Q&As from MLMC Stakeholder Calls
August 2016

	Questions	Answers
General DD Waiver Questions		
01	**Q:** What is the timeline for implementation of the redesign?	**A:** UPDATE: Waiver redesign was implemented September 1, 2016.
02	**Q:** Do we have any information as to whether we are getting closer?	**A:** We received some additional questions from CMS by email on Friday (7/29). We are currently going through those. There is no indication of a date for approval. We are waiting for an official go ahead before we set a date since the delays have been so disruptive. UPDATE: Waiver redesign was implemented September 1, 2016.
03	**Q:** With the CMS approval, did they make any changes or were there any reason why it is taking so long to approve the redesign?	**A:** The biggest reason for the delay had to do with the review of the rate methodology and information resubmitted as part of the response to questions CMS had.
04	**Q:** On September 1st, what will be the effect on families?	**A:** The hope is that the transition of waivers and services will be as seamless as possible as the current waivers will flow right into the successor waivers. Providers may need some time before they are ready/able to provide new services.
05	**Q:** Is there going to be guidance for a simple way to explain the waiver redesign to individuals and families?	**A:** We have two family resource consultants that are working to put together information specifically for individuals and families. Provider Development will be assisting with the development of guidance materials.
06	**Q:** When do we anticipate having the manual for the new regulations?	**A:** The regulations must be approved prior to completing/releasing the manual. The policy manual will come out some time after the regulations are approved. The manual is expected in January.
07	**Q:** Until the new manual comes out, is it safe to assume that providers should follow the manual that is closest to the new services until the manual comes out and if audited from 9/1 until the new manual comes out will auditors know that we did not have the new manual to follow?	**A:** Prior to (or on 9/1) allowable activities and information about them will be released. It will be a while before the manual comes out but the regulations will provide the majority of the information. Your notes, documentation and ISP will be the same. Regulations are what auditors are using, not a provider manual. Auditors will be using the regulations/manual from the time frame that they are reviewing. https://townhall.virginia.gov/L/ViewStage.cfm?stageid=7420
08	**Q:** Did I hear that the new regulations are out?	**A:** Yes. There are 5 sections out. There is a new section in the 500s about the competencies and then the 3 sections that address the amended waivers. They are all up on town hall and ready to review. https://townhall.virginia.gov/L/ViewStage.cfm?stageid=7420

Q&As from MLMC Stakeholder Calls
August 2016

Questions		Answers
09	**Q:** Do you have an update on the Individual and Family Support Program? Do you know when it will be available again?	**A:** At this time we do not have information on that.
10	**Q:** Can you provide an update on DSP and staff training?	**A:** The updated training for Supervisors is available on the Learning Management System. Current supervisors have 120 days to complete the basic requirements which include reviewing training materials, passing the test and signing the assurances. Supervisors will have 180 days to meet the advanced competencies. Currently qualified DSPs will have 180 days to complete the updated training and meet competencies.
11	**Q:** Once the emergency regulations are in place, we have 6 months to retrain staff, correct?	**A:** Yes. Currently qualified DSPs have 180 days to complete the new training.
12	**Q:** When you say Emergency Regulations, are you talking about licensing or changes in the waivers?	**A:** Those would be related to the amended waivers not licensing. We are waiting for CMS to approve the waiver redesign and once done, we have the regulations to be disseminated.
13	**Q:** What are the training requirements for newly hired staff effective 9/1?	**A:** DSP hired after 9/1 will need to complete the trainings prior to providing reimbursable direct care in the absence of other qualified staff who are documenting oversight of the DSP. The regulations read as follows: "Providers shall ensure that DSPs and DSP supervisors pass a DBHDS-approved objective, standardized test of skills, knowledge, and abilities covering the core competencies referenced above prior to providing direct, reimbursable services in the absence of other qualified staff who have passed the knowledge-based test and who document oversight of the individual who has not yet passed the test."
14	**Q:** When will the request for the waiver slots be submitted?	**A:** The application cannot be submitted until tomorrow. CMS federal guidelines states that you cannot have an open request and submit a second. We will submit after 9/1.
15	**Q:** CMS has 30 days to respond to what you have submitted, correct?	**A:** From the date of application, CMS has 60 days to respond and 90 days to approve. UPDATE: Waivers have been approved
16	**Q:** Does that mean there will be 90 days until the waivers are released?	**A:** That depends on whether CMS has questions which would stop the clock. UPDATE: Waivers have been approved

Q&As from MLMC Stakeholder Calls
August 2016

	Questions	Answers
17	**Q:** Now that the wait lists are combined, how long is it? How long was it before combined?	**A:** These numbers are not exact but combined they are somewhat over 10,000. Before they were combined, (as of July) the ID Waiver Waitlist was 8,444 and the DD Waiver Waitlist was 2,230.
18	**Q:** What are the plans to deal with the waitlist since those who were on the DD Waitlist are now lower? **Q:** How do we get more slots? **Q:** How many slots can be expected next year?	**A:** The wait list is no longer chronological, so you are not "lower." It is prioritized by need with the highest priority being screened for new slots. The list is large, but Virginia has managed 2 lists and requested slots for both lists from the General Assembly for quite some time. This doesn't necessarily change the overall need by merging. **A:** A parent or concerned advocate can get in touch with their legislator since the number of slots is determined by the General Assembly. Last year 200 slots were approved to address the DD Chronological wait list. Those slots have been distributed. There were also 140 slots approved for the FIS waiver and 300 slots of CL Waiver. The federal part of the funding still needs to be requested which will be done once the amendments have been approved, per CMS request. **A:** Next year we expect: FIS 25, CL 325.
19	**Q:** 200 slots were made available for people on the DD Waiver Waitlist. Why was there nothing similar for people on the ID Waiver Waitlist?	**A:** The DD WL has always been chronological, merging the waivers is a significant change in their waiting list. It was felt that those at the top of the list should have access to slots. #1 and #2 chronologically may be Priority 3, so the chance of receiving a slot becomes much more distant. IDWL has always been managed by urgency, and the new priority categories are very similar, so there is less chance of not being able to access the waiver.
20	**Q:** Are the amendments posted so the public can see it?	**A:** We can probably provide the information CMS is requesting. You can also check the documents from the general assembly as it lists the waivers and funds there.
21	**Q:** Are you breaking down the slots submitted by waiver and reserve slots?	**A:** When the number of slots it was initially requested, the amended waivers did not exist. The understanding is that there will be 40 reserve sots. The ID Waiver slots will move to Community Living and the DD Waiver slots will move to the Independent Family Supports waiver.
22	**Q:** Does that mean there will not be any	**A:** No, there were no additional slots specifically designated for

