

Day Support Waiver for Individuals with Mental Retardation

Definitions and General Requirements

12VAC30-120-1500. Definitions.

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

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

"Behavioral health authority" or "BHA" means the local agency, established by a city or county under Chapter 15 (§ 37.1-242 et seq.) of Title 37.1 of the Code of Virginia that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the locality that it serves.

"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 consumer service 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 consumer service 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 consumer service plan.

"Case manager" means the individual who performs case management services on behalf of the community services board or behavioral health authority, and who possesses a combination of mental retardation work experience and relevant education that indicates that the individual possesses the knowledge, skills and abilities as established by the Department of Medical Assistance Services 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 10 (§ 37.1-194 *et seq.*) of Title 37.1 of the Code of Virginia, that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the jurisdiction or jurisdictions it serves.

"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 consumer service plan.

"Consumer service plan" or "CSP" means documents addressing needs in all life areas of individuals who receive day support waiver services, and is comprised of individual service plans as dictated by the individual's health care and support needs. The case manager incorporates the individual service plans in the CSP.

"DMAS" means the Department of Medical Assistance Services.

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

"DMHMRSAS" means the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DMHMRSAS staff" means persons employed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DRS" means the Department of Rehabilitative Services.

"DSS" means the Department of Social Services.

"Day Support Waiver for Individuals with Mental Retardation" ("Day support Waiver") is the program that provides day support and prevocational services to selected individuals on the waiting list for the Mental Retardation Waiver.

"Day Support" means training, assistance, and specialized supervision in 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 maximum functional level.

"Enroll" means that the individual has been determined by the case manager to meet the eligibility requirements for the Day Support Waiver and DMHMRSAS has verified the availability of a Day Support Waiver slot for that 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.

"Home and community-based waiver services" or "waiver services" means the range of community support services approved by the Centers for Medicare and Medicaid Services (CMS) pursuant to § 1915(c) of the Social Security Act to be offered to persons with mental retardation and children younger than age six who are at developmental risk who would otherwise require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR.)

"Intermediate Care Facility for the Mentally Retarded" ("ICF/MR") 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 mentally retarded and persons with related conditions. These facilities must address the total needs of the residents, which include physical, intellectual, social, emotional, and habilitation, and must provide active treatment.

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

"Individual service plan" or "ISP" means the service plan related solely to the specific waiver service. Multiple ISPs help to comprise the overall consumer service plan.

"Mental retardation" or "MR" means mental retardation as defined by the American Association on Mental Retardation (AAMR).

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

"Preauthorized" means that an individual service has been approved by DMHMRSAS prior to commencement of the service by the service provider for initiation and reimbursement of services.

"Prevocational services" means services aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Prevocational services are provided to individuals who are not expected to be able to join the general work force without supports or to participate in a transitional sheltered workshop within one year of beginning waiver services (excluding supported employment programs). The services do not include activities that are specifically job-task oriented but focus on concepts such as accepting supervision, attendance, task completion, problem solving and safety. Compensation, if provided, is less than 50% of the minimum wage.

"Slot" means an opening or vacancy of 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.

12VAC30-120-1510. General coverage and requirements for Day Support Waiver Services.

A. Waiver service populations. Home and community-based waiver services shall be available through a §1915(c) of the Social Security Act waiver for individuals with mental retardation who have been determined to require the level of care provided in an ICF/MR.

B. Covered services.

1. Covered services shall include day support and prevocational services.

2. These services shall be the appropriate and necessary to maintain the individual in the community. Federal waiver requirements provide that the average per capita fiscal year expenditures under the waiver must not exceed the average per capita expenditures for the level of care provided in ICF/MR under the State Plan that would have been provided had the waiver not been granted.

3. Under this § 1915(c) waiver, DMAS waives §1902(a)(10)(B) of the Social Security Act related to comparability.

D. Appeals. Individual appeals shall be considered pursuant to 12VAC30-110-10 through 12VAC30-110-380. Provider appeals shall be considered pursuant to 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.

E. Slot Allocation.

1. DMHMRSAS will maintain one waiting list, the MR Waiver waiting list (12VAC30-120-211, et seq.) which will be used to assign slots in both the MR Waiver and Day Support Waiver. For Day Support Waiver services, DMHMRSAS will assign slots based on the application date reported by the case manager when the individual was placed on the MR Waiver waiting list while assuring that each CSB has at least one Day Support Waiver slot. Individuals interested in receiving Day Support Waiver services who are not currently on the MR Waiver waiting list may apply for services through the local CSB and if found eligible will be placed on the MR Waiver waiting list until a slot is available.

