

DD Waiver Emergency Regulations September 2016

12VAC30-50-455. Support coordination/case management for individuals with developmental disabilities (DD).

A. Target Group. Individuals who have a developmental disability as defined in state law (§ 37.2-100 of the Code of Virginia) shall be eligible for support coordination/case management.

1. An individual receiving DD support coordination/case management shall mean an individual for whom there is an Individual Support Plan (ISP) in effect which requires monthly direct- or in-person contact, communication or activity with the individual and family/caregiver, as appropriate, service providers, and other authorized representatives including at least one face-to-face contact between the individual and the support coordinator/case manager every 90-days. Billing shall be submitted for an individual only for months in which direct- or in-person contact, activity or communications occur and the support coordinator's/case manager's records document the billed activity. Service providers shall be required to refund payments made by Medicaid if they fail to maintain adequate documentation to support billed activities.

2. Individuals who have developmental disabilities as defined in state law but who are on the DD waiting list for waiver services may receive support coordination/case management services.

B. Services shall be provided in the entire State.

C. Comparability of Services: Services shall not be comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of § 1902(a)(10)(B) and (C) of the Act.

D. Definition of Services.

1. Developmental disability support coordination/case management services to be provided shall include:

a. Assessing and planning services, to include developing an ISP (does not include performing medical and psychiatric assessment but does include referral for such assessments);

b. Connecting, joining, arranging, associating the individual to or for services and supports specified in the ISP;

c. Assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources;

d. Coordinating services and service planning with other agencies and service providers involved with the individual;

e. Enhancing community integration by contacting other entities to arrange community access and involvement;

f. Making collateral contacts with the individual to promote implementation of the ISP and successful community adjustment;

g. Following and monitoring the individual to assess ongoing progress and ensuring services are delivered, and;

h. Educating and counseling which guides the individual and develops a supportive relationship that promotes the ISP.

2. There shall be no maximum service limits for support coordination/case management services except for individuals residing in institutions or medical facilities. For these individuals, reimbursement for support coordination/case management shall be limited to 90 days pre-discharge (immediately preceding discharge) from the institution into the community. While individuals may require re-entry to institutions or medical facilities for emergencies, discharge planning efforts should be significant to prevent readmission. For this reason, support coordination/case management may be billed for only two 90-day pre-discharge periods in a twelve month period.

E. Qualifications of providers:

1. Services shall not be comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Act is hereby invoked to limit support coordination/case management providers to the Community Services Boards/Behavioral Health Authorities (CSBs/BHAs). The CSBs/BHAs shall contract with private support coordinators/case managers for this service. CSBs/BHAs shall have current, signed provider agreements with DMAS and shall directly bill DMAS for reimbursement.

2. DD support coordinators/case managers shall not be (i) the direct care staff person, (ii) the immediate supervisor of the direct care staff person, (iii) otherwise related by business, or organization to the direct care staff person, or (iv) an immediate family member of the direct care staff person.

3. Parents, spouses, or any family living with the individual may not provide direct support coordination/case management services for the individual or spouse of the individual with whom they live, or be employed by a company that provides support coordination/case management for the individual, spouse, or the individual with whom they live.

4. Providers of DD support coordination/case management services shall meet the following criteria.

a. The provider shall guarantee that individuals have access to emergency services on a 24-hour basis;

b. The provider shall demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid;

c. The provider shall have the administrative and financial management capacity to meet state and federal requirements;

d. The provider shall have the ability to document and maintain individual case records in accordance with state and federal requirements; and

e. The provider shall be licensed as a developmental disability support coordination/case management entity contracted with the CSB.

5. Support coordinators/case managers who provide DD case management services after the effective date of these regulations shall possess a minimum of an undergraduate degree in a human services field. Support coordinators/case managers who do not possess a minimum of an undergraduate degree in a human services field may continue to provide support coordination/case management if they are employed by an entity with a Medicaid participation agreement to provide DD case management prior to February 1, 2005, and maintain employment with the provider under that agreement without interruption.

6. In addition to the requirements in subparagraph 5 above, the support coordinator/case manager shall possess developmental disability work experience or relevant education which indicates that the incumbent, at entry level, possesses the following knowledge, skills, and abilities which shall be documented in the employment application form or supporting documentation or during the job interview. The knowledge, skills, and abilities shall include:

a. Knowledge of:

- (1) The definition, causes and program philosophy of developmental disability;
- (2) Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination;
- (3) Different types of assessments and their uses in program planning;
- (4) Individual rights;
- (5) Local community resources and service delivery systems, including support services, eligibility criteria and intake process, termination criteria and procedures and generic community resources;
- (6) Types of developmental disability programs and services;
- (7) Effective oral, written and interpersonal communication principles and techniques;
- (8) General principles of record documentation, and
- (9) The service planning process and the major components of an Individual Support Plan.

b. Skills in:

- (1) Interviewing;
- (2) Negotiating with individual consumers and service providers;
- (3) Observing, recording, and reporting behaviors;
- (4) Identifying and documenting an individual consumer's needs for resources, services and other assistance;
- (5) Identifying services to meet the individual's needs;
- (6) Coordinating the provision of services by diverse public and private providers;
- (7) Analyzing and planning for the service needs of individuals with developmental disabilities;

(8) Formulating, writing, and implementing Individual Support Plans to promote goal attainment for individuals with developmental disabilities;

(9) Successfully using assessment tools, and;

(10) Identifying community resources and organizations and coordinating resources and activities.

c. Ability to:

(1) Demonstrate a positive regard for individuals and their families (e.g. permitting risk taking, avoiding stereotypes of individuals with developmental disabilities, respecting individuals' and families' privacy, believing individuals can grow);

(2) Be persistent and remain objective;

(3) Work as team member, maintaining effective inter- and intra-agency working relationships;

(4) Work independently, performing position duties under general supervision;

(5) Communicate effectively, verbally and in writing, and;

(6) Establish and maintain ongoing supportive relationships.

7. Support coordinators/case managers who are employed by an organization contracted with the CSB/BHA shall receive supervision within the employing organization. The supervisor of the support coordinator/case manager shall have at least a master's level degree in a human services field OR have five years of experience in the field working with individuals with developmental disability as defined in § 37.2-100 of the Code of Virginia, or both.

8. Support coordinators/case managers who are contracted with the CSB/BHA shall obtain one hour of documented supervision by the CSB every three months.

9. Support coordinators/case managers shall complete a minimum of eight hours of training annually in one or a combination of the areas described in the knowledge, skills and abilities (KSA) subdivision (above) and shall provide documentation to demonstrate that training is completed to his supervisor. The documentation shall be maintained by the supervisor of the support coordinator/case manager for the purposes of utilization review.

F. The State assures that the provision of support coordination/case management services shall not restrict an individual's free choice of providers in violation of § 1902(a)(23) of the Act.

1. To provide choice to individuals enrolled in these waivers, CSB/BHAs shall contract with private support coordination/case management entities to provide DD support coordination/case management, except if there are no qualified providers in that CSB/BHA's catchment area, then the CSB/BHA shall provide services. CSBs/BHAs shall be the only licensed entities permitted to provide DD support coordination/case management.