Q&As from MLMC Stakeholder Calls
August 2016

	Questions	Answers
	Building Independence Waivers?	BI, however, the Day Support Waiver already had some openings that can be used.
23	**Q:** Currently there are people on the ID Waiver who will be moving to the CL waiver who either receive a low number of in home hours or CD/PA services. At some point there was discussion about talking with families about switching to the FIS waiver to free up a comprehensive slot. How would a reallocation process go to get what is appropriate to a person's needs? I would hope that the provider would be involved in a discussion.	**A:** To be very clear, neither DMAS nor DBHDS will be forcing anyone off one waiver to another waiver. Discussions need to happen with families' agreement/ choice. If someone is not fully utilizing services on their waiver, it would be very appropriate for the team to discuss it with person and family and determine if they are willing to have needs met by another waiver. As far as WaMS implications with a change of waivers, the billing codes are the same across the waivers and would not affect the provider if there as a change in waiver. The waivers do not have a "use it or lose it" stipulation.
24	**Q:** Is it true that if we are not looking for a group home at this time, we could not be offered a Community Living slot?	**A:** No
25	**Q:** My daughter is 17 and is graduating with a standard diploma. I understand there is a waiting period that will increase once the waivers have merged. Am I too late in starting this process? **Q:** Is this like DARS?	**A:** You are never too late. Go to your local CSB and let them know you are interested in having your daughter screened. They will do the VIDES and requests certain documents to determine her priority of need. If all the criteria is met, she will be placed on the waiting list. The list has about 10,000 people. With the merging of the waivers it is no longer based on chronological order but it is based on the urgency of need. **A:** This is different. When you are screened for the DD waivers, you are not also screened for DARS.
26	**Q:** For school aged kids that leave school services early (prior to the end of IDEA eligibility), does this mean they cannot meet priority one criteria at any point? **Q:** If a child has a waiver slot, there is nothing that prohibits them from leaving school early, correct?	**A:** They would not qualify for that category until age 22 when IDEA services would normally end. Students need to take advantage of their IDEA services. **A:** The concern is that kids will leave early to get on the waiver. Waiver requires that Medicaid is the funding source of last resort. Other funding options still must be explored, even when there is access to a waiver.
27	**Q:** Is anyone not Priority 1 considered for a waiver slot? **Q:** Priority 1 guidelines are extremely	**A:** Not until all individuals in the state who are a Priority 1 are served. **A:** Because there are so many people in dire situations, we have

Q&As from MLMC Stakeholder Calls
August 2016

	Questions	Answers
	concerning. A person / family must be in a dire situation to be considered for a slot. Is there any hope for our children over 27?	determined that we must give slots to individuals who have the greatest need. The only way that would change is if we received enough funding to serve all of the individuals identified as Priority 1. Until that time, IFSP can be used and some CSBs have funding that can be used for supports.
28	**Q:** What is the process of switching someone to the Community Living Waiver?	**A:** The CBS will need to notify DBHDS to request a reserve slot as well as provide information as to why the reserve slot is needed. We do not have a group of reserve slots at this time.
29	**Q:** Do you have a timeframe for when the amendments will be approved and the FY2017 slots are made available?	**A:** It is dependent on how quickly CMS responds to the slot amendments.
30	**Q:** When the amendments are approved, will there be new waiver slots available?	**A:** There will be no new waiver slots right away because the slots have not been funded by CMS. UPDATE: Community Living slots will be available soon. Additional slots have been submitted to CMS for approval.
31	**Q:** Can waivers be traded in an emergency situation?	**A:** This will have to be looked at on an individual case by case basis.
32	**Q:** I (SC) have an individual that is at REACH because he had a crises and he cannot return home. We are now trying to find placement and are wondering how to go about doing that. He currently has a DD waiver. How do we change the waiver so that he can move to the CL waiver and how soon can this occur?	**A:** There are reserve slots that will allow some movement but they are going to be very limited. We are working out a process where vacated slots can be used for people waiting to move between waivers. More info will come out shortly. If the individual has a DD Waiver, even though that does not include group homes or sponsored homes, it does have supported living which is an apartment style set up and includes In-home. I want to caution against the idea that people automatically need to have group home services. Please consider other options before automatically requesting to move to a different waiver.
33	**Q:** I have a 29 year old daughter. She finally got a DD W. She is living at home and is totally helpless. Sooner or later I am going to die. Is she going to be able to get a group home? Will she need to move to a different waiver?	**A:** We plan to have reserve slots every year if the General Assembly continues to fund for movement between waivers. Again, we need to look at the individuals need. Group homes are not necessarily the model that everyone needs or what is best for each person.
34	**Q:** If a Community Living slot does not come available, will she be stuck in a nursing home?	**A:** We certainly don't want that. DBHDS and DMAS would work with you and case manager to determine needs and the appropriate waiver.

Q&As from MLMC Stakeholder Calls
August 2016

Questions		Answers
35	**Q:** Is there a time frame for when the members of the WSAC will be trained and ready to meet?	**A:** An e-mail announcement about training will go out to WSAC members about beginning the training. There is also an e-mail going to the CBS to clarify their role in the WSAC meetings providing them with a uniform form. RSS and the WSAC facilitator will vet the dates for the meetings. UPDATE: WSAC members have been trained through webinars and online HIPPA training .
36	**Q:** What are the standards for making the determination (WSACs)? Do they make the decision about who gets the waiver?	**A:** WSACs are members of your community. Tools have been developed that help to determine most needy individual. A lot depends on discussions in WSAC by case managers. Tools can be found at http://www.dbhds.virginia.gov/individuals-and-families/developmental-disabilities/my-life-my-community Under **Waiver Redesign Training/Handouts/ Stakeholder (MLMC) Weekly Calls Q&As (NEW 7/1/16):**
37	**Q:** While reviewing the fee schedule on the DMAS website, it references a start date of 10/1/16. Is this correct?	**A:** No. It should say 9/1/16. This will be corrected.
38	**Q:** For programs that have ratios that affect the rate, how do we verify the size of the group in documentation?	**A:** DBHDS will have to take that into consideration as guidance and policy are developed.
39	**Q:** Are the ratios recommended or required?	**A:** Generally the ratios are recommended however in cases such as Community Engagement it is required that the 1:3 ratio not be exceeded.
40	**Q:** Any more clear information about residential staff providing community engagement or community coaching?	**A:** Information was sent to DMAS for review. There has not been a definitive answer. We understand that there may be a limited talent pool and as an agency you want to utilize all staff to the best of their ability. The concerns are limiting staff at the locations they may be leaving. We need to be contentious of how the services relate to day services and how CE and CC are implemented. Utilizing residential staff for CE and CC should not supplant expectations for residential services to be an active part of community involvement. Access to the community should not be based on staff. Having safe guards in place allows for community involvement and is not limited to secluded or segregated activities.