2. Each CSB will be assigned one Day Support Waiver slot by DMHMRSAS. This slot will remain a CSB slot that, when vacated, will be offered to the next individual on the MR Waiver waiting list from that CSB. The remaining slots will be distributed to the CSBs by DMHMRSAS based on the statewide MR Waiver waiting list. When vacated, these slots will be assigned by DMHMRSAS to the next individual on the waiting list, based upon the application date.

3. Individuals may remain on the MR Waiver waiting list while receiving Day Support Waiver Services.

F. Reevaluation of service need and utilization review. Case managers shall complete reviews and updates of the CSP and level of care as specified in 12VAC30-120-1520 D. Providers shall meet the documentation requirements as specified in 12VAC30-120-1530 B.

12VAC30-120-1520. Individual eligibility requirements.

A. Individuals receiving services under this Waiver must meet the following requirements.

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

1. 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 nonfinancial Medicaid eligibility criteria and meet the institutional level of care criteria. 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.

2. Virginia shall reduce its payment for home and community-based waiver 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 the deductions listed below:

a. For individuals to whom § 1924(d) applies and for whom Virginia waives the requirement for comparability pursuant to § 1902(a)(10)(B), deduct the following in the respective order:

(1) The basic maintenance needs for an individual, which is equal to the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. 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% 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. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual 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.

(3) For an individual with a spouse or children at home, an additional amount for the maintenance needs of the family determined in accordance with §1924(d) of the Social Security Act.

(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 not covered under the plan.

b. For individuals to whom § 1924(d) does not apply and for whom Virginia waives the requirement for comparability pursuant to § 1902(a)(10)(B), deduct the following in the respective order:

(1) The basic maintenance needs for an individual, which is equal to the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. 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% 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. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

(2) For an individual with a dependent child or children, an additional amount for the maintenance needs of the child or children, which shall be equal to the Title XIX medically needy income standard based on the number of dependent children.

(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 not covered under the State Plan for Medical Assistance.

B. Assessment and enrollment.

1. To ensure that Virginia's home and community-based waiver programs serve only individuals who would otherwise be placed in an ICF/MR, home and community-based waiver services shall be considered only for individuals with a diagnosis of mental retardation. For the case manager to make a recommendation for waiver services, Day Support Waiver services must be determined to be an appropriate service alternative to delay or avoid placement in an ICF/MR, or promote exiting from either an ICF/MR placement or other institutional placement.

2. The case manager shall recommend the individual for home and community-based waiver services after completion of a comprehensive assessment of the individual's needs and available supports. This assessment process for home and community-based waiver services by the case manager is mandatory before Medicaid will assume payment responsibility of home and community-based waiver services. The comprehensive assessment includes:

a. Relevant medical information based on a medical examination completed no earlier than 12 months prior to beginning waiver services;

b. The case manager's functional assessment which demonstrates a need for each specific service. The functional assessment must be a DMHMRSAS approved assessment completed no earlier than 12 months prior to beginning waiver services;

c. The level of care required by applying the existing DMAS ICF/MR criteria (12VAC30-130-430 et seq.) completed no more than six months prior to the start of waiver services. The case manager determines whether the individual meets the ICF/MR criteria with input from the individual, family/caregivers, and service and support providers involved in the individual's support in the community; and,

d. A psychological evaluation which reflects the current psychological status (diagnosis), current cognitive abilities, and current adaptive level of functioning of the individuals.

3. The case manager shall provide the individual and family/caregiver with the choice of Day Support Waiver services or ICF/MR placement.

4. The case manager shall send the appropriate forms to DMHMRSAS to enroll the individual in the Day Support Waiver or, if no slot is available, to place the individual on the Mental Retardation Waiver waiting list. DMHMRSAS shall only enroll the individual if a slot is available.

