PUBLIC COMMENTS – vaACCSES
DD Waiver Final Regulations – April 2019

General Comments

- Benefits Planning, Community Guide, Non-medical Transportation/Employment & Community Transportation Services, Peer Support Services are not included in the proposed regulations but are current available waiver services. A Medicaid Memo was published September 4, 2018 for Community Guide, including Community Housing Guide, Peer Mentor Supports and Benefits Planning Services. Sufficient time has elapsed to include these services in the final DD Waiver regulations for consistency in waiver implementation. We recognize that including them at this stage is a substantive change. However, to continue on without regulatory authority is unacceptable. All waiver services should be included for the purposes of public review and comment.
- DMAS and DBHDS should create the option for a single agency to have one Plan for Supports per individual regardless of the number of services provided to an individual in order to streamline documentation and reduce the number of quarterly reports required. This was a unanimous recommendation of the DBHDS's own Provider Issues Resolution Workgroup (PIRW) in its report published August 2018.
- Support the allowance of employment services organizations (ESOs) to be providers of Peer Mentor Supports, Employment & Community Transportation Services and Community Guide services.
- Support the consistent use of "progress notes" as defined in the DD Waiver regulations versus
- the use of "daily note" references. We support the definition of "progress notes" as defined in 12VAC30-122-20 "Definitions" for consistency. "Progress notes" means individual-specific written documentation that (i) contains unique differences specific to the individual's circumstances and the supports provided, and the individual's responses to such supports; (ii) is signed and dated by the person who rendered the supports; and (iii) is written and signed and dated as soon as is practicable but no longer than one week after the referenced service."
- Support changing the 10-day requirement to a 15-day requirement for service providers to submit quarterly reports.
- Semi-Annual Supervisory Notes for DSPs including "individual's satisfaction with service provision". Requirement should be eliminated or changed per comments below:

    - Community Coaching (122-310.E.2), Community Engagement (122-320.E.2), Group Day (122-380.D.5.), Group Residential (122-390.D.5), Crisis Support Services (122-350.E.2) and Center-Based Crisis Support Services (122-300.E.2) all have additional burdensome requirements under Service Documentation or Provider requirements that state that there must be written supervision notes for each DSP, signed by the supervisor and included semi-annual documentation of individual's satisfaction by the supervisor. (Center-based Crisis Supports does not include the semi-annual requirement.) Semi-Annual supervisory documentation of an individual's "Satisfaction with service provision" or "observation of satisfaction" is also required.
        - This is duplicative of the initial and annual thereafter required documentation of proficiency of staff competencies included under 122-180. Not to mention, much more stringent.
        - Why some services and not others?
        - Consistency between the services does not exist. Group Day requires documentation of "observation of satisfaction".
        - The requirement of semi-annual notes in the DSP supervision note regarding "satisfaction of the individual" or "observation of satisfaction of the individual" is not consistent with the already required individualized documentation.

    - If any one should be documenting an “individual’s satisfaction with service provision” or “observation of satisfaction” – it should be the support coordinator/case manager during their regular visits. Someone other than the provider should be evaluating whether an individual is satisfied with the service they are receiving from the provider. It’s like the proverbial “rooster guarding the hen house”. The support coordinator/case manager is the more appropriate person and, if required, it should be required for all waiver services and not just some services.
    - The requirement of proscribed supervisory notes on a regular semi-annual basis is another added administrative burden layered on top of the annual DSP staff competency requirement which was added after the waiver rates were set. Both cumbersome documentation requirements are not included in any rate.
- Recommend that DMAS and DBHDS actively work with CMS to develop and seek approval of a checklist to substitute for “progress notes” (narrative daily notes) - the demands of which detract from providers’ resources to effectively support individuals.
- Virginia should develop and implement a central provider audit tool to decrease multiple requests of providers for the same information across reviewers. This tool should bring together the various monitoring entities and result in collaboration and consistency in interpretation across agencies and reviewers eliminating redundancy in documentation requests. This includes reviews by DBHDS subcontractors, human rights, licensing and Medicaid regulations and interpretations by contractors, specialists, quality management and provider integrity.
- Provide for the opportunity for deemed provider status for providers that hold a national accreditation (CARF) or specific certification to reduce the frequency of reviews. This would reduce both state government and provider time and money.