2. Individuals who are eligible for the BI, CL, and FIS waivers shall have free choice of the providers of support coordination/case management services within the parameters described above and as follows:

a. For those individuals that receive ID case management services:

- (1) The CSB that serves the individual will be the provider of support coordination/case management.
- (2) The CSB shall provide a choice of support coordinator/case managers within the CSB.
- (3) If the individual or family decides that no choice is desired in that CSB, the CSB shall afford a choice of another CSB with whom the responsible CSB has a memorandum of agreement.
- (4) At any time, an individual may make a request to change their support coordinator/case manager.

b. For those individuals that receive DD case management services:

- (1) The CSB that serves the individual will be the provider of support coordination/case management.
- (2) The CSB shall provide a choice of support coordinator/case managers within the CSB.
- (3) If the individual or family decides that no choice is desired in that CSB, the CSB shall afford a choice of another CSB with whom the responsible CSB has a memorandum of agreement.
- (4) If the individual or family decides not to choose the responsible CSB or the CSB with whom there is a memorandum of agreement, then they will be given a choice of a private provider with whom the responsible CSB has a contract for support coordination/case management.
- (5) At any time, an individual may make a request to change their support coordinator/case manager.

3. Individuals who are eligible for the BI, CL, and FIS waivers shall have free choice of the providers of other medical care under the plan.

4. When the required support coordination/case management services are contracted out to a private entity, the CSB/BHA shall remain the responsible provider and only the CSB/BHA may bill DMAS for Medicaid reimbursement.

G. Payments for support coordination/case management services under the Individual Support Plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same or similar purpose.

H. The support coordinator/case manager shall maintain the following documentation, in either hard copy or electronic format, for a period of not less than six years from each individual's last date of service or in the case of a minor child, six years after the minor child's 18th birthday:

1. All assessments and re-assessments completed for the individual, all ISPs for the individual, and every service providers' Plan for Supports completed for the individual;
2. All supporting documentation related to any change in the ISP;
3. All related communication (including dates) with the individual; family/caregiver, consultants, providers, DBHDS, DMAS, DSS, DARS or other related parties;
4. An ongoing log that documents all contacts (including dates) made by the support coordinator/case manager related to the individual and family/caregiver; and

5. A copy of the current DMAS-225 form.

I. Individual choice of provider entities. The individual shall have the option of selecting the provider of his choice from among those providers meeting the individual's needs. The support coordinator/case manager shall inform the individual, and family member/caregiver as appropriate, of all available enrolled waiver service providers in the community in which he desires services, and he shall have the option of selecting the provider of his choice from the list of enrolled service providers.

J. Support coordinator/case manager's responsibility for the Medicaid Long Term Care Communication Form (DMAS-225). It shall be the responsibility of the support coordinator/case manager to notify DMAS, DBHDS, and DSS, in writing within five business days, when any of the following circumstances occur:

1. Home and community-based waiver services are implemented.
2. An individual dies.
3. An individual is discharged or terminated from waiver services.
4. Any other circumstances (including hospitalization) that cause home and community-based waiver services to cease or be interrupted for more than 30 calendar days.
5. A selection by the individual or his family/caregiver, as appropriate, of a different support coordination/case management provider.

12VAC30-60-360. Criteria for care in facilities for individuals with developmental disabilities including intellectual disabilities.

A. Definitions. The following words and terms, when used in these criteria, shall have the following meaning, unless the context clearly indicates otherwise:

"Active treatment" means the same as §42 CFR 483.440(a).

"No assistance" means no help is needed.

"Often" means that a behavior occurs two to three times per month.

"Prompting/structuring" means that an individual requires, prior to the functioning, some verbal direction or some rearrangement, or both, of the environment.

"Rarely" means that a behavior occurs once a quarter or less frequently.

"Regularly" means that a behavior occurs once a week or more frequently.

"Some direct assistance" means that an individual requires a helper to be present and provide some physical guidance/support (with or without verbal direction).

"Sometimes" means that a behavior occurs once a month or less frequently.

"Supervision" means that an individual requires a helper to be present during the function and provide only verbal direction, general prompts, or guidance, or all of these.

"Total care" means that an individual requires a helper to perform all or nearly all of the functions.

B. This section establishes standard criteria for an individual to receive care in facilities. Medicaid covers care only when the individual is receiving appropriate services and when active treatment is being provided. An individual's need for care shall meet the level of functioning criteria in the VIDES form, referenced in 12VAC30-120-530, before any authorization for payment by Medicaid will be made for institutional services.

C. Care in facilities for individuals with developmental or intellectual disabilities requires planned programs of services to address habilitative needs or health needs, or both, that exceed the level of room, board, and general supervision of daily activities.

1. Such care may be a combination of habilitative, rehabilitative, and health services directed toward increasing the functional capacity of the individual. Examples of such care shall include (i) training in the activities of daily living, (ii) task-learning skills, (iii) learning socially acceptable behaviors, (iv) basic community living programming, or (v) health care and health maintenance.

2. The overall objective of programming shall be the attainment of the optimal physical, intellectual, social, or task learning level which the individual can presently or potentially achieve.

D. The evaluation and re-evaluation for determination of the ICF level of care in a facility for individuals with development/intellectual disabilities shall be based on (i) the needs of the individual, (ii) the reasonable expectations of the individual's capabilities, (iii) the appropriateness of programming, (iv) the progress is demonstrated from the training, and (v) in an institution, whether the services could reasonably be provided in a less restrictive environment.

E. Individual assessment criteria. The individual assessment criteria shall be evaluated in detail to determine the skills, abilities, and status that will be the basis for the development of an Individual Support Plan. The evaluation process shall indicate a need for an Individual Support Plan that addresses the individual's skills, abilities, or need for health care services which have been organized in the seven major categories set forth in subsection F. Level of functioning in each category is graded from the most dependent to the least dependent. In some categories, the dependency status is rated by the degree of assistance required. In other categories, the dependency is established by the frequency of a behavior or the ability to perform a given task.

F. Dependency level. The individual shall demonstrate two or more of the skills or statuses listed in subdivisions 1 through 7 of this subsection. To demonstrate a skill or exhibit a status, the individual shall meet the dependency level described for that skill or status. The questions referenced in subdivisions 1 through 7 of this subsection to meet a dependency level are found in Table 1 of this subsection.

1. Health status. To meet this category:

- a. Two or more questions must be answered with a 4, OR
- b. Question "j" must be answered "yes."

2. Communication skills. - To meet this category, three or more questions must be answered with a 3 or a 4.

3. Task learning skills. - To meet this category, three or more questions must be answered with a 3 or a 4.

4. Personal care skills. –To meet this category, either:

- a. Question "a" must be answered with a 4 or a 5 or
- b. Question "b" must be answered with a 4 or a 5 or
- c. Questions "c" and "d" must be answered with a 4 or a 5.

5. Mobility status. To meet this category any one question must be answered with a 4 or a 5.

6. Behavior Status. To meet this category any one question must be answered with a 3 or a 4.

7. Community living skills. To meet this category

- a. Any two of the questions "b", "e", or "g" must be answered with a 4 or a 5; or
- b. Three or more questions must be answered with a 4 or a 5.

