12VAC30-120-220. General coverage and requirements for home and community-based care services.

A. Waiver service populations. Home and community-based services shall be available through a §1915(c) waiver. Coverage shall be provided under the waiver for the following individuals who have been determined to require the level of care provided in an intermediate care facility for the mentally retarded:

1. Individuals with mental retardation.

2. Individuals with related conditions currently residing in nursing facilities but who are being discharged to the community and determined to require specialized services.

3. Individuals under the age of six at developmental risk. At age six, these individuals must be determined to be mentally retarded to continue to receive home and community-based care services.

B. Covered services.

1. Covered services shall include: residential support, day support, supported employment, personal assistance, respite care, assistive technology, environmental modifications, nursing services, therapeutic consultation, and crisis stabilization.

2. These services shall be clinically appropriate and necessary to maintain these individuals in the community. Federal waiver requirements provide that the average per capita fiscal year expenditure under the waiver must not exceed the average per capita expenditures for the level of care provided in an intermediate care facility for the mentally retarded under the State Plan that would have been made had the waiver not been granted.

C. Patient eligibility requirements.

1. Virginia shall apply the financial eligibility criteria contained in the State Plan for the categorically needy. Virginia has elected to cover the optional categorically needy group under 42 CFR 435.211, 435.217 and 435.230. The income level used for 435.211, 435.217 and 435.230 is 300% of the current Supplemental Security Income payment standard for one person.

2. Under this waiver, the coverage groups authorized under §1902(a)(10)(A)(ii)(VI) of the Social Security Act will be considered as if they were institutionalized for the purpose of applying institutional deeming rules. All recipients under the waiver must meet the financial and non-financial Medicaid eligibility criteria and be Medicaid eligible in an institution. The deeming rules are applied to waiver eligible individuals as if the individual were residing in an institution or would require that level of care.

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

a. For individuals to whom §1924(d) applies, Virginia intends to waive the requirement for comparability pursuant to §1902(a)(10)(B) to allow for the following:

(1) ~~An amount for the maintenance needs of the individual which is equal to the categorically needy income standard for a non-institutionalized individual unless the individual is a working patient. Those individuals involved in a planned habilitation program carried out as a supported employment or prevocational or vocational training shall be allowed to retain an additional amount not to exceed the first $75 of gross earnings each month and up to 50% of any additional gross earnings up to a maximum personal needs allowance of $575 per month (149% of the SSI payment level for a family of one with no income).~~

An amount for the maintenance needs of the individual which is equal to the categorically needy income standard for a non-institutionalized individual. Working individuals have a greater need due to expenses of employment; therefore, an additional amount of income shall be deducted. Earned income shall be deducted within the following limits: (i) for individuals employed 20 hours or more, earned income shall be disregarded up to a maximum of 300% of SSI and (ii) for individuals employed at least eight but less than 20 hours, earned income shall be disregarded up to a maximum of 200% of SSI. However, in no case, shall the total amount of income (both earned and unearned) disregarded for maintenance exceed 300% of SSI.

(2) For an individual with only a spouse at home, the community spousal income allowance determined in accordance with §1924(d) of the Social Security Act, the same as that applied for the institutionalized patient.

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

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

b. For all other individuals:

(1) ~~An amount for the maintenance needs of the individual which is equal to the categorically needy income standard for a non-institutionalized individual unless the individual is a working patient. Those individuals involved in a planned habilitation program carried out as a supported employment or prevocational or vocational training will be allowed to retain an additional amount not to exceed the first $75 of gross earnings each month and up to 50% of any additional gross earnings up to a maximum personal needs allowance of $575 per month (149% of the SSI payment level for a family of one with no income).~~

An amount for the maintenance needs of the individual which is equal to the categorically needy income standard for a non-institutionalized individual. Working individuals have a greater need due to expenses of employment; therefore, an additional amount of income shall be deducted. Earned income shall be deducted within the following limits: (i) for individuals employed 20 hours or more, earned income shall be disregarded up to a maximum of 300% of SSI and (ii) for individuals employed at least eight but less than 20 hours, earned income shall be disregarded up to a maximum of 200% of SSI. However, in no case, shall the total amount of income (both earned and unearned) disregarded for maintenance exceed 300% of SSI.