12VAC30-50-490. Support Coordination/case management for individuals with developmental disabilities, including autism.

- Eliminate the term “autism” in the section header. Autism/Autism Spectrum Disorders (ASD) are included in the term developmental disability.
- A. Eliminate the limitation of case management to individuals who are six years of age and older and who are on the waiting list or receiving services. Since we have moved to a DD Waiver system that does not differentiate based on diagnosis, there should not be an age restriction to the receipt of case management services. This is a remnant from the old IFDDS waiver where children under six were all served through the ID waiver. If individuals under the age of six are not in the target group, then it is unclear how they would gain a slot on the DD Waiver wait list or receive a DD waiver.

12VAC30-122-20. Definitions.

General:

- Definitions for benefits planning, community guide, non-medical transportation/employment and community transportation services should be added to section.
- Assistive Technology- add following *environment* “, actively participate in other waiver services which are part of their plan.”; delete “in which they live”. The current definition does not account for all of the new and possible future expansive use of technology in all available waiver services. Expanding the definition will enable waiver services to adapt to the fast pace of changing technology in all walks of life.
- Community Coaching – add following *participating* “or to support an individual when there is an ongoing barrier to participation . . .” [This is an issue of access to the Community Engagement

service; individuals with chronic medical, sensory or mobility issues, challenging behavioral issues or a condition which is progressively more debilitating will be barred from Community Engagement as 1:1 staff exceeds the parameters of the service.]

- Community engagement – delete "one staff person to" or change the last sentence to "Community Engagement Services shall be provided in groups no larger than 3 individuals with a minimum of one staff". Basically, delete the reference to "staff" in the definition. The goal is to limit the size of the group.

- Independent Living – Add a definition. The term is used throughout the proposed regulations with no definition. Proposed 12VAC30-122-90 defines the eligibility criteria for the Priority One waiting list to include young adults who are no longer eligible for IDEA services and who are transitioning to "independent living." The regulations describe the individuals whom the Building Independence Waiver is designed to support as "individuals who reside in an integrated, independent living arrangement...." (proposed 12VAC30-122-240). Additionally, the Independent living support service described in proposed 12VAC30-122-420 is available to adults 18 years of age and older to provide the skill building and supports "necessary to secure and reside in an independent living situation." Nowhere in the regulations, however, is the phrase "independent living" as used in these sections defined.
- Positive Behavior Supports – use the definition of the American Association for Positive Behavior Supports and delete the language provided. This will bring the service in line with the national standard.
- Progress Note – We support this definition as written and object to the variations contained in the Provider Requirement sections of the several service descriptions. See our "General Comments" above.
- QDDP – add a reference to all sections in this regulation which permit "QDDP" for the purposes of developing service plans and/or the supervision of staff to be defined in accordance with 12VAC35-105; while it is not necessary for the purposes of the definition, it will add clarity to the regulations.
- Face-to-face visit- add following *support coordinator "*or shared living administrative provider" [Face-to-face is the term used for the periodic meetings required in that service]
- Independent Living – Add a definition
- Service Authorizations- Strike the word "medically". DD waiver services are all Medicaid-funded services. However, not all services authorized or funded under the waiver are medical in nature. (e.g. supported employment, community engagement, etc). While we understand the Medicaid standard of "medical necessity" for payment, it implies that services must have a physician's order and not be developed by the Person-Centered planning process.
- Supported living residential- delete following *a service* "taking place in an apartment setting"; add following *operated by a DBHDS-licensed provider*. Change to "taking place in an individual's own home". There is no operational reason to limit the choice of the type of living arrangement.