Table 1 – Level of functioning survey				
1. Health status: How often is nursing care or nursing supervision by a licensed nurse required for the following? (Key:1=Rarely, 2=Sometimes, 3=Often, and 4=Regularly)				
a. Medication administration or evaluation for effectiveness of a medication regimen?	1	2	3	4
b. Direct services: i.e., care for lesions, dressings, or treatments, (other than shampoos, foot powder, etc.)	1	2	3	4
c. Seizures control	1	2	3	4
d. Teaching diagnosed disease control and care, including for diabetes	1	2	3	4
e. Management of care of diagnosed circulatory or respiratory problems	1	2	3	4
f. Motor disabilities that interfere with all activities of daily living (i.e. bathing, dressing, mobility, toileting, etc.)	1	2	3	4
g. Observation for choking or aspiration while eating or drinking?	1	2	3	4
h. Supervision of use of adaptive equipment, (i.e., special spoon, braces, etc.)	1	2	3	4
i. Observation for nutritional problems (i.e., undernourishment, swallowing difficulties, obesity)	1	2	3	4
j. Is age 55 or older, has a diagnosis of a chronic disease and has been in an institution 20 years or more	1	2	3	4
2. Communication skills: how often does this person: Key 1=regularly, 2=often, 3=sometimes, 4=rarely				
a. Indicate wants by pointing, vocal noises, or signs?	1	2	3	4
b. Use simple words, phrases, short sentences?	1	2	3	4
c. Ask for at least ten things using appropriate names?	1	2	3	4
d. Understand simple words, phrases or instructions containing prepositions: i.e., on in behind?	1	2	3	4
e. Speak in an easily understood manner?	1	2	3	4

f. Identify self, place of residence, and significant others?	1	2	3	4	
3.Task learning skills: How often does this person perform the following activities? (Key: 1=regularly, 2=often, 3=sometimes, 4=rarely)					
a. Pay attention to purposeful activities for five minutes?	1	2	3	4	
b. Stay with a three-step task for more than 15 minutes?	1	2	3	4	
c. Tell time to the hour and understand time intervals	1	2	3	4	
d. Count more than 10 objects	1	2	3	4	
e. Do simple addition, subtraction	1	2	3	4	
f. Write or print ten words	1	2	3	4	
g. Discriminate shapes, sizes, or colors	1	2	3	4	
h. Name people or objects when describing pictures	1	2	3	4	
i. Discriminate between one, many, and a lot	1	2	3	4	
4. Personal and self care: With what type of assistance can this person currently (Key: 1= no assistance, 2= prompting/structures, 3= supervision, 4= some direct assistance, 5= total care)					
a. Perform toileting functions: i.e., maintain bladder and bowel continence, clean self, etc.?	1	2	3	4	5
b. Perform eating or feeding functions (i.e., drinks liquids and eats with spoon or fork, etc.)?	1	2	3	4	5
c. Perform bathing function (i.e., bathes, runs bath, dries self, etc.)?	1	2	3	4	5
d. Dress himself completely, (i.e., including fastening, putting on clothes, etc.)?	1	2	3	4	5
5. Mobility: With what type of assistance can this person currently (Key: 1= no assistance, 2= prompting/structures, 3= supervision, 4=some direct assistance, 5= total care)					
a. Move, (i.e., walking, wheeling) around his environment?	1	2	3	4	5

b. Rise from lying down to sitting positions, or sits without support?	1	2	3	4	5
c. Turn and position himself in bed, or roll over?	1	2	3	4	5
6. Behavior: How often does this person (Key:1= rarely, 2= sometimes, 3= often, and 4= regularly)					
a. Engage in self destructive behavior?	1	2	3	4	
b. Threaten or do physical violence to others?	1	2	3	4	
c. Throw things, damage property, have temper outbursts?	1	2	3	4	
d. Respond to others in a socially unacceptable manner - (without undue anger, frustration, or hostility)	1	2	3	4	
7. Community Living Skills: With what type of assistance can this person currently:(Key:1= no assistance, 2= prompting/structures, 3= supervision, 4=Some Direct some direct assistance, 5= total care)					
a. Prepare simple foods requiring no mixing or cooking?	1	2	3	4	5
b. Take care of personal belongings, and room (excluding vacuuming, ironing, clothes washing and drying, wet mopping)?	1	2	3	4	5
c. Add coins of various denominations up to one dollar?	1	2	3	4	5
d. Use the telephone to call home, doctor, fire, and police?	1	2	3	4	5
e. Recognize survival signs and words: (i.e., stop, go, traffic lights, police, men, women, restrooms, danger, etc.)?	1	2	3	4	5
f. Refrain from exhibiting unacceptable sexual behavior in public?	1	2	3	4	5
g. Go around cottage, ward, building, without running away, wandering off, or becoming lost?	1	2	3	4	5
h. Make minor purchases (i.e., candy, soft drink, etc)?	1	2	3	4	5

12VAC30-80-110

12VAC30-80-110. Fee-for-service: case management.

A. Targeted case management for early intervention (Part C) children.

1. Targeted case management for children from birth to three years of age who have developmental delay and who are in need of early intervention is reimbursed at the lower of the state agency fee schedule or actual charge (charge to the general public). The unit of service is one month. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates are effective for services on or after October 11, 2011. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management defined for another target group shall not be billed concurrently with this case management service except for case management services for high risk infants provided under 12VAC30-50-410. Providers of early intervention case management shall coordinate services with providers of case management services for high risk infants, pursuant to 12VAC30-50-410, to ensure that services are not duplicated.

3. Each entity receiving payment for services as defined in 12VAC30-50-415 shall be required to furnish the following to DMAS, upon request:

a. Data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate; and

b. Cost information by practitioner.

4. Future rate updates will be based on information obtained from the providers. DMAS monitors the provision of targeted case management through post-payment review (PPR). PPRs ensure that paid services were (i) rendered appropriately, in accordance with state and federal laws, regulations, policies and program requirements, (ii) provided in a timely manner, and (iii) paid correctly.

B. Reimbursement for targeted case management for high risk pregnant women and infants and children.

1. Targeted case management for high risk pregnant women and infants up to two years of age defined in 12VAC30-50-410 shall be reimbursed at the lower of the state agency fee schedule or the actual charge (charge to the general public). The unit of service is one day. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of September 10, 2013, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management may not be billed when it is an integral part of another Medicaid service.

3. Case management defined for another target group shall not be billed concurrently with the case management service under this subsection except for case management for early intervention provided under 12VAC30-50-415. Providers of case management for high risk pregnant women and infants and children shall coordinate services with providers of early intervention case management to ensure that services are not duplicated.

4. Each provider receiving payment for the service under this subsection will be required to furnish the following to the Medicaid agency, upon request:

- a. Data on the hourly utilization of this service furnished to Medicaid members; and
- b. Cost information used by practitioners furnishing this service.

5. Rate updates will be based on utilization and cost information obtained from the providers.

C. Reimbursement for targeted case management for seriously mentally ill adults and emotionally disturbed children and for youth at risk of serious emotional disturbance.

1. Targeted case management services for seriously mentally ill adults and emotionally disturbed children defined in 12VAC30-50-420 or for youth at risk of serious emotional disturbance defined in 12VAC30-50-430 shall be reimbursed at the lower of the state agency fee schedule or the actual charge (charge to the general public). The unit of service is one month. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of September 10, 2013, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management for seriously mentally ill adults and emotionally disturbed children and for youth at risk of serious emotional disturbance may not be billed when it is an integral part of another Medicaid service.