Q&As from MLMC Stakeholder Calls
August 2016

	Questions	Answers
	Support Coordination/Case Management	
41	**Q:** What is the reimbursement for DD screenings?	**A:** Reimbursements completed by the CSB can be billed at $300 for the rest of state and $350 for NOVA. To be reimbursed, the CSB will send the information to DBHDS and they will send a report to DMAS who will then reimburse the CSB.
42	**Q:** What will the turnaround time be for DBHDS when they are reviewing screenings for people with DD (not ID) once things slow down?	**A:** The DD assessments will not be sent to DBHDS. The intake will follow the process set up by the CSB.
43	**Q:** How does not having an implementation date effect the execution of the CSBs and the DDW contracts as well as the CSBs as the single point of entry that was supposed to occur on 8/1?	**A:** Case Management is not a waiver service, so it is not affected by waiver redesign. CSBs as the single point of entry went into effect 7/1. We hear concerns about executing contracts by 8/1 however there is some flexibility through December. It is not recommended to wait until Dec 31; that was meant as a full transition period to get to know each other and work together. If there are problems, email or call Ann Bevan. There should be no automatic cutoff 8/1, but just a guide to getting the contracts. Both parties need to be making best efforts to transition people and allow for making choices.
44	**Q:** Will the CSB be doing anything with billing if we have not ended the agreement with DMAS?	**A:** Per the 29 August 2016 FAQ: ***Question 2:*** *DMAS was moving to ensure CSBs will have the provider class type placed on their NPIs in the MMIS so they will be able to bill DD TCM as of July 1. Can you advise if this has been completed?* ***Answer:*** *No. CSBs cannot currently bill. DMAS has updated the MMIS system to allow all CSBs to bill and is also in the process of sending guidance to the enrollment contractor that will assist them in understanding that CSBs will be submitting applications for DD CM and that the DBHDS License for ID case management meets the requirement to be a DD case management provider. CSBs will be allowed to back bill for services provided from July 1, 2016.*
45	**Q:** How do DD CMs discontinue billing and transfer the billing over to the CSB? Who do we contact?	**A:** Review the Medicaid Memo released on 7/1. Once the private provider has a contract with the CSB, the CSB will contact DMAS and DMAS will end the provider agreement. The private provider will continue to bill until they are under contact with the CSB. **Updated response from DMAS:** Once all DD cases have been transferred to the CSBs, the private provider will contact DMAS to end their provider agreement. Please follow FAQ regarding

Q&As from MLMC Stakeholder Calls
August 2016

Questions		Answers
		DD CM. http://www.dbhds.virginia.gov/professionals-and-service-providers/developmental-disability-services-for-providers/my-life-my-community-waiver-redesign
46	**Q:** The DD Waiver provider will need to contact DMAS to transfer billing correct?	**A:** Correct. We do not want to end the provider agreement until all the cases have been transferred.
47	**Q:** Once the contract is in place, we discontinue billing DMAS but work with the CSB?	**A:** Correct. Do not end agreement with DMAS until all of the contracts are in place for all of the individuals you support.
48	**Q:** Who should the DD CM contact once all cases have been transferred?	**A:** Contact provider enrollment via the helpline, send an email to the CSB and CC Ann Bevan (Ann.Bevan@dmas.virginia.gov) to assure there are no issues with the transition.
49	**Q:** I contacted the DMAS provider hotline and they seem to not understand what I'm asking. Is there a person in place so this can happen smoothly?	**A:** Talk to Ann Bevan or Challis Smith (challis.smith@dbhds.virginia.gov) with questions about the process.
50	**Q:** When the DD CM is prepared to end the provider agreement, should DMAS be contacted directly or is there a contact at Xerox?	**A:** Contact the Provider Helpline: The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are: 1-804-786-6273 Richmond area and out-of-state long distance 1-800-552-8627 All other areas (in-state, toll-free long distance) Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.
51	**Q:** What information will DMAS need when we call to report that all cases have been transferred?	**A:** Be prepared to provide the name of your agency, your NPI number and inform them that you as an agency are no longer billing Medicaid.
52	**Q:** Where can I find the DD CM FAQs?	**A:** http://www.dbhds.virginia.gov/professionals-and-service-providers/developmental-disability-services-for-providers/my-life-my-community-waiver-redesign
53	**Q:** I (DD SC) tried to fax several plans on 8/23 but the lines were busy. Will there be any exceptions to plans that were	**A:** As we talked about before, there will be a 60 day transition period plan. Make sure the SC and PA know you were trying get that information in. Be reassured that everything will be fine.

Q&As from MLMC Stakeholder Calls
August 2016

	Questions	Answers
	submitted after 5?	Just follow up with your PA consultant.
54	**Q:** Is there a timeline for when the MOA should be in place?	**A:** At this time there is not. Follow up will have to occur with VACSB. The thinking is they are trying to follow the same timeline as the private providers.
55	**Q:** After contacting the CSB requesting to be a case manager, I was told they were no longer accepting case managers. Can that be correct?	**A:** If you were requesting to be a potential contractor as part of the RFP, there is a period of time which a vendor can apply and once that closes, it will not open again until the next year. If you were currently providing services to an individual receiving waiver services then if you met the qualifications, wanted to contract with the board and the individual you were supporting wanted to continue to receive your services, the CSB would do what they could to put a contract in place.
56	**Q:** Is there any standardization of the forms required when an individual enters the CSB as the single point of entry for waiver services or is each CSB creating their own?	**A:** Each of the 40 CSB's are independent entities. Some are under the governance of cities or counties and must follow the legal advice of those jurisdictions. All of the boards fall under DBHDS Human Rights and Licensing regulations and will have documents in place to comply with those regulations. While there are certain standard forms for Medicaid and Medicaid Waiver, there are not standardized intake forms. If you have concerns, talk with representatives of from the CSB you are working with.
57	**Q:** Will anyone from the Office of Human Rights be on the call? **Q:** I had a specific question related to assigning ARs that I have not received a response to.	**A:** These calls are related to implementation issues around My Life My Community. If you have questions related to human rights please contact the Office of Human Rights or your local human rights advocate. Contact information is on the website. **A:** There were two questions related to ARs that will come out on the DD CM FAQ. This is currently being vetted and will be out soon.
58	**Q:** Is there information available for someone wanting to become a new provider?	**A:** On the provider enrollment memo, there is some helpful info about qualifications, how the license will work and what to do to move forward.
59	**Q:** I was on the DMAS Provider Website and I could not open the memos. I was told I can only use IE and I do not have access to IE on a MAC. How can I access the Medicaid Memos?	**A:** The system was down yesterday. Try again today.