(2) For an individual with a family at home, an additional amount for the maintenance needs of the family which shall be equal to the medically needy income standard for a family of the same size.

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

4. The following four criteria shall apply to all mental retardation waiver services:

a. Individuals qualifying for mental retardation waiver services must have a demonstrated clinical need for the service resulting in significant functional limitations in major life activities. The need for the service must arise from (i) a diagnosed condition of mental retardation; (ii) a child younger than six years of age who is at developmental risk of significant functional limitations in major life activities; or (iii) a person with a related condition as defined in these regulations;

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

c. Services must be approved by the case manager based on a current functional assessment using the Inventory for Client and Agency Planning (ICAP) or other DMHMRSAS approved assessment and demonstrated need for each specific service; and

d. Individuals qualifying for mental retardation waiver services must meet the ICF/MR level of care criteria.

D. Assessment and authorization of home and community-based care services.

1. The individual's need for home and community-based care services shall be determined by the CSB case manager after completion of a comprehensive assessment of the individual's needs and available support. The case manager shall complete the assessment, determine whether the individual meets the intermediate care facility for the mentally retarded (ICF/MR) criteria and develop the Consumer Service Plan (CSP) with input from the recipient, family members, service providers and any other individuals involved in the individual's maintenance in the community.

2. An essential part of the case manager's assessment process shall be determining the level of care required by applying the existing DMAS ICF/MR criteria (12VAC30-130-430 et seq.).

3. The case manager shall gather relevant medical, social, and psychological data and identify all services received by the individual. Medical examinations shall be current, completed prior to the individual's entry to the waiver, no earlier than 12 months prior to beginning waiver services. Social assessments must have been completed within 12 months prior to beginning waiver services. Psychological evaluations or standardized developmental evaluations for children under the age of six years must reflect the current psychological status (diagnosis), current cognitive abilities, and current adaptive level of functioning of the individuals.

4. The case manager shall explore alternative settings to provide the care needed by the individual. Based on the individual's preference, preference of parents or guardian for minors, or preference of guardian or authorized representative for adults, and the assessment of needs, a plan of care shall be developed for the individual. For the case manager to make a recommendation for waiver services, community-based care services must be determined to be an appropriate service alternative to delay, avoid placement in an ICF/MR, or promote exiting from either an ICF/MR placement or inappropriate nursing facility placement.

5. Community-based care waiver services may be recommended by the case manager only if:

a. The individual is Medicaid eligible as determined by the local office of the Department of Social Services,

b. The individual is either mentally retarded as defined in §37.1-1 of the Code of Virginia, is a child under the age of six at developmental risk, or is a person with a related condition who would, in the absence of waiver services, require the level of care provided in an ICF/MR facility, the cost of which would be reimbursed under the Plan,

c. The individual requesting waiver services shall not receive such services while an inpatient of a nursing facility or hospital.

6. The case manager must submit the results of the comprehensive assessment and a recommendation to the DMHMRSAS staff for final determination of ICF/MR level of care and authorization for community-based care services. DMHMRSAS authorization must be obtained prior to referral for service initiation and Medicaid reimbursement for waiver services. DMHMRSAS will communicate in writing to the case manager whether the recommended service plan has been approved or denied and, if approved, the amounts and type of services authorized.

7. All Consumer Service Plans are subject to approval by DMAS. DMAS is the single state authority responsible for the supervision of the administration of the community-based care waiver. DMAS has contracted with DMHMRSAS for recommendation of pre-authorization of waiver services and utilization review of those services.

CERTIFIED:

9/6/2000
Date

/s/ Dennis G. Smith
Dennis G. Smith, Director
Dept. of Medical Assistance Services