3. Case management defined for another target group shall not be billed concurrently with the case management services under this subsection.

4. Each provider receiving payment for the services under this subsection will be required to furnish the following to the Medicaid agency, upon request:

- a. Data on the hourly utilization of these services furnished to Medicaid members; and
- b. Cost information used by the practitioner furnishing these services.

5. Rate updates will be based on utilization and cost information obtained from the providers.

D. Reimbursement for targeted case management for individuals with intellectual disability or developmental disability.

1. Targeted case management for individuals with intellectual disability defined in 12VAC30-50-440 and individuals with developmental disabilities defined in 12VAC30-50-450 shall be reimbursed at the lower of the state agency fee schedule or the actual charge (the charge to the general public). The unit of service is one month. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of July 1, 2016, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov

2. Case management for individuals with intellectual disability or developmental disability may not be billed when it is an integral part of another Medicaid service.

3. Case management defined for another target group shall not be billed concurrently with the case management service under this subsection.

4. Each provider receiving payment for the service under this subsection will be required to furnish the following to the Medicaid agency, upon request:
 - a. Data on the hourly utilization of this service furnished to Medicaid members; and
 - b. Cost information by practitioners furnishing this service.
5. Rate updates will be based on utilization and cost information obtained from the providers.

12VAC30-120-500. FIS, CM, and BI Waiver establishment, legal authority, description; waiver population, SIS® requirements.

A. Selected home and community-based waiver services shall be available through § 1915(c) waivers of the *Social Security Act*. The waivers shall be named: Family and Individual Supports (FIS), Community Living (CL) and Building Independence (BI) (collectively referred to as the Developmental Disabilities (DD) Waivers). Under these waivers, DMAS has waived § 1902(a) (10) (B) and (C) of the *Social Security Act* related to comparability of services. These services shall be required, appropriate and necessary to maintain the individual in the community instead of placement in institutions.

B. Federal waiver requirements, as established in § 1915 of the *Social Security Act* and 42 CFR 430.25, provide that the average per capita fiscal year expenditures in the aggregate under these waivers shall not exceed the average per capita expenditures in the aggregate for the level of care provided in ICFs/IID, as defined in 42 CFR 435.1010 and 42 CFR 483.440, under the State Plan that would have been provided had these waivers not been granted.

C. DMAS shall be the single state agency pursuant to 42 CFR 431.10 responsible for administrative authority over service authorizations and delegates the processing of service authorizations and daily operations to DBHDS. DMAS shall be the single state agency authority pursuant to 42 CFR 431.10 for payment of claims for the services covered in these waivers and for obtaining federal financial participation from CMS.

D. Individuals, as defined in 12VAC30-120-510, shall have the right to appeal actions taken by DMAS or its designee, or both, consistent with 12 VAC 30-110-10 et. seq.

E. Waiver service populations. These waiver services shall be provided for individuals, including children, with a developmental disability (DD) as defined in § 37.2-100 of the Code of Virginia and who have been determined to require the level of care provided in an ICF/IID. Such services can only be covered if required by the individual to avoid institutionalization. These services shall be appropriate and necessary to ensure community integration.

F. The FIS, CL, and BI waivers' services shall not be authorized or reimbursed by DMAS for an individual who resides outside of the physical boundaries of the Commonwealth. Waiver services shall not be furnished to individuals who are inpatients of a hospital, nursing facility, ICF/IID, or inpatient rehabilitation facility. Individuals with DD who are inpatients of these facilities may receive service coordination/case management services as described in 12VAC30-50-455. The support coordinator/case manager may recommend waiver services that would promote the individual's exiting from the institutional placement; however, these waiver services shall not be provided until the individual has been enrolled in the waiver.

G. An individual shall not be simultaneously enrolled in more than one waiver. An individual who has a diagnosis of DD may be on the waiting list for one of these waivers while simultaneously being enrolled in the Elderly or Disabled with Consumer Direction (EDCD) or the Technology Assisted waivers if he meets applicable criteria for both.

H. DMAS, or its designee, shall assure only eligible individuals receive home and community-based waiver services and shall terminate the individual from the waiver and such services when

the individual is no longer eligible for the waiver. Termination from these waivers shall occur when either: (i) the individual's health and medical needs can no longer be safely met, or (ii) when the individual is no longer eligible.

I. The individual's responses from the combination of the SIS® and Virginia Supplemental Questions shall determine the individual's required level of supports and establish the basis for the ISP.

J. No waiver services shall be reimbursed until after both the provider enrollment process and individual eligibility process have been completed. No back dated payments shall be made for services that were rendered before the completion of the provider enrollment process and the individual eligibility process.

12VAC30-120-510. Definitions.

"Applicant" means an individual (or his representative acting on his behalf) who has applied for or is in the process of applying for and is awaiting a determination of eligibility for admission to a DD waiver.

"BI" means the Building Independence Waiver as set out in 12 VAC 30-120-1500 et. seq.

"CL" means the Community Living Waiver as set out in 12 VAC 30-120-1000 et. seq.

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

"Developmental disability" or "DD" means the same as defined in §37.2-100 of the Code of Virginia.

"DD waivers" means the BI (12 VAC 30-120-1500 et seq.), the CL (12 VAC 30-120-1000 et seq.), and FIS (12 VAC 30-12-700 et seq.) waivers in the collective.

"Enroll" with respect to an individual means (i) the local department of social services has determined the individual's financial eligibility for Medicaid as set out in 12 VAC 30-120-500 et seq., (ii) the individual has been determined by the support coordinator/case manager to meet the functional eligibility requirements in the VIDES form (referenced in 12VAC30-120-530) for the waiver, (iii) DBHDS has verified the availability of a waiver slot for the individual, and (iv) the individual has agreed to accept the waiver slot.

"Family" means, for the purpose of receiving individual and family/caregiver training services, the unpaid people who live with or provide care to an individual served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws but shall not include persons who are compensated, by any possible means, to care for the individual.

"FIS" means the Family and Individual Support Waiver as set out in 12 VAC 30-120-700 et. seq.

"Health, safety, and welfare standard" means the same as defined in 12VAC30-120-1000.

"IDEA" means the Individuals with Disabilities Education Act (20 U.S.C. §1400 et seq.).

"Individual" means the Commonwealth's citizen, including a child, who meets the income and resource standards in order to be eligible for Medicaid-covered services, has a diagnosis of developmental disability, and is eligible for the BI, CL, or FIS waivers. The individual may be a person on the DD waiting list or a person enrolled and receiving waiver services.

"Levels of support" means the level (1-7) to which an individual is assigned as a result of the utilization of the SIS® score and the Virginia Supplemental Questions. The level of support is derived from a calculation using the SIS® score and correlates to an individual's needs. The Virginia Supplemental Questions form is completed to gather additional information regarding the needs of an individual whose SIS® responses regarding medical and/or behavioral needs indicate a high level of support needs. For individuals in Levels 6 and 7, the Virginia Supplemental Questions may also be used to determine the level of support.

"Positive behavior support" means an applied science that uses educational methods to expand an individual's behavior repertoire and systems change methods to redesign an individual's living environment to enhance the individual's quality of life and minimize his challenging behaviors.

"Risk assessment" means the same as defined in 12VAC30-120-1000.