Q&As from MLMC Stakeholder Calls
August 2016

	Questions	Answers
60	**Q:** It was previously stated that any SC hired after Aug. 1st would require a degree. With the delay of the waiver redesign, is that requirement delayed too?	**A:** Yes.
61	**Q:** If a SC starts after 9/1, what are the qualifications, degree and experience they will need?	**A:** Any ID CMs hired after 9/1 needs to have a bachelor's degree and meet KSAs based on licensing. In the emergency regulations, it does have a requirement of an undergrad. DD CMs will be licensed under the umbrella of the CSB license. The CBS will assure CMs receive the training required.
	Employment and Day Services	
62	**Q:** Effective 9/1, prevoc services will end correct?	**A:** Correct.
63	**Q:** Can programs continue to operate without a provider participation agreement?	**A:** Did you get your license? If so, you need to make sure you submit your agreement and authorizations in the month of September. As long as you do that, the billing will go back to the first of the month.
64	**Q:** Can people who attend center based programs be paid wages?	**A:** There is nothing in the regulations that states that people who are a part of group day cannot work and receive wages.
65	**Q:** I am the parent of an individual who has previously received individual supported employment but DARS is saying she has to work in an enclave. She does not want to work in an enclave and because of this, her case with DARS was closed. Does this have to do with the waiver?	**A:** No. That is not the direction we are going.
66	**Q:** I have a day support program that starts from a single location, goes out into the community, returns for lunch then goes out again. To offer this service, can I only bill community engagement for services that occur solely in the community?	**A:** Community Engagement is a service that only takes place in the community. From the time the individuals depart the center until the time they return can be billed through Community Engagement. The time at the center can be billed through Group Day. The only exception is for planning the day with the individual. Community Engagement allows for 10% of the monthly hours to occur at the center for this purpose. Providers should be cautious about the use of that time. This time is not to be used for transitions or lunch.

Q&As from MLMC Stakeholder Calls
August 2016

	Questions	Answers
67	**Q:** For programs that are non-center based, are we allowed to bill starting when we pick the person up?	**A:** Community engagement and coaching starts at the time the individual gets on the van to go to the activity. Also, there is a 10% allotment for Community Engagement where they are allowed to be in the center face to face with a staff person to set their schedule.
68	**Q:** We (day support provider) are going to be doing interactive services where an individual actively interacts with persons without disabilities. If they go to a park and are not actively interacting with someone, can we still bill?	**A:** The language used in the service description refers to spending time in the community at naturally occurring times to interact with individuals that would naturally be in that setting. The purpose of the community engagement and community coaching programs are to develop relationships. Time in the community not focused on developing relationships can always be billed as group day.
69	**Q:** If we (group day) hold an activity outside of our DS building (dances, put on a play, etc.), is that CE?	**A:** Whether or not an activity qualifies as CE is based on the number of individuals who are participating as well as engagement with the public. Those activities sound like more than 3 individuals receiving supports would be participating so it would not be CE, but could be day services.
70	**Q:** With the requirement of multiple plans and quarterlies, has there been consideration regarding the dramatic increase in paperwork that may occur and might reduce the amount of time in the community? This has been a growing concern for day support providers already provide SE and Center-Based Day Support. As we move into community engagement, it will be double the work. We are talking in the neighborhood of 12 quarterlies per year. This is presenting concerns with man power. A member of the employment first advisory committee noted that the goal at the time was to create a more flexible kind of services. We understand that DMAS wants to assure that providers are providing adequate documentation but we feel the burden of documentation will lead to the unintended consequence of a decrease in the quality and quantity of services. We question if Burns and Asso.	**A:** DBHDS is working diligently to find something that will streamline the process. OL allows for one plan with separate objectives for each service in their regulations. DMAS expects to see separate plans for each service.

	Questions	Answers
	recognized this when developing their rates. Licensing allows a provider to maintain a single ISP as long as the provider documents separate outcomes and notes. We really would like to see some attention focused on this. There needs to be another way to deal with this to not take away from consumers.	
71	**Q:** Has there been any finalization on the documentation requirements for multiple services? **Q:** So what do we do? **Q:** So if we are providing supports for community engagement, community coaching and group day, we need separate ISPs?	**A:** There are resolutions on two points. 1) DBHDS is not considering the combination of quarterly reviews at this time. 2) Currently a shared plan is not in the emergency regulations. **A:** Write a separate service for each plan. **A:** Yes. Those are separate services, which would require separate plans.
72	**Q:** What type of documentation is needed for coming and going within two services? Do we need to separate out the documentation for the two services?	**A:** You will need to show the differentiation from the time the person was in the center and when they were receiving other services (CC or CE).
73	**Q:** Will documentation still be per outcome?	**A:** DBHDS is writing the guidance and hope to have that done shortly. Supports must still be documented every time they are provided and the plan must be reviewed at least quarterly.
74	**Q:** On any given day, group day may go out for part of the day. Will we need two Part V's?	**A:** You can do all of this under group day. If you are offering community engagement as well as group day then you will need separate authorizations and separate part V's. Remember, for each new service you offer, you will need to update your provider participation agreement before you can request an authorization for that service.
75	**Q:** Was the time required for having to pull staff to write all of these reports considered in the rates?	**A:** Yes, the rate methodology accounted for this. Each program rate was looked at as a single rate, not as combined services.