C. Waiver approval process: authorizing and accessing services.

1. Once the case manager has determined an individual meets the criteria for Day Support Waiver services, has determined that a slot is available, and that the individual has chosen this service, the case manager shall submit updated enrollment information to DMHMRSAS to confirm level of care eligibility and the availability of a slot.
2. Once the individual has been enrolled by DMHMRSAS, the case manager will submit a DMAS-122 along with a written confirmation from DMHMRSAS of level of care eligibility, to the local DSS to determine financial eligibility for the waiver program and any patient pay responsibilities.
3. After the case manager has received written notification of Medicaid eligibility by DSS and written enrollment confirmation from DMHMRSAS, the case manager shall inform the individual or family/caregiver so that the CSP can be developed. The individual or individual's family/caregiver will meet with the case manager within 30 calendar days following the receipt of written notification to discuss the individual's needs and existing supports, and to develop a CSP that will establish and document the needed services. The case manager provides the individual and family/caregiver with choice of needed services available under the Day Support Waiver, alternative settings and providers. A CSP shall be developed for the individual based on the assessment of needs as reflected in the level of care and functional assessment instruments and the individual's, family/caregiver's preferences. The CSP development process identifies the services to be rendered to individuals, the frequency of services, the type of service provider or providers, and a description of the services to be offered. Only services authorized on the CSP by DMHMRSAS according to DMAS policies will be reimbursed by DMAS.

4. The individual or case manager shall contact chosen service providers so that services can be initiated within 60 days of receipt of enrollment confirmation from DMHMRSAS. The service providers in conjunction with the individual, individual's family/caregiver and case manager will develop Individual Service Plans (ISP) for each service. A copy of these plans will be submitted to the case manager. The case manager will review and ensure the ISP meets the established service criteria for the identified needs. The ISP from each waiver service provider shall be incorporated into the CSP.

5. If waiver services are not initiated within 60 days from receipt of enrollment confirmation, the case manager must submit written information to DMHMRSAS requesting more time to initiate services. A copy of the request must be provided to the individual or the individual's family/caregiver. DMHMRSAS has the authority to approve the request in 30-day extensions or deny the request to retain the waiver slot for that individual. DMHMRSAS shall provide a written response to the case manager indicating denial or approval of the extension. DMHMRSAS shall submit this response within 10 working days of the receipt of the request for extension.

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 services. DMHMRSAS shall, within 10 working days of receiving all supporting documentation, review and approve, pend for more information, or deny the individual service requests. DMHMRSAS will communicate in writing to the case manager whether the recommended services have been approved and the amounts and type of services

authorized or if any have been denied. Medicaid will not pay for any home and community-based waiver services delivered prior to the authorization date approved by DMHMRSAS if preauthorization is required.

7. Day Support 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 has a diagnosis of mental retardation as defined by the American Association on Mental Retardation and 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 contents of the individual service plans are consistent with the Medicaid definition of each service; and

d. The individual requesting waiver services is not receiving such services while an inpatient of a nursing facility, an ICF/MR, hospital, or inpatient rehabilitation facility.

8. All consumer service plans are subject to approval by DMAS. DMAS shall be the single state agency authority responsible for the supervision of the administration of the Day Support Waiver and is responsible for conducting utilization review activities. DMHMRSAS shall conduct preauthorization of waiver services.

D. Reevaluation of service need.

1. The consumer service plan.

a. The case manager shall update the CSP annually based on relevant, current assessment data; in updating the CSP, the case manager shall work with the individual, the individual's family/caregiver, other service providers, consultants, and other interested parties.

b. The case manager shall be responsible for continuous monitoring of the appropriateness of the individual's services and revisions to the CSP as indicated by the changing needs of the individual. At a minimum, the case manager must review the CSP every three months to determine whether service goals and objectives are being met and whether any modifications to the CSP are necessary.

c. Any modification to the amount or type of services in the CSP must be authorized by DMHMRSAS.

2. Review of level of care.

a. The case manager shall complete a reassessment annually, in coordination with the individual, family/caregiver, and service providers. The reassessment shall include an update of the level of care and functional assessment instrument and any other appropriate assessment data. If warranted, the case manager shall coordinate a medical examination and a psychological evaluation for the individual. The CSP shall be revised as appropriate.

b. A medical examination must be completed for adults based on need identified by the individual, family/caregiver, provider, case manager, or DMHMRSAS staff. Medical

examinations and screenings for children must be completed according to the recommended frequency and periodicity of the EPSDT program.

c. A new psychological evaluation shall be required whenever the individual's functioning has undergone significant change and is no longer reflective of the past psychological evaluation.

3. The case manager will monitor the service providers' ISPs to ensure that all providers are working toward the identified goals of the affected individuals.

4. Case managers will be required to conduct monthly onsite visits for all Day Support Waiver individuals residing in DSS-licensed assisted living facilities or approved adult foster care placements.