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

"Support coordination/case management" means the same as defined in 12VAC30-50-455(D).

"Support coordinator/case manager" means the person who provides support coordination/case management services to individuals enrolled in one of the DD waivers or are listed on the DD waivers waiting list in accordance with 12VAC30-50-455.

"Supporting documentation" means any written or electronic materials used to record and verify the individual's support needs, services provided, and contacts made on behalf of the individual and may include, but shall not be limited to, the personal profile, Individual Support Plan, service providers' plans for supports, progress notes, reports, medical orders, contact logs, attendance logs, and assessments. Supporting documentation shall be maintained to support claims for all services submitted to DMAS for reimbursement.

"Support package" means a profile of the mix and extent of services anticipated to be needed by individuals with similar levels, needs, and abilities.

"Supports Intensity Scale®" or "SIS®" means an assessment tool and form that is published by the American Association on Intellectual and Developmental Disabilities (AAIDD) and administered through a thorough interview process that measures and documents an individual's practical support requirements in personal, school- or work-related, social, behavioral, and medical areas in order to identify and determine the types and intensity levels of the supports required by that individual in order to live successfully in the community.

"Tiers of reimbursement" means tiers that are tied to an individual's level of support, so that providers are reimbursed for services provided to individuals consistent with that level of support.

"Waiver Slot Assignment Committee" or "WSAC" means an impartial body of trained volunteers established for each locality/region with responsibility for recommending individuals eligible for a waiver slot according to their urgency of need. All WSACs will be composed of community members who will not be employees of a CSB or a private provider of either support coordination/case management or waiver services. WSAC members will be knowledgeable and have experience in the DD service system.

12VAC30-120-514

12VAC30-120-514. FIS, CM, and BI waivers: provider enrollment, requirements, and termination.

A. No waiver services shall be reimbursed until after the provider has enrolled with DMAS and the individual eligibility process has been completed and both the provider (including consumer-directed companions and assistants) and individual are eligible and enrolled to participate. Individuals who are enrolled in these waivers who chose to employ their own companions or assistants prior to the completion of the provider enrollment process shall be responsible for reimbursing such costs themselves. No backdating of provider enrollment requirements shall be permitted in order for DMAS to pay for prematurely incurred costs.

B. DMAS or its designee shall be responsible for assuring continued adherence to provider participation standards. DMAS or its designee shall conduct ongoing monitoring of compliance with provider participation standards and applicable laws, regulations, and DMAS' policies. A provider's noncompliance with applicable Medicaid laws, regulations, and DMAS' policies and procedures, as required in the provider's participation agreement may result in termination of the provider participation agreement. For DMAS to approve enrollment of a provider for home and community-based waiver services, the following standards shall be met:

1. For services that have licensure or certification requirements, the standards of any state licensure or certification requirements, or both as applicable;
2. Disclosure of ownership pursuant to 42 CFR §§ 455.104, 455.105, and 455.106; and
3. The ability to document and maintain individual records in accordance with federal and state requirements.

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

1. Screen, on a monthly basis, all new and existing employees and contractors to determine whether any are excluded from eligibility for payment from federal healthcare programs, including Medicaid (i.e., via the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals or Entities (LEIE) website). Immediately, upon learning of an exclusion, report in writing to DMAS such exclusion information to: DMAS, ATTN: Program Integrity/Exclusions, 600 E. Broad St., Suite 1300, Richmond, VA 23219 or email to providerexclusion@dmass.virginia.gov

2. Immediately notify DMAS and DBHDS, in writing, of any change in the information that the provider previously submitted for the purpose of the provider agreement to DMAS and DBHDS.

3. Assure the individual's freedom to refuse medical care, treatment, and services, and document that potential adverse outcomes that may result from refusal of services were discussed with the individual.
4. Accept referrals for services only when staff is available to initiate services within 30 calendar days and perform such services on an ongoing basis.
5. Provide services and supplies for individuals in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000d et seq.), which prohibits discrimination on the grounds of race, color, or national origin; the Virginians with Disabilities Act (Title 51.5 (§ 51.5-1 et seq.) of the Code of Virginia); § 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act, as amended (42 USC § 12101 et seq.), which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications.
6. Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public.
7. Submit reimbursement claims to DMAS for the provision of covered services and supplies for individuals in amounts not to exceed the provider's usual and customary charges to the general public and accept as payment in full the amount established by the DMAS payment methodology from the individual's authorization date for waiver services.
8. Use program-designated billing forms for submission of claims for reimbursement.
9. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided. Provider documentation that fails to support services claimed for reimbursement may subject the provider to recovery actions by DMAS or its designee.
 - a. Such records shall be retained for at least six years from the last date of service or as provided by applicable state and federal laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved. Records of minors shall be kept for at least six years after such minor has reached the age of 18 years.
 - b. Policies regarding retention of records shall apply even if the provider discontinues operation. Providers shall notify DMAS in writing of storage, location, and procedures for obtaining records for review should the need arise. The location, agent, or trustee of the provider's records shall be within the Commonwealth of Virginia.
 - c. Providers shall maintain an attendance log or similar document, such as daily progress notes, that indicates the date services were rendered, type of services rendered, and number of hours or units provided (including specific time frame) for each service type except for one-time services such as Assistive Technology, Environmental Modifications, Transition Services, Individual and Family Caregiver Training, Electronic Home-Based Services, and Personal Emergency Response System, where initial documentation to support claims shall suffice. Such documentation shall be provided to DMAS or its designee upon request. Documentation shall not be created or modified once an audit has started.

10. Agree to furnish information on request and in the form requested to DMAS, DBHDS, the Attorney General of Virginia or his authorized representatives, federal personnel, and the State Medicaid Fraud Control Unit. The Commonwealth's right of access to provider premises and records shall survive any termination of the provider participation agreement. No business or professional records shall be created or modified by providers, employees, or any other interested parties, either with or without the provider's knowledge, once an audit has been initiated.

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

12. Perform criminal history record checks for barrier crimes in accordance with applicable licensure requirements at § 37.2-416 or § 32.1-162.9:1 of the Code of Virginia. If the individual enrolled in the waiver to be served is a minor child, also perform a search of the VDSS Child Protective Services Central Registry. The provider shall not be compensated for services provided to the individual enrolled in the waiver effective on the date that any of these records checks verifies that he has been convicted of barrier crimes described in § 37.2-416 or § 32.1-162.9:1 of the Code of Virginia (whichever is applicable to the provider's license) or if he has a finding in the VDSS Child Protective Services Central Registry.

a. For CD services, the CD employee shall submit to a criminal history records check conducted by the fiscal employer agent within 30 days of employment. If the individual enrolled in the waiver is a minor child, the CD employee shall also submit to a search of the VDSS Child Protective Services Central Registry. The CD employee shall not be compensated for services provided to the waiver individual effective the date on which the record check verifies that the CD employee has been convicted of barrier crimes described in § 37.2-416 of the Code of Virginia or if the CD employee has a founded complaint confirmed by the VDSS Child Protective Services Central Registry.

b. The provider or CD employer shall require direct support professionals or CD employees to notify the employer of all convictions occurring subsequent to the initial record check. Direct support professionals or CD employees who refuse to consent to VDSS Child Protective Services registry checks shall not be eligible for Medicaid reimbursement.