Q&As from MLMC Stakeholder Calls
August 2016

	Questions	Answers
76	**Q:** Will the provider manual for day services include what documentation is expected once we go to hourly billing?	**A:** A workgroup has been started to look at all the manuals that will be more detailed than the regulations. The manual will clearly lay out service descriptions, limitations, documentation requirements etc.
77	**Q:** What will the hourly billing look like for group day? Will it be the sum of the hours, or account hour by hour for everything people are doing?	**A:** That depends on the services you are offering. If you are doing day services, you just need total hours for billing purposes, but still need a schedule of activities and what people are doing for documentation.
78	**Q:** The WaMS web portal is set up for units. Will it change to hours?	**A:** DBHDS is working on the back end with FEI to make sure all the changes are made.
79	**Q:** How will the billing work for day services until we switch to the new services?	**A:** Until you change your plan, you will bill group day under the current structure you have today.
80	**Q:** For day support plans that were approved prior to 9/1, can we continue to bill blocks in September then switch to hours moving forward after 10/1?	**A:** The block billing will continue until a new service authorization is initiated. This can be at the annual or as an update to the current authorization, whichever comes first.
81	**Q:** For people who are currently approved for 2 units, will this be uploaded into WaMS as four hours? Will we (provider) need to give a list of the correct hours to the SC?	**A:** No. Unless the person's annual plan is coming up, you will continue to get reimbursed at the unit rate until they have an updated plan or new annual plan.
82	**Q:** For someone whose current service authorization is 2 units but they are supported for 5 hours, does this mean we will bill for 5 hours in WaMS?	**A:** No you will bill 2 units until you update the authorization or until the annual plan comes around, whichever is first.
83	**Q:** Day support – as we convert from block billing to hourly, can we use 6.99 hours as hourly max?	**A:** Why would you not use 7 hours? Recommend using that as it's an actual hour.
84	**Q:** If an agency is providing group day and community engagement, do we need two different service authorizations?	**A:** Assuming you mean service approvals, yes. Just as it is now, with any new services, you will need to request a new service authorization. Please reference the 6/22 & 6/23 Medicaid memos.
85	**Q:** If we are planning to provide community supports and day supports, can we just bill	**A:** No. You have to do a new provider participation agreement with DMAS and be approved to provide that service through an

Q&As from MLMC Stakeholder Calls
August 2016

	Questions	Answers
	under the new services after 9/1?	authorization in WaMS. Remember this is a new service so you will need to do a separate Part V as well.
86	**Q:** When is the provider participation agreement going to come out?	**A:** A Memo should come out this week. The actual one will be up no later to 9/1/16.
87	**Q:** If the provider participation agreement is not available until 9/1, how do we get it approved and back in time? Can we have something in writing that says we will get paid?	**A:** That provider memo will come out this week. Review it and see if that has the information you need. That memo is what providers should be following.
88	**Q:** When can we expect to see the Medicaid Memo on provider enrollment?	**A:** Medicaid Memos on provider enrollment, provider competencies, crisis services and service authorization processes will hopefully be out later this week. UPDATE: Enrollment memo came out on 8/30/16.
89	**Q:** We are billing units now and the SA was in units. Do we have to redo the authorization?	**A:** If you are going to continue with someone in the existing day support service, your billing will not change. If you move to hourly, you will make the change in WaMS. If you leave someone in the current day support structure, VAMMIS will continue to support billing in the unit structure.
90	**Q:** We support individuals that are great 75% of the time, but at times we cannot safely support them in the community and have to stay in. How do we bill?	**A:** Most providers are offering a combination of supports. Schedule says hours/day but service authorization says hours/month. Service authorizations should be set up in such a way so that there is some daily flexibility. DBHDS and DMAS are exploring the issue and plan to send out guidance to providers on how to develop service authorizations
91	**Q:** The limit for day services is 66 hours/week. Can the entire time be used for only one service?	**A:** There are no limits with day services with the exception of SE which is capped at no more than 40 hours/week. There are no other limits to day services other than the 66 hour combined limit.
92	**Q:** Day services – If someone is already in a community based day support program, will they automatically go into community engagement or will they go into group day?	**A:** For any day support you are providing, you will not move into one of the new waiver services until you made the change in WaMS. The rates will continue at the current rate until you make the changes. If you want to move from community based day support to community engagement, you need to make the change in WaMS.

Q&As from MLMC Stakeholder Calls
August 2016

	Questions	Answers
93	**Q:** Do day support supervisors require a bachelor's?	**A:** No. It is not a requirement if they can meet equivalency as described in the Licensing Regulations.
94	**Q:** Have competencies for workplace assistance been completed yet?	**A:** The competencies are being developed with the employment first advisory group. They are not yet finalized. For employment service organizations, it is assumed that they have the competencies necessary to provide this service.
	Residential - Supported Living	
	Residential – Sponsored	
95	**Q:** Can a sponsor have a respite bed as well?	**A:** Not in addition to the two beds allowed. Licensing regulations would allow one respite bed and one sponsored bed. The beds could not be interchangeable. If someone has designated a respite bed on their license, they would always have to use that bed as a respite bed. If someone has designated two sponsored beds they would always have to use those sponsored beds as such, unless they notify licensing using the appropriate forms to change their license. It is also important to note that staffing may need to be increased or supports in a home when someone is admitted for respite services, if the provider is use to only providing supports for one sponsored person.
96	**Q:** I would like to provide sponsored services to my child because I cannot get the supports she needs. Are there regulations that state age restrictions?	**A:** Chapter II of ID Waiver Manual on DMAS portal. The manual notes that paid supports cannot be provided by a parent to a minor child. This is a federal regulation.
97	**Q:** Regarding questions about the Landlord Tenant Act, we know that the organization will hold the lease for group homes, but for sponsored homes, is it the responsibility of the home or the agency?	**A:** In all likelihood, it would be developed by the agency. It is possible that individual homes might want to add some things to the lease. Refer to answers in the July Q&A document as well.
	Residential Group Home	
	Residential General Questions	
98	**Q:** Multiple providers are upset that under tier three, levels three and four are reflected. Will there be any discussion of changing the levels in each tier?	**A:** No, not at this point.