12VAC30-122-40. Waiver services; when not authorized.

- B. Clarify that transition services can be provided to individuals who are inpatients at the listed facilities when they are preparing for discharge**.** The subsection states that waiver services shall not be furnished to individuals who are inpatients of a hospital, nursing facilities, ICF/IID, or inpatient rehabilitation facility. It goes on to state that waiver services shall not be provided until the individual has exited the institution and has been enrolled in the waiver. However, some of the costs covered by transition services would have to be incurred prior to the individual exiting the

institution, in order for the individual to have an alternative place to live. Such expenses include security deposits, set-up fees, or deposits for utilities, etc.

12VAC30-122-60. Financial eligibility standards for individuals.

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

12VAC30-122-80. Waiver approval process; authorizing and accessing services.

- C.3.- add at the end "and other service plans as applicable."
- C.4.- Following *initiated within* change "30 days" to "90 days," Taking into account the existing workforce recruitment timeframes, training requirements, etc., services may not realistically be

initiated in only 30 days. If there are other requirements to notify DSS within that timeframe then the 30-day requirement in line 4 will have to remain. Ensure that references to days (days vs. calendar days) are consistent. There are a variety of reasons that can create a delay of service initiation beyond 30 days. The individual should not be penalized by having to undergo another financial eligibility determination because the provider does not initiate services in a timely manner. It is unlikely that there would be a significant change in financial circumstances within a 30-day period. Furthermore, since the individual/family have up to 30 days to contact the provider, should this contact be made on day 29, services clearly could not be initiated by day 30.

- C.6.c.- Following *approve* change "suspend" to "pend" whh is the terminology currently utilized when seeking more information.

12VAC30-122-90. Waiting list; criteria; slot assignment; emergency access; reserve slots.

- C.1.a. – Following *care for the individual* add "a primary care giver who is 70 years of age or greater". While we recognize that the age criterion was removed during the "redesign," we feel that the impact has been significant on older families. It also limits the family's ability to assist their adult children to make life decisions before it is an emergency.
- C.1.a- Following *there are no* strike "other"
- C.1.b.(1)- Following *effectively managed* strike "by the primary caregiver or unpaid provider". Not everyone has a primary caregiver.
- C.1.b.(2)- Following *managed* strike "by the primary caregiver"
- C.1.d- Following *IDEA services and* strike "is transitioning to independent living" and add "has expressed a desire to live independently"
- E.3- Strike "A regional WSAC session will then be held for the remainder of available slots, reviewing those individuals meeting criteria for the Priority Two and then Priority Three." We feel strongly that all slots should be for the Priority 1 list – if the service array in the BI Waiver is not attractive to those on Priority 1 then either the slots should be re-purposed or the service array should be changed.

12VAC30-122-120. Provider requirements.

- A.4.- Change "30 calendar days" to "90 calendar days" (See comment above in Section 80)
- A.5.- Strike "medically necessary services and supplies" and add "services and supports"
- A.6.- Strike "supplies" and add "supports"
- A.10.d- Strike "Such documentation shall be written on the date of service delivery." This is not in keeping with the definition of Progress Note in 122-20 and as referenced earlier in comments.
- A.10.d- Strike "medical" in the first sentence
- A.10.f- Add "if applicable" within the parenthetical phrase "including specific timeframe"
- A.13- Change 37.2-600 to 37.2-607
- A.14- Strike "-s of Licensing and". Abuse and neglect are reported to the Office of Human Rights not the Office of Licensing.
- D- Strike "may" add "shall" in last sentence. If the purpose is to improve or remove poor providers - then this should not be an option.

12VAC30-122-180. Orientation testing; professional competency requirements; advanced competency requirements.