D. Pursuant to 42 CFR Part 431, Subpart F, 12VAC30-20-90, and any other applicable federal or state law or regulation, all providers shall hold confidential and use for DMAS or DBHDS authorized purposes only all medical assistance information regarding individuals served. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits or the data are necessary for purposes directly related to the administration of the State Plan.

E. Change of ownership. When ownership of the provider changes, the provider shall notify DMAS at least 15 calendar days before the date of change.

F. For ICF/IID facilities covered by § 1616(e) of the Social Security Act in which respite care as a home and community-based waiver service will be provided, the facilities shall be in compliance with applicable regulatory standards.

G. Suspected abuse or neglect. Pursuant to §§ 63.2-1509 and 63.2-1606 of the Code of Virginia, if a participating provider knows or suspects that an individual receiving a home and community-based waiver services is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or exploitation shall report immediately at first knowledge to the local DARS adult or DSS child protective services agency, to DMAS, and to the DBHDS Offices of Licensing and Human Rights, if applicable.

H. Adherence to provider participation agreement, Medicaid laws, and the DMAS provider manual. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the requirements outlined in federal and state laws, regulations, their individual provider participation agreements and in the applicable DMAS provider manual.

I. DMAS may terminate the provider's Medicaid provider agreement pursuant to § 32.1-325 of the Code of Virginia and as may be required for federal financial participation. Such provider agreement terminations shall conform to 12VAC30-10-690 and Part XII (12VAC30-20-500 et seq.) of 12VAC30-20. DMAS shall not reimburse for services that may be rendered subsequent to such terminations.

J. Direct marketing. Providers are prohibited from performing any type of direct marketing activities to Medicaid individuals or their family/caregivers.

K. Providers shall participate, as may be requested, in the completion of the DBHDS-approved assessment instruments when the provider possesses specific, relevant information about the individual enrolled in the waiver.

L. Felony convictions. A provider who has been convicted of a felony, or who has otherwise pled guilty to a felony, in Virginia or in any other of the 50 states, the District of Columbia, or the U.S. Territories shall, within 30 days of such conviction, notify DMAS of this conviction and relinquish its provider agreement. Such provider agreement terminations shall be effective immediately and conform to 12 VAC 30-10-690.

1. Providers shall not be reimbursed for services that may be rendered between the conviction of a felony and the provider's notification to DMAS of the conviction.

M. Except as otherwise provided by applicable statute or federal law, the Medicaid provider agreement may be terminated by DMAS at will on 30 days written notice. The agreement may be terminated immediately if DMAS determines that the provider poses a threat to the health, safety, or welfare of any individual enrolled in a DMAS administered program. DMAS may also immediately terminate a provider's participation agreement if the provider does not fulfill its obligations as described in the provider participation agreement. Such action precludes further payment by DMAS for services provided for individuals subsequent to the date specified in the termination notice.

N. A participating provider may voluntarily terminate his participation with DMAS by providing 30 days written notification.

O. Fiscal employer/agent, as defined in 12VAC30-120-1000, requirements. Pursuant to a duly negotiated contract or interagency agreement, the contractor or entity shall be reimbursed by DMAS to perform certain employer functions including, but not limited to, payroll and

bookkeeping functions on the part of the individual/employer who is receiving consumer-directed services.

1. The fiscal employer/agent shall be responsible for administering payroll services on behalf of the individual enrolled in the waiver including, but not limited to:

- a. Collecting and maintaining citizenship and alien status employment eligibility information required by the Department of Homeland Security;
- b. Securing all necessary authorizations and approvals in accordance with state and federal tax requirements;
- c. Deducting and filing state and federal income and employment taxes and other withholdings;
- d. Verifying that assistants' or companions' submitted timesheets do not exceed the maximum hours prior authorized for individuals enrolled in the waiver;
- e. Processing timesheets for payment;
- f. Making all deposits of income taxes, FICA, and other withholdings according to state and federal requirements; and
- g. Distributing bi-weekly payroll checks to individuals' companions and assistants.

2. All timesheet discrepancies shall be reported promptly upon their identification to DMAS for investigation and resolution.

3. The fiscal employer/agent shall maintain records and information as required by DMAS and state and federal laws and regulations and make such records available upon DMAS' request in the needed format.

4. The fiscal employer/agent shall establish and operate a customer service center to respond to individuals' and assistants'/companions' payroll and related inquiries.

5. The fiscal employer/agent shall maintain confidentiality of all Medicaid information pursuant to HIPAA and DMAS requirements. Should any breaches of confidential information occur, the fiscal/employer agent shall assume all liabilities under both state and federal law.

P. Changes to or termination of services. DMAS or its designee shall have the authority to approve changes to an individual's Individual Support Plan, based on the recommendations of the support coordination/case management provider.

1. Service providers shall be responsible for modifying their Plan for Supports, with the involvement of the individual enrolled in the waiver and the individual's family/caregiver, as appropriate, and submitting such revised Plan for Supports to the support coordinator/case manager any time there is a change in the individual's condition or circumstances that may warrant a change in the amount or type of service rendered.

a. The support coordinator/case manager shall review the need for a change and may recommend a change to the Plan for Supports to the DMAS designee.

b. DBHDS shall approve, deny, or suspend for additional information, the provider's requested change or changes to the individual's Plan for Supports. DBHDS shall communicate its

determination to the support coordinator/case manager within 10 business days of receiving all supporting documentation regarding the request for change or in the case of an emergency within three business days of receipt of the request for change.

2. The individual enrolled in the waiver and the individual's family/caregiver, as appropriate, shall be notified in writing by the support coordinator/case manager of his right to appeal pursuant to DMAS client appeals regulations, Part I of 12VAC30-110, a decision to reduce, terminate, suspend, or deny services. The support coordinator/case manager shall submit this written notification to the individual enrolled in the waiver within 10 business days of the decision. Once the individual receives the written notification, the clock for filing an appeal, as set forth in the DMAS client appeals regulations, begins to run.

3. In a nonemergency situation, when a service provider determines that services to an individual enrolled in the waiver must be terminated, the service provider shall give the individual and the individual's family/caregiver, as appropriate, and support coordinator/case manager written notification of the service provider's intent to discontinue services at least 10 business days in advance of discontinuation of services. The notification letter shall provide the reasons for the planned termination and the effective date the service provider will be discontinuing services. The effective date shall be at least 10 business days from the date of the notification letter. The individual enrolled in the waiver may pursue services from another enrolled service provider.

4. In an emergency situation when the health, safety, or welfare of the individual enrolled in the waiver, other individuals in that setting, or provider personnel are endangered, the support coordinator/case manager and DBHDS shall be notified by the service provider prior to discontinuing services. The 10-business-day prior written notification period shall not be required. The local department of social services adult protective services unit or child protective services unit, as appropriate, and the DBHDS Offices of Licensing and Human Rights shall be notified immediately by the support coordinator/case manager and the provider when the individual's health, safety, or welfare may be in danger.

5. The support coordinator/case manager shall have the responsibility to identify those individuals who no longer meet the level of functioning criteria or for whom home and community-based waiver services are no longer an appropriate alternative. In such situations, DMAS or its designee shall discharge the individuals from the waiver.

a. The support coordinator/case manager shall notify the individual and family/caregiver, as appropriate, of this determination and the right to appeal such discharge.

b. The individual shall be given the option to continue his waiver services pending the final outcome of his appeal. Should the outcome of the appeal confirm the determination by DMAS or its designee that the individual should be discharged from the waiver, the individual shall be responsible for the costs of his waiver services incurred by DMAS during his appeal.