Q&As from MLMC Stakeholder Calls
August 2016

Questions	Answers

99	**Q:** For individuals on the ID Waitlist, MFP will fund residential services. For individuals on the DD waitlist, it will not. Will this change?	**A:** Under the amended waivers, the individual, regardless of diagnosis, will have the ability to request movement to any of the three waivers and the corresponding services. This is assuming there is a slot open.
100	**Q:** Currently if you have a DD Waiver, you cannot utilize waiver services if you are living in a congregate group home. Will that change after September 1?	**A:** Yes. Once the amendments are approved, the DD waiver will no longer be in existence and everyone on the DD waiver will be transitioned into the Family, Individual and Supports Waiver. Congregate group home services, however, will only be funded under the Community Living Waiver.
101	**Q:** Will current providers of ID Waiver services who plan to accept people with a DD (non-ID) diagnosis have to write a new program description and submit a license modification?	**A:** No new license is required, however if they are accepting individuals with a DD (non-ID) diagnosis and have not before, they would need to update their program description to reflect this change in population. Licensing could ask to see this at an unannounced visit as well as during an annual review.
102	**Q:** Is it true that a provider can negotiate rates if they are supporting an individual with significant medical and/or behavioral support needs?	**A:** Yes. You will be able to apply for a customized rate if someone has very high medical and/or behavioral support needs (levels 6 or 7). There is a form that is completed then the submitted information sent to a committee that reviews the documentation. It could be that the person requires 2:1 or may require that the direct support staff have a higher degree. Just because an individual has high medical/behavioral needs, doesn't mean you will be getting the extra rate.
103	**Q:** In regards to the recent Medicaid Memo is there anything providers of In Home Services need to do for the July billing? Will we need to unbill then rebill?	**A:** Billing submitted between July 1st and July 29th has been zeroed out and reprocessed under the new code with the new rate. If a provider billed the old rate from July 29th on, they will need to go into the system and manually correct that.
104	**Q:** The rate model has 2 and 3 member rates for in home services but this was not addressed in the 8/1/16 Medicaid Memo. Do you know why?	**A:** We are not permitted to use the 2 and 3 member rates yet. We have to wait until CMS approves the amendments. Right now only the one person higher rate is available. UPDATE: Now that the waivers are approved you may submit SA requests for 2 & 3 member rates.
105	**Q:** This question came from the ARC Conference. Historically we have group homes and we understand the daily rate and with in-home we only have 1:1 now, but will have 1:2 and 1:3. Are there any	**A:** Likely not. Generally that service would be billed under group home or supported living, however, we have recently had a related question we submitted to Burns and we may need to explore that more with some providers. Providers operating group homes should not be billing the in-

	Questions	Answers
	situations where 2 or 3 people living in the same house where 1:3 in-home would be an appropriate service as opposed to group home?	home rate nor should apartments operated by a provider that should be supported living.
106	**Q:** You said there are no periodic supports so what if a person wants to stay home?	**A:** Group homes no longer bill hourly; they bill at a per diem rate. Effective 9/1/16, periodic supports do not exist anymore (with the exception of sponsored homes who have access to periodic supports until 12/31/16).
107	**Q:** For people where it's not as simple as saying let's go and they are consistently choosing not to go, what do we do?	**A:** Maybe we can do some TA for you. Contact Heather Norton to schedule some support.
108	**Q:** CD service facilitators have had individuals take advantage of periodic support but that is none existent effective tomorrow, correct?	**A:** Correct.
110	**Q:** If there is a service authorization in IDOLS that was approved prior to 9/1/16, can they bill periodic supports? **Q:** Will the periodic support hours pull over to show the daily rate even if it is still awaiting approval?	**A:** After Sept. 1, 2016 periodic supports will no longer be billable for any service (except for Sponsored Residential through December 31, 2016).
111	**Q:** If a residential service authorization was already approved with the hourly and periodic support and the start date is 9/1/16, can we bill periodic support until we change the authorization?	**A:** Any active authorization will be ended 8/31/16 and populated under the new billing code of H2022.
112	**Q:** You said periodic supports are only for sponsored residential. Can it not be used for In Home, AD or CD.	**A:** No. We do not have any regularity or federal authority to offer that periodic supports. As of 9/1/16, periodic supports do not exist.
	Nursing, Crisis, Therapeutic Consultation, PERs	
113	**Q:** Will the DSP training be required for therapeutic consultation providers? We have been cited for not having it, will there be clarification?	**A:** This relates to DSPs and supervisors. If the therapeutic consultant also supervises DSPs, they would need the orientation. Information will be clear in the Medicaid memo and materials.

Q&As from MLMC Stakeholder Calls
August 2016

	Questions	Answers
		UPDATE: DMAS memo regarding this came out on 9/1/16.
114	**Q:** If my agency was providing Skilled Nursing in a group home, will we need a DBHDS license for private duty nursing or do we just need a new provider agreement with DMAS?	**A:** You will definitely need a new DMAS agreement. Qualification requirements for skilled and private duty nursing are the same. DBHDS does not license nurses.
115	**Q:** The rate in the memo regarding Skilled Nursing is lower than the rate that was published in the Burns rate model. Is this the rate just for now or will it increase?	**A:** Burns suggested a higher rate that was not approved by the General Assembly. The rate in the memo is the rate that will be used.
116	**Q:** Under the reimbursement scale for therapeutic consultations, what credentials are you considering a therapist? **Q:** What about an LCSW or LPC?	**A:** Speech and Language Pathologist, Physical Therapist, Occupational Therapist, Recreational Therapist **A:** They would fall into the other category.
117	**Q:** For therapeutic consultation, we bill in units. Since it is now hours, will those authorizations need to be resubmitted?	**A:** Therapeutic Consultation has always billed hourly but as there are different reimbursement amounts and codes, you will need to initiate a new authorization request in WaMS.
118	**Q:** We (day support provider) have a lot of individuals that are training center discharges. Their residential providers are receiving an exceptional support rate due to their level of need. We are having issues with having a service authorization approved for skilled nursing to provide training, education and oversight of physician's orders. Can skilled nursing be used for this purpose?	**A:** It's important that whatever you are requesting it is listed as an allowable activity. Reach out to the SA consultant to explain what you are doing and ask for guidance on how to request the service.
119	**Q:** Is there a place I can find a list of providers who offer behavior supports through therapeutic consultation?	**A:** There is a list of Positive Behavioral Support Specialist online. Go to www.personcenteredpractices.org. Click on Virginia Positive Behavior Support on the left hand side. The second link says find endorsed providers. You can also request this information from your SC/CM.
120	**Q:** I (SC) have an individual that is at REACH because he had a crises and he cannot return home. We are now trying to find placement and are wondering how to go	**A:** There are reserve slots that will allow some movement but they are going to be very limited. DBHDS is working out a process where vacated slots can be used for people waiting to move between waivers. More info