- A.2. refers to the standardized test as “DMAS approved” while the 2016 version of the regulations refers to the test as “DBHDS” approved. Please clarify which agency must approve the test, describe the process of approval, and include a list of approved standardized tests and resources for providers.
- C5. The orientation is a knowledge-based assessment, while the competencies are both knowledge and action based. On many of the competencies, you are required to assess action and knowledge. Where I have found the deficiencies to be is in the action part of the competencies. Therefore, retaking the orientation test is not a valid way of training for action. Having statewide readily available online training tools for the competencies from department would be helpful.
- D.1- The reference should to the “personnel file” not the “provider record”
- D.2- Change sentence to “Completed documentation from the online certificate shall be maintained in the Personnel File.”
- E.7- Add “only” before *specific to the needs*; and following *specific to the needs* strike “and level”
- E.8- add “only” before “specific to the needs”; strike “and service levels”. These changes clarify the intent have the advanced competencies applicable as the needs of the individual requires.

12VAC30-122-190. Individual support plan; plans for supports; reevaluation of service need.

- A.8- Add “by the support coordinator” before *with a copy of the.* This clarifies that the support coordinator is responsible for providing a copy of the ISP to the individual family.

12VAC30-122-200. Supports Intensity Scale® requirements; Virginia Supplemental Questions; levels of support; supports packages.

- A.1- Delete “to 72” and add “or older” after “years of age.” If the SIS is only validated to age 72 then language should be added to automatically assign all individuals age 72 or older to Level 5, Tier 4. Level 5 is the highest level denoting significant need in general but not specifying it to medical or behavioral. Tier 4 is mid-range denoting significant need, which is appropriate for an aging population. However, there should be a statement that these individuals shall not be excluded from consideration of an individualize rate because of medical or behavioral needs.
- Recommend the addition of “Individuals who are older than 72 years of age shall be assessed using either the SIS or an alternative instrument (alternative instrument or instruments to be named in the regulations).”
- A.2.a - Change “three” to “four” to stay consistent with the CL application
- A.4.- DELETE. The specific scoring protocol should be in a Medicaid Memo, not in the regulations.
- D – DELETE entre section/paragraph. This is a reserved section intended to explain the establishment of supports packages as a profile of the mix and extent of services anticipated to be needed by individuals with similar levels, needs and abilities. Due to 2019 General Assembly budget language which prohibits the implementation of supports packages unless specifically authorized by the General Assembly, this section is not necessary.
- Add a new D – “Requires that the results of the SIS be provided within 10 days of scoring in an understandable format and that the service coordinated be required to explain the results and implications of the SIS score and avenues of appeal.”
- Add a new E.- “An automatic, independent review of the SIS administration process and results when an individual’s SIS Score changes despite a lack of change in their health or other circumstances, upon request.”

12VAC30-122-210. Payment for covered services (tiers).

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

12VAC30-122-240. Services covered in the Building Independence Waiver.

- Add Agency and CD Companion and Personal Assistance, and Individual & Caregiver Training to the BIS waiver. With the addition of these services, there may be more interest in utilizing this lower cost waiver by persons on the Priority 1 waiting list.

12VAC30-122-250. Services covered in the Community Living Waiver.

- Add Family and Caregiver Training. This service is applicable to all individuals and families and should not be limited to the FIS waiver.

12VAC30-122-260 – Services covered: Family and Individual Support Waiver.

- Add Independent Living Services to the FIS waiver. This service can assist individuals living on their own or wishing to live on their own.

12VAC30-122-270 - Assistive technology service.

- A.(ii)- STRIKE “with the environment in which they live” and ADD a new (iii) “actively participate in other waiver services that are part of their plan.” Renumber the current item (iii) to item (iv). AT should be available to support any service in a person’s ISP. It should not be limited to the environment in which the individual lives. It should be available to support an individual in any approved service and promote inclusion in all aspects of an individual’s life.

12VAC30-122-280 - Benefits Planning Services (reserved).