Q. Documentation requirements for service providers.

1. The need of each individual enrolled in the waiver for each service shall be clearly set out in the Individual Support Plan containing each service provider's Plan for Supports.

2. Documentation shall confirm attendance and the individual's amount of time in services and provide specific information regarding the individual's response to various settings and supports

as agreed to in the ISP objectives. Observation results shall be available in at least a daily note. Data shall be collected as described in the ISP, analyzed to determine if the strategies are effective, summarized, and then clearly documented in the progress note, task analysis checklist, or support checklist.

3. Service providers shall maintain contemporaneous documentation for each unit of service delivered, and the documentation shall correspond with billing. Providers shall maintain separate documentation for each type of service rendered for an individual. Documentation shall include all correspondence and contacts related to the individual.

4. A quarterly ISP update shall be conducted, and any updates shall be reviewed by the service provider with the individual, and this written review shall be dated and submitted to the support coordinator/case manager with goals, desired outcomes, and support activities, modified as appropriate.

5. Documentation shall be maintained for routine supervision and oversight of all services provided by direct support professional staff. All significant contacts shall be documented and dated.

6. A qualified developmental disabilities professional shall provide supervision of direct support professional staff. Documentation of supervision shall be completed, signed by the staff person designated to perform the supervision and oversight, and include the following:

a. Date of contact or observation;

b. Person or persons contacted or observed;

c. A summary about direct support professional staff performance and service delivery for any monthly contacts and any semi-annual home visits;

d. Any action planned or taken to correct problems identified during supervision and oversight; and

e. On a semi-annual basis, the qualified developmental disabilities professional shall document observations concerning the individual's satisfaction with service provision.

7. Claims for payment that are not supported by supporting documentation shall be subject to recovery by DMAS or its designee as a result of utilization reviews or audits.

R. Providers of services under any of the DD waivers shall not be the parents (natural, adoptive, foster, or step-parents) of individuals enrolled in the waiver who are minor children, or the individual's spouse. Payment shall not be made for services furnished by other family members who are living under the same roof as the individual receiving services unless there is objective, written documentation as to why there are no other providers available to provide the care. Such other family members if approved to provide services shall meet the same provider requirements as all other licensed providers.

12VAC30-120-515. General Requirements for Waivers: competencies, utilization review, and quality management review (QMR).

A. Core Competency Requirements for Direct Support Professionals (DSPs) and their supervisors in programs licensed by DBHDS.

1. Providers shall ensure that DSPs and DSP supervisors providing services to individuals with developmental disabilities receive training on the following core competencies:

- a. The characteristics of developmental disabilities and Virginia's DD Waivers,
- b. Person-centeredness, positive behavioral supports, effective communication,
- c. DBHDS-identified health risks and the appropriate interventions, and
- d. Best practices in the support of individuals with developmental disabilities.

2. 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. Evidence of completed core competency training, a copy of the DSP completed test, the DBHDS-issued certificate of completion for supervisors, and documentation of assurances (DMAS Form P242a, P243a, P245a or P256a as applicable), shall be retained in the provider record and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes.

3. Providers shall ensure that supervisors of DSPs complete the competencies checklist (DMAS Form P241a) for each DSP they supervise within 180 days of the DSP passing the DBHDS test with annual updates thereafter.

4. The director of the service provider or the director's designee shall complete the competencies checklist (DMAS Form P241a) for each DSP supervisor within 180 days of the DSP supervisor passing the DBHDS test with annual updates thereafter.

5. The checklist shall be retained in the provider record and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes.

6. Providers shall ensure that all DSPs and DSP supervisors hired on or after the effective date of this regulation shall demonstrate, within 180 days of hire, the presence of the competencies listed in subsection A through the administration and passage of the DBHDS-approved objective, standardized test, which shall be documented in the personnel records of each staff member and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes. Continued knowledge of the core competencies by DSPs and DSP supervisors shall be confirmed in accordance with subsections (A)(3) and (A)(4).

7. Providers shall ensure that DSP supervisors who were hired prior to the effective date of this regulation shall be in compliance with these competency training requirements within 120 days of the effective date of this regulation through the administration and passage of the DBHDS-approved objective, standardized test, which shall be documented in the personnel records of

each staff and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes.

8. Providers shall ensure that DSPs who were hired prior to the effective date of this regulation shall be in compliance with these competency training requirements within 180 days of the effective date of this regulation through the administration and passage of the DBHDS-approved objective, standardized test, which shall be documented in the personnel records of each staff and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes. Continued knowledge of the core competencies by DSPs and DSP supervisors shall be confirmed in accordance with subsection (A)(3) and (A)(4).

B. Core Competency Requirements for Support Coordinators/Case Managers (RESERVED)

C. Core Competency Requirements for QDDPs. (RESERVED)

D. Advanced Core Competency requirements for DSPs and DSP supervisors serving individuals with developmental disabilities with the most intensive needs.

1. Providers shall ensure that DSPs and DSP supervisors supporting individuals identified as having the most intensive needs, as determined by assignment to Levels 5, 6, or 7 (as referenced in 12 VAC 30-120-570) based on a completed Supports Intensity Scale® assessment, shall receive training specific to the individuals' needs and levels.

2. DSPs and DSP supervisors supporting individuals with extraordinary medical support needs shall receive training on advanced core competencies in the area of medical supports as established by DBHDS.

3. DSPs and DSP supervisors supporting individuals with extraordinary behavioral support needs shall receive training on advanced core competencies in the area of behavioral supports as established by DBHDS.

4. DSPs and DSP supervisors supporting individuals with autism shall receive training on advanced core competencies in the area of characteristics of autism as established by DBHDS.

5. Evidence of completed advanced core competency training through documentation of assurances (DMAS Form XX) completed by DSPs and DSP supervisors shall be retained in the provider record and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes.

6. Providers shall ensure that DSP supervisors complete the advanced core competencies checklist(s) (DMAS Form P240a, P244a and XX) specific to the needs and levels of the individuals supported for each DSP they supervise within 180 days of the DSP signing the documentation of assurances with annual updates thereafter.

7. The director of the provider agency or designee shall complete the advanced core competencies checklist(s) (DMAS Form P240a, P244a and XX) specific to the needs and level of the individuals supported for each DSP supervisor within 180 days of the DSP supervisor signing the documentation of assurances with annual updates thereafter. The checklist(s) shall be retained in the provider record and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes.

8. Providers shall ensure that DSPs and DSP supervisors who render services to individuals in Levels 5, 6, or 7 who were hired prior to the effective date of this regulation shall demonstrate the presence of the advanced core competencies listed above within 180 days of the effective date of this regulation through the completion of the applicable advanced core competencies checklist(s) based on the needs and levels of the individuals supported (DMAS Form P240a, P244a and XX), which shall be documented in the personnel records of each staff and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes. Continued knowledge of the advanced core competencies by DSPs and DSP supervisors shall be confirmed in accordance with subsections (D)(6) and (D)(7).