	Questions	Answers
	about doing that. He currently has a DD waiver. How do we change the waiver so that he can move to the CL waiver and how soon can this occur?	will come out shortly. If the individual has a DD Waiver, even though that does not include group homes or sponsored homes, it does have supported living which is an apartment style set up and includes In-home. We caution against the idea that people automatically need to have group home services. Please consider other options before automatically requesting to move to a different waiver.
121	**Q:** Under the redesign, an individual can receive 90 days of crisis stabilization which is more than the 60 currently allotted. For people who used the 60 days, will they have the 30 left after 9/1?	**A:** Under the new waiver and because it's a new procedure code, everyone is starting all over on 9/1 so you will not be penalized for days used prior to 9/1. **Per the emergency regulations:** Medically necessary crisis prevention may be authorized for up to 60 days per ISP year. Medically necessary crisis intervention may be authorized in increments of no more than 15 days at a time for up to 90 days per ISP year. Medically necessary crisis stabilization may be authorized in increments of no more than 15 days at a time for up to 60 days per ISP year.
	WaMS/SIS/Billing	
122	**Q:** There was an email that said e in Stage 2. What does that mean? Will the SC still be responsible for doing the service entry?	**A:** WaMS is being implemented in three phases with increasing functionality across these phases. Because of the delay in approval, the WaMS upgrade that allows providers to enter information into the service authorization was able to occur. Effective 9/1 providers will have the ability to put in the provider information as well as upload the ISP Part 5.
123	**Q:** When WaMS goes live tomorrow, will the CSB be able to see the individuals with DD waiver or will the people who are their current CMs will be able to see them?	**A:** The private entities would have to be in there but the individual may not be assigned to a CSB yet. We will follow up with the WaMS implementation team.
124	**Q:** Will there be any training available on using WaMS?	**A:** FEi is in the process of creating a training that will be available. Both notification and training guidance will be issued in advance of 9/1.
125	**Q:** Will providers who were not previously trained on WaMS have to navigate that on their own?	**A:** That is the understanding. Remember that there is a 60 day grace period. **UPDATE:** There are training videos available on the DBHDS

Q&As from MLMC Stakeholder Calls
August 2016

	Questions	Answers
		website: http://www.dbhds.virginia.gov/professionals-and-service-providers/developmental-disability-services-for-providers/my-life-my-community-waiver-redesign
126	**Q:** Will there be a "hands on" WaMS training for providers?	**A:** DBHDS is in the process of hiring contractors to provide trainings.
127	**Q:** Is there clarification as to who can access what in WaMS.	**A:** There is an access control list. DBHDS will be providing specific user roles including who is authorized to preform what function.
128	**Q:** The WaMS manual lists various roles. Will these roles be defined in the manual?	**A:** The WaMS training documents are navigational guides which are meant to show you where to go and how to preform various functions. The guide will not go into the responsibility of SC or provider nor identify what roles or access they have within the system. Training from your direct supervisor will show you what you are responsible for.
129	**Q:** Can you provide some guidance on what procedure codes to use for residential providers? **Q:** So on our claims we are just going to enter the modifier for our bed size and we will work with board to put in the bed size into WaMS?	**A:** SC and providers will need to put in the H2022 code with the correct modifier. (See Medicaid Memo 5/31/16). WaMS has the tier preloaded but does not have the bed number. After 9/1 a service authorization will be in place allowing time for corrections. When the provider goes to bill, they will need to use the PA number and bill the H2022 code as well as the procedure code with the bed size for that location. That will bill for the appropriate size and tier. Proper bed size will need to be entered into WaMS manually. If you do not add that modifier, your claim will be denied. You must rectify that prior to 10/31. If you have a 6 person home and your try to bill for a four person home, it will be rejected. Your billing dept. should understand what to do to bill. **A:** Correct.
130	**Q:** In WaMS the service authorization for residential services says days per month. How should we fill that out since we can only bill for 344 days per year?	**A:** DBHDS will check on this.

Q&As from MLMC Stakeholder Calls
August 2016

	Questions	Answers
131	**Q:** For months that have 31 days, can we bill for 31 days for a group home?	**A:** Because the authorization is for 344, you can bill for the total number of days each month while not exceeding a total of 344 days in a given ISP year.
132	**Q:** If the SA already exists, will it automatically roll over or will it need a new authorization?	**A:** Not every service automatically rolls over. Some require actions. A Service Authorization memo will be coming out and will tell you how the various services will be effected and which require manual changes. Group home will roll over, however they will have an end date of 10/31/16 requiring a new code with the modifier to identify the size of the home prior to that time. Skilled nursing will roll over but will be entered under a new procedure code. New services will have to be requested in WaMS.
133	**Q:** After 9/1 will the SC type or scan their plan (part 1-4) into WaMS? **Q:** Will providers scan their plans in as well?	**A:** Yes. That will be scanned in. **A:** Yes. They will scan and upload the plan as well.
134	**Q:** Is there a size limit on the files that will need to be uploaded into WaMS?	**A:** There may be. DBHDS will follow up.
135	**Q:** Are quarterlies going to be required to be uploaded in WaMS?	**A:** There has been no discussion regarding uploading quarterlies at this time.
136	**Q:** Will there be an issue with updating a service authorization this year in WaMS because VIDES will not be in the system?	**A:** There are sections that require information from the VIDES to move forward. DBHDS will have to follow up.
137	**Q:** During the testing phase of WaMS, when a second VIDES was entered, it cleared the first one. *We requested that we be able to document against the previous VIDES.* Do you know if this was addressed?	**A:** DBHDS will have to follow up.
138	**Q:** For services where the rate is dependent on the number of people in the group, how do we bill when the size of the group changes due to callouts, change in work schedule, etc.	**A:** You do not need to change the group size every day just because one individual does not attend. You can only bill what you are authorized for.

