying individuals currently enrolled in the ID waiver, that demonstrates extensive supports are being delivered in the areas of 'extensive support needs' in the SIS®. For those qualifying individuals who are new to the waiver, a protocol shall be developed.

b. An ISP, developed by the qualifying individual's support team, which demonstrates the needed supports and contains support activities to address these, and

c. Evidence of the provider's ability to meet the qualifying individual's exceptional support needs, for all that apply: documentation of staff training, employment of or contract with an RN, involvement of a behavior or psychological consultant, or crisis team involvement) and other additional requirements as set forth in 12VAC30-120-1062.

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

12VAC30-120-1072. Exceptional CRS rate reimbursement for certain congregate residential support services.

A. CRS providers that obtain authorization to receive the exceptional reimbursement rate for qualifying individuals shall receive the rate only for services provided in accordance with a qualifying individual s Plan for Supports.

B. At any time that there is a significant change in the qualifying individual's medical or behavioral support needs, the provider shall notify the qualifying individual's case manager and document such changes in the qualifying individual's Plan for Supports. Upon receiving provider notification, the case manager shall confer with DBHDS about these changes to determine what modifications are indicated in the Plan for Supports, including whether or not the individual continues to qualify for receipt of the exceptional supports.

C. This exceptional rate shall be established in the DMAS fee schedule as posted on www.dmas.feeschedule.

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

12VAC30-120-1082. Exceptional rate utilization review.

A. In addition to the utilization review and level of care review requirements in 12VAC30-120-1080, the case manager shall conduct face-to-face monthly contacts with the qualifying individual.

B. The case manager shall provide to DBHDS updated versions of the required documentation consistent with the requirements of 12VAC30-120-1012 at least every three years or whenever there is a significant change in the qualifying individual's needs or status. The provider shall be responsible for transmitting this information to the case manager.

1. This updated version shall include:

a. A review of the qualifying individual's response to the provision of exceptional supports developed with the qualifying individual and the CRS provider.

b. A description of the incremental step-down provisions included in the qualifying individual's Plan for Supports.

2. The DBHDS review committee shall make a determination about the provider's continued eligibility for exceptional rate reimbursement for a given qualifying individual.