- This service is now available (Medicaid Memo Sept. 4, 2018). It should be included in the final DD Waiver regulations out for public comment.

12VAC30-122-300 - Community-based crisis support service.

- After means add “planned crisis prevention and emergency crisis stabilization services provided to”; strike “a service”. This brings it in line with Center-based Crisis.

12VAC30-122-310 - Community coaching service.

- A- After *barriers* add “or to support an individual’s participation when there is an ongoing barrier to participation” See definition.
- C.3- Strike “This service shall not be provided within a group setting.” This sentence is not necessary and has the potential the individual from learning how to interact and communicate with others in a community engagement setting – the entire purpose of the service. Requiring the service to be one-on-one is sufficient.

12VAC30-122-320 - Community Guide Service. (reserved);

- This service is now available (Medicaid Memo Sept. 4, 2018). It should be included in the final DD Waiver regulations out for public comment.

12VAC30-122-340 - Companion service.

- C.1- Strike second sentence and limiting the service to eight hours per 24-hour day. While the occasions might be rare, this service can support those who can otherwise function reasonably independently at a modest cost – the 8 hour per day limitation can interfere with that. The waivers already allow a combination of various services to flexibly accommodate an individual’s needs. Companion services are inexpensive and there may be times when an individual requires more than eight hours of this service in a given day. The authorization should be an annual amount or hours that can be used as the individual needs them. Eight hours per day is an arbitrary cap.
- D.4.b- Replace with “Providers that are licensed by DBHDS, a supervisor meeting the requirements of 12VAC35-105 shall provide supervision of direct support professional staff.” This brings it in line with other similar services.

12VAC30 – 122-350 - Crisis Support service.

- The three-levels described here are not included in the other two crisis support services – they should be consistent.

12VAC30 – 122-360 - Electronic Home-Based Support Service.

- B.1.- STRIKE “physically”. The section notes that the individual must be “physically” capable of using the equipment provided via EHBS service. Some EHBS services may be voice activated and not require physical manipulation. Although voice activation could be considered “physical”, this provision could be misunderstood and, thus, misapplied by authorizers or auditors.
- C.1. Recommend an increase to the cost of electronic home-based supports from the current maximum of $5,000 per calendar year. This limit is not sufficient for up-to-date technology as well as any associated monthly monitoring fees. The purpose of these supports is to enable individuals who so desire to live more independently with less staff intrusion into their lives. The benefit should be consistent with the average cost of this type of support. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new electronic home-based supports technology without raising the overall multi-year dollar limits.

12VAC20-122-370 - Environmental Modification Service.

- C.2. Recommend an increase to the $5,000 annual limit for environmental modifications from the current maximum annual cap of $5,000 to a level deemed appropriate to the cost of such modifications. This limit is years old and it is increasingly difficult for families and individuals to secure modifications that will allow them to remain in their homes over their lifespan for this small amount of funding. If raising the overall limit is not feasible at this time, we recommend adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new environmental modifications without raising the overall multi-year dollar limits.
- C.6.- We recommend that an exception process be put into place for the uncommon circumstance in which the expansion of square footage to the home (which is prohibited) is an incidental result of a modification that will enable the individual to remain in the home (e.g. a larger, accessible bathroom). Limits could be put into place for how much additional square footage would be allowable in an exceptions process.

12VAC30-122-380 - Group Day Service.

- B.1. Support the addition of the following that are included in the new CL waiver renewal application but are not currently included in the proposed final regulations:
    - Participation in community volunteer opportunities or education programs;
    - Staff coverage for transportation of the individual between service activity sites. Transportation is included as part of the service. The provider may be reimbursed for the time spent transporting the individual to community locations as part of the waiver billing
    - Personal types of activities (i.e. assistance with ADLs). These allowable activities are critical for individuals that need them but are not necessarily “skill building”.
    - Allowable activity of “providing safety supports in a variety of community settings”: This allowable activity is not included in the CL Waiver renewal application. Further, the CL renewal application includes “personal care types of activities (i.e. assistance with ADLs)” yet this allowable activity is not listed in either these proposed regulations nor in the “2016” version of regulations. These refer to activities rather than the requirement for skill-building; this phrase offers more flexibility for providers who are spending significant time in personal care than in skill-building. Consistent language should be included in these proposed regulations.