Q&As from MLMC Stakeholder Calls
August 2016

	Questions	Answers
139	**Q:** Currently we bill in units. It's either 1 or 2 units. How do we bill for 4 hours and 17 minutes?	**A:** You will use the standard rounding rule. It is laid out in detail in the ED/CD manual in Chapter 5 on page 12. When DBHDS does our revision to the provider manual, we will add those instructions to chapter 5. For any extra time, you will hold those pieces until the end of the month then add those pieces together when you submit your billing.
140	**Q:** Therapeutic consultation: If we are in the home for a 4 minute meeting, we bill by the hour, per regulation, and we bill per day to correspond with our notes. If we are in the home where two individuals are being supported for a total of 90 minutes, we would bill one hour for each person and bill for that day. How does this match what has been stated early about monthly billing?	**A:** Rounding of hours is addressed in the EDCD manual, Chapter 5. DBHDS will make sure this is clearly addressed in the new DD manual. We will double check to make sure this also applies to Therapeutic Consultation including the round down of the half hour.
141	**Q:** If a BCBA is working in a group home with 2 people receiving Therapeutic Consultation and the BCBA is doing observation and data gathering for an hour, (watching interactions among the people in the house), is that 2 worth of billing or two half hours?	**A:** Only bill the total of one hour. The time should be split between the 2 individuals.
142	**Q:** Is the rounding policy operational going forward? Does it include all waiver services including day support?	**A:** Yes and yes.
143	**Q:** We (private provider) received a spreadsheet from the CSB of SIS scores and corresponding levels/tiers, however, there are about 15 individuals we support no listed. What should we do?	**A:** If you haven't asked the CSB, start by doing that. When the levels and tiers where sent to the CSB, they went to the CSB they would have been associated with based on zip code. If someone has moved since the time of their SIS, the individual's information would have gone to the previous board. This could be a reason as to why you didn't receive a score. Another reason could be that the individual you support needs to have their score verified and as such is not currently available. If you have questions, ask the ID Director then ask the RSS and they can do some inquiry to find out the individuals tier information. The information will also be available in WaMS.

Q&As from MLMC Stakeholder Calls
August 2016

Questions		Answers
144	**Q:** If an individual has not had a new SIS, will they be listed on the spreadsheet?	**A:** The spreadsheet of SIS/levels/tiers will represent anyone who has had a SIS assessment completed, even those done prior to ASCEND. Once ASCEND has completed the SIS, the information will be updated For someone who has never had a SIS completed because they are new to waiver, or they are on the DD waiver and theirs was not completed by the time we go live, we are going to assign them to Tier 2 and bill at that rate. Once the SIS assessment is completed, you can adjust your billing. You won't have to back pay funds if their tier goes down. If someone's tier goes up, you can adjust billing back to the beginning to accommodate that change.
145	**Q:** We (private provider) have not received any new rate or tier levels. Should we reach out to the CSBs? Are they expected to contact us with that information?	**A:** It is a mutual effort. If you have not heard anything from the CSB, reach out to them and ask. It was not a requirement that the boards release this information to private providers. Some chose to do wo. When WaMS goes live, that information will be available on there as well.
146	**Q:** We (CSB) received correspondence from DBHDS with data about SIS scores/levels/tiers for only 227 of the 449 individuals we support. Who should I contact? **Q:** We should let providers know that when WaMS is up they will know?	**A:** All of that information will be available in WaMS. **A:** Yes. Tell them to look for that information in WaMS. DMAS is trying to work with MMIS to have that information available there as well.
147	**Q:** We (CSB) received a spreadsheet that included individuals that we do not serve. I was under the impression that another spreadsheet would be coming out.	**A:** We don't have the ability to know where people are if their demographic information has changed since receiving their last SIS assessment. The individuals cannot be sorted by CSBs so zip codes were used instead.
148	**Q:** We (private provider) have not received any SIS spreadsheets. Should we be concerned?	**A:** DBHDS only sent information to the CBSs. You can request that from them. Some boards may have proactively sent that information out. It was not a requirement.
149	**Q:** CSBs do not automatically send a spread sheet to providers correct? We have to request that info from the CSB?	**A:** DHBHS did not require that the CSB transmit that information to all providers. If you are able to estimate the SIS scores to project a budget that will get you in the ball park. If you need more information, contact the CSB.

Q&As from MLMC Stakeholder Calls
August 2016

	Questions	Answers
150	**Q:** If a SIS has been completed and the scores we have not received the results, how will we know how to bill?	**A:** The level and tier should be assigned in WaMS.
151	**Q:** You mentioned that the math could be done in a different way. Can you clarify that? I thought it was the A,B,E score plus exceptional supports.	**A:** The information that you have related to those scores is not as precise as the information DBHDS has. The scores you have would be whole number and one or two decimal points. DBHDS may have a whole number and ten decimal points. We may end up with a more precise answer. We want to make sure the level and tier assigned is the most generous possible; as mathematically elegant a process as possible.
152	**Q:** We noticed a data entry issue when the tier is not matching what we presumed it to be. How do we correct that? **Q:** I've heard the number will always be higher. Is that correct?	**A:** CM will have access to the levels and tiers in WaMS as determined by the latest SIS. Mathematically, there are times that the number in the system is different than the score you found manually. **A:** Because it deals with more than whole numbers it allows for a more exact number that thus far has been higher than the number calculated with the manual equation.
153	**Q:** What if families have not had that SIS? **Q:** Then they only have access to Level 2 services?	**A:** Those who have not had a SIS will be placed into Level 2 -> tier 2. This will apply to someone who utilizes services that are tier based in services. The will bill tier 2 until the SIS is completed. If an individual is receives a rating of a level 1, the provider will be held harmless. If individual's support needs meet tier 3 or 4, they can adjust their billing and backdate to the day supports started. **A:** It's just a matter of reimbursement. It doesn't change the services the individual has access too.
154	**Q:** I understand that the SIS establishes level of need and is not appealable. Why? **Q:** Is this true in other states? **Q:** How is this different than IDEA parents who appeal and win on procedural matters, not content?	**A:** The SIS is appealable if what is being appealed are the SOPs. Levels and tiers are not appealable. There are a good number of look backs and verification processes in place. **A:** This is not true in other states. **A:** The procedural processes are appealable.

Q&As from MLMC Stakeholder Calls
August 2016

	Questions	Answers
	Q: The results of these scores determine the person's ability to access services. It is a problem that substantiated info that determines level is not appealable.	**A:** The levels and tiers do not affect what services an individual has access to.
	Q: There is less money coming out to providers who support people with lower levels. It would be beneficial to give someone a low evaluation that would not entitle people to a full complement of services wouldn't it?	**A:** Quality and accuracy of SIS assessment is of primary importance. Trained, audited quarterly, lots of oversight, inter-rater reliability is of paramount importance. SIS interviewers are trained at length.
	Q: Can we revisit the appeal issue?	**A:** No. If there are concerns, family members are welcome to call Joan Bender at DBHDS.
	Integrated Supports and The Planning Calendar	
155	**Q:** We are located in a rural area where there are not a lot of community activities. We are thinking of sponsoring some activities for the community onsite. Would this be acceptable?	**A:** No. Reversed integration does not meet the HCBS regulations and would not satisfy the criteria to bill for community engagement.