5. The case manager must request an updated DMAS-122 form from DSS annually and forward a copy of the updated DMAS-122 form to all service providers when obtained.

12VAC30-120-1530. General requirements for home and community-based participating providers.

A. Providers approved for participation shall, at a minimum, perform the following activities:

1. Immediately notify DMAS and DMHMRSAS, in writing, of any change in the information that the provider previously submitted to DMAS and DMHMRSAS;

2. Assure freedom of choice to individuals in seeking services from any institution, pharmacy, practitioner, or other provider qualified to perform the service or services required and participating in the Medicaid program at the time the service or services were performed;

3. Assure the individual's freedom to refuse medical care, treatment and services;

4. Accept referrals for services only when staff is available to initiate services and perform such services on an ongoing basis;

5. Provide services and supplies to individuals in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000d *et seq.*), which prohibits discrimination on the grounds of race, color, or national origin; the Virginians with Disabilities Act (§ 51.5-1 *et seq.* of the Code of Virginia); § 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act, as amended (42 USC § 12101 *et seq.*), which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications;

6. Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public;

7. Submit charges to DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public and accept as payment in full the amount established by DMAS payment methodology from the individual's authorization date for the waiver services;

8. Use program-designated billing forms for submission of charges;

9. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided:

a. In general, such records shall be retained for at least six years from the last date of service or as provided by applicable state or federal laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved. Records of minors shall be kept for at least five years after such minor has reached the age of 18 years.

b. Policies regarding retention of records shall apply even if the provider discontinues operation. DMAS shall be notified in writing of storage location and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth of Virginia;

10. Agree to furnish information on request and in the form requested to DMAS, DMHMRSAS, the Attorney General of Virginia or his authorized representatives, federal personnel, and the state Medicaid Fraud Control Unit. The Commonwealth's right of access to provider premises and records shall survive any termination of the provider agreement;

11. Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of Medicaid;

12. Hold confidential and use for authorized purposes only all medical assistance information regarding individuals served, pursuant to 42 CFR Part 431, Subpart F, 12VAC30-20-90, and any other applicable state or federal law.

13. Notify DMAS when ownership of the provider changes at least 15 calendar days before the date of change;

14. Properly report cases of suspected abuse or neglect. Pursuant to §§ 63.2-1509 and 63.2-1606 of the Code of Virginia, if a participating provider knows or suspects that a home and community-based waiver service individual is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or exploitation shall report this immediately from first knowledge to the local DSS adult or child protective services worker and to DMHMRSAS Offices of Licensing and Human Rights as applicable; and

15. Adhere to the provider participation agreement and the DMAS provider manual. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their individual provider participation agreements and in the DMAS provider manual.

B. Documentation requirements.

1. The case manager must maintain the following documentation for utilization review by DMAS for a period of not less than six years from each individual's last date of service:

a. The comprehensive assessment and all CSPs completed for the individual;

b. All ISPs from every provider rendering waiver services to the individual;

c. All supporting documentation related to any change in the CSP;

d. All related communication with the individual, family/caregiver, consultants, providers,

DMHMRSAS, DMAS, DSS, DRS or other related parties; and

e. An ongoing log that documents all contacts made by the case manager related to the individual and family/caregiver.

f. A copy of the current DMAS-122 form.

2. The service providers must maintain, for a period of not less than six years from the individual's last date of service, documentation necessary to support services billed. DMAS staff shall conduct utilization review of individual-specific documentation. This documentation shall contain, up to and including the last date of service, all of the following:

a. All assessments and reassessments.

b. All ISP's developed for that individual and the written reviews.

c. An attendance log that documents the date services were rendered and the amount and type of services rendered.

d. Appropriate data, contact notes, or progress notes reflecting an individual's status and, as appropriate, progress or lack of progress toward the goals on the ISP.

e. Any documentation to support that services provided are appropriate and necessary to maintain the individual in the home and in the community.

f. A copy of the current DMAS-122 form.

C. An individual's case manager shall not be the direct staff person or the immediate supervisor of a staff person who provides Day Support Waiver services for the individual.

12VAC30-120-1540. Participation standards for home and community-based waiver services participating providers.

A. Requests for provider participation will be screened to determine whether the provider applicant meets the basic requirements for participation.

B. For DMAS to approve provider agreements with home and community-based waiver providers, the following standards shall be met:

1. Licensure and certification requirements pursuant to 42 CFR 441.302;

2. Disclosure of ownership pursuant to 42 CFR 455.104 and 455.105; and

3. The ability to document and maintain individual case records in accordance with state and federal requirements.

C. The case manager must inform the individual of all available waiver providers. The individual shall have the option of selecting the provider of his choice from among those providers meeting the individual's needs.