- C. Add 6. Recommend annual allocation for Group Day and Community Engagement hours to allow increased flexibility. Currently, Group Day hours and Community Engagement hours are authorized on a monthly basis with additional estimated "flex hours". We recommend that there period of authorization be lengthened to allow more flexibility and consumer choice. For example, individuals choose whether they want to go out in the community or stay in a center on any given day. Because of weather or other personal circumstances of the individual, the individual may want to stay in the center more often in the winter and in the community more often in the Spring/Summer/Fall. Hours could then be drawn from a quarterly, semi-annual or annual "pool" of hours based on their person-centered plan.
- D.5. Supervision - There is NO reference to Licensing regulations to define "supervisor." Licensing does not define a "supervisor" but does define a QDDP. The 2016 version of the Waiver regulations included the phrase "or a provider who has documented equivalent experience" to allow providers to substitute experience for a college degree, but this phrase is not included in either the new (2018) Licensing regulations or within the definition of QDDP in these Waiver regulations. Providers request consistency and clarity within and between regulations when defining QDDP since there are numerous QDDP responsibilities within these regulations.

12VAC30-122-390 - Group Home Residential Service.

- E.1.c- Change "at least a daily note" to "a Progress Note". This makes it consistent with other requirements. See previous comments under "General Comments".
- Move C.3 under letter D. It is under this section in other service descriptions.

12VAC30-122-400 - Group and Individual Supported Employment Service.

- Add Employment Services Organizations (ESOs) as qualified providers of Employment & Community Transportation Services.
- Add Employment Services Organizations (ESOs) as qualified providers of Peer Mentor Support Services.
- Add Employment Services Organizations (ESOs) as qualified providers of Community Guide Services.
- A.3.a. – Strike "limited" after *but reimbursement shall not.* (2nd sentence, 4th line)
- B.1. – Add "and enrolled in school" after *for individuals younger than 22 years of age.* Strike "for the individual enrolled in the waiver".
- C.3. – Strike "and individual". Individual SE must be able to be provided in an individual's home for purposes of self-employment or other individuals that work from home for other employers (telecommuting, etc.)
- C.4. – Strike "service" after employment. Strike "in combination with other day service or residential service" and Change to "concurrently with other waiver services for purposes of job discovery". Should read as follows: "For time limited and service authorized periods (not to exceed 24 hours) individual supported employment ~~service~~ may be provided ~~in combination with~~ *concurrently with other waiver services* for purposes of job discovery." This revision helps with clarity.

- D.4. – Second paragraph under this Provider Requirements section is duplicative to 400.A.3.b (Service Description) and is not related to Provider Requirements.
- E.1.c. – Sentence needs to be reworked. "Documentation confirming the individual's time in service" is for Group Supported Employment (GSE) only. "Daily note" is only applicable to GSE as well. Strike "daily note" and insert "progress note" to be consistent with other sections and definition of "progress note" in Section 122-20.
- E.1.f. - Sentence needs to be reworked. Should read "*Documentation that indicates the date, type of service rendered, and the number of hours provided, including specific timeframe. An attendance log or similar document shall be maintained for Group Supported Employment*". An attendance log or similar document is not required for ISE since the individual is competitively employed.
- E.1.i. – After *group,* Insert "for Group Supported Employment".

12VAC30-122-410 - In-Home Support Service.

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

12VAC30-122-420 - Independent Living Support Service.