D. DMAS shall be responsible for assuring continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies and periodically recertify each provider for participation agreement renewal with DMAS to provide home and community-based waiver services.

E. A participating provider may voluntarily terminate his participation in Medicaid by providing 30 days' written notification. DMAS may terminate at will a provider's participation agreement on 30 days written notice as specified in the DMAS participation agreement. DMAS may also immediately terminate a provider's participation agreement if the provider is no longer eligible to participate in the program. Such action precludes further payment by DMAS for services provided to individuals subsequent to the date of termination.

F. A provider shall have the right to appeal action taken by DMAS. Provider appeals shall be considered pursuant to 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.

G. Section 32.1-325 D2 of the Code of Virginia mandates that "any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states or Washington, DC, must, within 30 days, notify the Medicaid Program of this conviction and relinquish its provider agreement. In

addition, termination of a provider participation agreement will occur as may be required for federal financial participation.

H. Case manager's responsibility for the Individual Information Form (DMAS-122). It shall be the responsibility of the case management provider to notify DMHMRSAS and DSS, in writing, within five (5) business days of being informed of any of the circumstances described in (1) through (5) below;

1. Home and community-based waiver services are initiated.

2. A recipient dies.

3. A recipient is discharged from Day Support Waiver services.

4. Any other circumstances (including hospitalization) that cause home and community-based waiver services to cease or be interrupted for more than 30 days.

5. A selection by the individual or family/caregiver of a different community services board/behavioral health authority providing case management services.

I. Changes or termination of services. DMHMRSAS shall authorize changes to an individual's CSP based on the recommendations of the case management provider. Providers of direct service are responsible for modifying their Individual Service Plans (ISPs) with the involvement of the individual or family/caregiver, and submitting them to the case manager any time there is a change in the individual's condition or circumstances that may warrant a change in the amount or type of service rendered. The case manager will review the need for a change and may

recommend a change to the ISP to the DMHMRSAS staff. DMHMRSAS will review and approve, deny, or pend for additional information the requested change to the individual's ISP, and communicate this to the case manager within 10 working days of receiving all supporting documentation regarding the request for change or in the case of an emergency, within 72 hours of receipt of the request for change.

The individual or family/caregiver will be notified, in writing, of the right to appeal the decision or decisions to reduce, terminate, suspend or deny services pursuant to DMAS client appeals regulations, Part I (12VAC30-110-10 et seq.) of 12VAC30-110. The case manager must submit this notification to the individual in writing within 12 days of the decision. All CSPs are subject to approval by the Medicaid agency.

1. In a nonemergency situation, the participating provider shall give the individual or family/caregiver and case manager 12 days prior written notice of the provider's intent to discontinue services. The notification letter shall provide the reasons why and the effective date the provider is discontinuing services. The effective date that services will be discontinued shall be at least 12 days from the date of the notification letter.

2. In an emergency situation, when the health and safety of the individual, other individuals in that setting, or provider personnel is endangered, the case manager and DMHMRSAS must be notified prior to the provider discontinuing services. The 12- day written notification period shall not be required. If appropriate, the local DSS adult protective services or child protective services and DMHMRSAS Offices of Licensing and Human Rights must be notified immediately.

3. In the case of termination of home and community-based waiver services by the CSB/BHA, DMHMRSAS or DMAS staff, individuals shall be notified of their appeal rights by the case manager pursuant to Part I (12VAC30-110-10 et seq.) of 12VAC30-110. The case manager shall have the responsibility to identify those individuals who no longer meet the level of care criteria or for whom home and community-based waiver services are no longer an appropriate alternative.

12VAC30-120-1550. Services: Day Support and Prevocational Services.

A. Service descriptions.

1. Day support means training, assistance, and specialized supervision in 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 maximum functional level.

2. Prevocational services means services aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Prevocational services are provided to individuals who are not expected to be able to join the general work force without supports or to participate in a transitional sheltered workshop within one year of beginning waiver services (excluding supported employment programs). The services do not include activities that are specifically job-task oriented but focus on concepts such as accepting supervision, attendance, task completion, problem solving and safety. Compensation, if provided, is less than 50% of the minimum wage.

B. Criteria.

1. For day support services, individuals must demonstrate the need for functional training, assistance, and specialized supervision offered primarily in settings other than the individual's own residence that allow an opportunity for being productive and contributing members of communities.

2. For prevocational services, the individual must demonstrate the need for support in skills that are aimed toward preparation of paid employment that may be offered in a variety of community settings.

C. Service Levels. The amount and type of services included in the individual's service plan is determined according to the services required for that individual. There are two types of services: center-based, which is provided primarily at one location/building, and noncenter-based, which is provided primarily in community settings. Both types of services may be provided at either intensive or regular levels.

D. Intensive level criteria. To be authorized at the intensive level, the individual must meet at least one of the following criteria: (1) require physical assistance to meet the basic personal care needs (toileting, feeding, etc); (2) have extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish his service goals; or (3) require extensive constant supervision to reduce or eliminate behaviors that preclude full participation in the program. In this case, written behavioral objectives are required

to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.

E. Service units. Services are billed in units. Units shall be defined as:

1. One unit is 1 to 3.99 hours of service a day.
2. Two units are 4 to 6.99 hours of service a day.
3. Three units are 7 or more hours of service a day.

F. Service Limitations.

1. There must be separate supporting documentation for each service and each must be clearly differentiated in documentation and corresponding billing.
2. The supporting documentation must provide an estimate of the amount of services required by the individual. Service providers are reimbursed only for the amount and type of services included in the individual's approved ISP based on the setting, intensity, and duration of the service to be delivered.
3. Services shall be limited to a total of 780 units per CSP year. If an individual receives a combination of day support and prevocational services, the combined total shall not exceed 780 units per CSP year.
4. For day support services:

a. Day support cannot be regularly or temporarily provided in an individual's home or other residential setting (e.g., due to inclement weather or individual illness) without prior written approval from DMHMRSAS.

b. Non-center-based day support services must be separate and distinguishable from other services.

G. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, service providers must meet the following requirements:

1. The provider of day support services must be licensed by DMHMRSAS as a provider of day support services. The provider of prevocational services must be a vendor of extended employment services, long-term employment services, or supported employment services for DRS, or be licensed by DMHMRSAS as a provider of day support services.

2. In addition to any licensing requirements, persons providing services are required to participate in training in the characteristics of mental retardation and appropriate interventions, training strategies, and support methods for persons with mental retardation and functional limitations. All providers of services must pass an objective, standardized test of skills, knowledge, and abilities approved by DMHMRSAS and administered according to DMHMRSAS' defined procedures.

3. Required documentation in the individual's record. The provider agency must maintain records of each individual receiving services. At a minimum these records must contain the following:

a. A functional assessment conducted by the provider to evaluate each individual in the service environment and community settings.

b. An ISP that contains, at a minimum, the following elements:

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

(2) The individual's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

(3) Services to be rendered and the frequency of services to accomplish the above goals and objectives;

(4) A timetable for the accomplishment of the individual's goals and objectives as appropriate;

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

(6) The provider staff responsible for the overall coordination and integration of the services specified in the ISP.

c. Documentation confirming the individual's attendance and amount of time in services and specific information regarding the individual's response to various settings and supports as agreed to in the ISP objectives. An attendance log or similar document must be maintained that indicates the date, type of services rendered, and the number of hours and units provided.

d. Documentation indicating whether the services were center-based or non-center-based.

e. In instances where staff are required to ride with the individual to and from the service, the staff time can be billed as day support or prevocational services, provided that the billing for this time does not exceed 25% of the total time spent in the day support or prevocational activity for that day. Documentation must be maintained to verify that billing for staff coverage during transportation does not exceed 25% of the total time spent in the service for that day.

f. If intensive services are requested, documentation indicating the specific supports and the reasons they are needed. For ongoing intensive services, there must be clear documentation of the ongoing needs and associated staff supports.

g. The ISP goals, objectives, and activities must be reviewed by the provider quarterly, annually, and more often as needed and the results of the review submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual or family/caregiver.

h. Copy of the most recently completed DMAS-122 form. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

i. For prevocational services, documentation regarding whether prevocational services are available in vocational rehabilitation agencies through § 110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA). If the individual is not eligible for services through the IDEA, documentation is required only for lack of DRS funding. When services are provided through these sources, the ISP shall not authorize such services as a waiver

expenditure. Prevocational services can only be provided when the individual's compensation is less than 50% of the minimum wage.

12VAC30-120-1551 through 12VAC30-120-1599 RESERVED.