- A – Add following *receiving this service* "lives, or is preparing to live, alone . . ."; strike "typically". This service should be available to those planning to transition to more independent living and not just those already living independently.
- A- Add "or FIS waiver" at the end of the last sentence. There are individuals that wish to live independently in the FIS waiver who wish to live independently, particularly transition age you who could benefit from this service. It should not be limited to those already in an independent living setting.
- C.1.- Add "If the hours consistently exceed 21 hours per month, the individual shall be immediately eligible for a reserve slot."
- E.1.c. – add "observations of individual's responses to services shall be available in Progress notes"
- E.1.d – strike "and the documentation will correspond with billing"

12VAC30-122-430 - Individual and Family/Caregiver Training Service.

- A- Strike "FIS waiver" Add "in all of the DD waivers". There is no reason that it is only included in the FIS waiver. Individuals and their families can benefit from this service.

- Strike C.1

12VAC30-122-440 - Nonmedical Transportation Service (Reserved).

- This service is now available (Medicaid Memo Sept. 4, 2018). It should be included in the final DD Waiver regulations and out for public comment.
- The name of this service needs to be consistent. Is it Employment and Community Transportation or Nonmedical Transportation Service. Needs to be consistent between DD Waiver renewals and regulations.

12VAC30-122-450 - Peer Support Service (reserved).

- This service is now available (Medicaid Memo September 4, 2018). It should be included in the final DD Waiver regulations and out for public comment.

12VAC30-122-460 - Personal assistance service.

- A.3. – Add "Personal Assistance can be provided simultaneously with supported employment services and can be billed concurrently". The provision currently states that an additional component of personal assistance services is to aid and supports to individuals in the work place, with the final sentence stating, "Work related personal assistance service shall not duplicate supported employment service." The addition of the suggested sentence at the end of this section clarifies that both can be provided at the same time and that they are distinctly different services.
- A.4- Change to "in all DD waivers". As previously stated, it is unclear why this service is not available in the BI waiver. Individuals in the BI waiver are more likely individuals with physical developmental disabilities who may require personal assistance services in order to live independently in their homes. PA services can be critical to this population.
- C.7.a & b.- Strike "Companion" Add "Personal Assistance". This is a typographical error.

12VAC30-122-480 - Private Duty Nursing Service.

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

12VAC30-122-520 - Skilled Nursing Service.

- See comment above regarding Private Duty Nursing Service and support of the VBPD recommendation.

12VAC30-122-530 Sponsored Residential Support Service.

- E.1.c.- Strike "confirming the amount of the individual's time in service and"
- E.1.c.- End of second sentence strike "at least a daily note" add "in a progress note". This makes documentation consistent as previously stated.

12VAC30-122-540 - Supported Living Residential Service.

- First sentence - match the definition in section 122-20 to be consistent. DELETE “an apartment setting” and changing to a service “taking place in the individual’s own home.” Not all supported living residential settings are apartments.

12VAC30-122-550 - Therapeutic Consultation Service.

- B.2.i - Support Dr. Walker’s comments
- C.3- Strike “written preparation and telephone communication”
- D (1**)** Recommend adding Registered Behavior Technicians (RBT) to list of people that may provide direct support under the supervision of Board Certified Behavior Analyst. (RBT’s would not provide consultation, rather direct support).

12VAC30-122-570 - Workplace Assistance Service (12VAC30-122-570).

- B.4. – Add (e) at the end of the lettered list which adds “Phone, media and in-person contacts with a Job Coach” as an allowable/billable activity. There may be times when a workplace assistant may need to consult with the individual’s job coach in order to meet the needs of the individual and to ensure consistency of strategies to support the individual to be successful in the workplace.
- D.3. – Providers of Workplace Assistance that are CARF accredited employment vendors of DARS satisfy staff competency requirements for Workplace Assistance Services.
- Recommend that Workplace Assistance Services be added to the BI Waiver as individuals on this Waiver may have health and/or safety monitoring needs in a place of employment.