9. Providers shall ensure that DSPs and DSP Supervisors who render services to individuals in Levels 5, 6, or 7 who are hired on or after the effective date of this regulation shall demonstrate the presence of the advanced core competencies listed above within 180 days of hire through the completion of the applicable advanced core competencies checklist(s) based on the needs and levels of the individuals supported ((DMAS Form P240a, P244a and XX), which shall be documented in the personnel records of each staff and subject to review by DBHDS for licensing compliance and by DMAS for quality management review and financial audit purposes. Continued knowledge of the advanced core competencies by DSPs and DSP supervisors shall be confirmed in accordance with subsections (D)(6) and (D)(7).

E. Plan for Supports. The Plan for Supports shall include, at a minimum, the following elements:

1. The individual's strengths, desired outcomes/goals/objectives, required or desired supports or both, and skill-building needs;
2. The individual's support activities to meet the identified outcomes;
3. The services to be rendered and the schedule for such services to accomplish the desired outcomes and support activities, a timetable for the accomplishment of the individual's desired outcomes and support activities; the estimated duration of the individual's need for services; and the provider staff responsible for overall coordination and integration of the services specified in the Plan for Supports.

F. Reevaluation of service need.

1. The Individual Support Plan.

a. The ISP shall be collaboratively developed annually by the support coordinator/case manager with the individual and the individual's family/caregiver, as appropriate, other service providers, consultants as may be needed, and other interested parties.

b. The support coordinator/case manager shall be responsible for continuous monitoring of the appropriateness of the individual's services and revisions to the ISP as indicated by the changing needs of the individual. At a minimum, the support coordinator/case manager shall review the ISP every three months to determine whether the individual's desired outcomes and support activities are being met and whether any modifications to the ISP are necessary. The results of such reviews shall be documented in the individual's record even if no change occurred during the review period. This documentation shall be provided to DMAS and DBHDS upon request.

c. Any modification to the amount or type of services in the ISP shall be service authorized by DMAS or its designee.

d. All requests for increased waiver services by individuals enrolled in one of the DD waivers shall be reviewed by the support coordinator/case manager to ensure health, safety, and welfare and for consistency with cost effectiveness. This assures that an individual's ability to receive a waiver service is dependent on the finding that the individual needs the service, based on appropriate assessment criteria and a written Plan for Supports, and that services can be safely and cost effectively provided in the community.

2. Review of level of care.

a. The support coordinator/case manager shall complete a reassessment annually, at minimum, in coordination with the individual and the individual's family/caregiver, as appropriate, and service providers. The reassessment shall include an update of the level of care and Personal Profile, risk assessment, and any other appropriate assessment information. The ISP shall be revised as appropriate.

b. At least every three years for those individuals who are 16 years of age and older and every two years for those individuals who are ages birth through 15 years of age, or when the individual's support needs change significantly (such as a loss of abilities that is expected to last longer than 30 days), the support coordinator/case manager, with the assistance of the individual and other appropriate parties who have knowledge of the individual's circumstances and needs for support, shall request an updated SIS® assessment and the Virginia Supplemental Questions, as appropriate, or a DBHDS-approved alternative instrument for children younger than the age of five years.

c. A medical examination shall be completed for adults based on need identified by the individual and the individual's family/caregiver, as appropriate, provider, support coordinator/case manager, or DBHDS staff. Medical examinations and screenings for children shall be completed according to the recommended frequency and periodicity of the EPSDT (42 CFR 440.40 and 12 VAC 30-50-130) program.

d. A new psychological or other diagnostic evaluation shall be required whenever the individual's functioning has undergone significant change (such as an increase or loss of abilities that is expected to last longer than 30 days) and is no longer reflective of the past evaluation. The evaluation shall reflect the current diagnosis, adaptive level of functioning, and presence of a functional delay that arose during the developmental period.

3. The support coordinator/case manager shall monitor the service providers' plans for supports to ensure that all providers are working toward the desired outcomes for these individuals.

4. Support coordinators/case managers shall be required to conduct and document evidence of monthly onsite visits for all individuals enrolled in these waivers who are residing in VDSS-licensed assisted living facilities or approved adult foster care homes. Support coordinators/case managers shall conduct and document a minimum of quarterly onsite home visits to all other individuals.

G. Utilization Review and quality management reviews (QMR).

1. QMR shall be performed by the DMAS Division of Long Term Care Services or its designee. Utilization review of rendered services shall be conducted by the DMAS Division of Program Integrity (PI) or its designee.
2. DMAS staff shall conduct utilization review of individual-specific documentation.
3. DMAS shall not reimburse providers for the costs of participation in social or recreational activities.

12VAC30-120-520. Financial eligibility standards for individuals in the FIS, CL and BI Waivers; criteria for services; assessment and enrollment.

A. Individuals receiving services under the Family and Individual Supports (FIS) Waiver (12 VAC 30-120-700 et seq.), Community Living (CL) Waiver (12 VAC30-120-1000 et seq.), and Building Independence (BI) Waiver (12 VAC 30-120-1500 et seq.), shall meet the following Medicaid eligibility requirements. The Commonwealth shall apply the financial eligibility criteria contained in the State Plan for the categorically needy. The Commonwealth covers the optional categorically needy groups under 42 CFR 435.211, 42 CFR 435.217, and 42 CFR 435.230.

1. The income level used for 42 CFR 435.211, 42 CFR 435.217 and 42 CFR 435.230 shall be 300% of the current Supplemental Security Income (SSI) payment standard for one person.
2. Under these waivers, the coverage groups authorized under § 1902(a)(10)(A)(ii)(VI) of the Social Security Act shall be considered as if they were institutionalized for the purpose of applying institutional deeming rules. All individuals under the waivers shall meet the financial and nonfinancial Medicaid eligibility criteria and meet the institutional level-of-care criteria for an ICF/IID. The deeming rules shall be applied to waiver eligible individuals as if the individuals were residing in an ICF/IID or would require that level of care.
3. The Commonwealth shall reduce its payment for home and community-based waiver services provided to an individual who is eligible for Medicaid services under 42 CFR 435.217 by that amount of the individual's total income (including amounts disregarded in determining eligibility) that remains after allowable deductions for personal maintenance needs, other dependents, and medical needs have been made, according to the guidelines in 42 CFR 435.735 and § 1915(c)(3) of the Social Security Act as amended by the Consolidated Omnibus Budget Reconciliation Act of 1986. DMAS shall reduce its payment for home and community-based waiver services by the amount that remains after the deductions listed in this subdivision:
 - a. For individuals to whom § 1924(d) applies and for whom the Commonwealth waives the requirement for comparability pursuant to § 1902(a)(10)(B), DMAS shall deduct the following in the respective order:
 - (1) The basic maintenance needs for an individual under these waivers, which shall be equal to 165% of the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least eight but less than 20 hours per week,

earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, shall be added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

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

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

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

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

(1) The basic maintenance needs for an individual under these waivers, which is equal to 165% of the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, shall be added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

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

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

B. The following four criteria shall apply to all individuals who seek these waiver services:

1. The need for these waiver services shall arise from an individual having a diagnosed condition of DD as defined in §37.2-100 of the Code of Virginia. Individuals qualifying for these waivers' services shall have a demonstrated need for the covered services due to significant functional limitations in major life activities;

2. Individuals qualifying for these waivers' services shall meet the ICF/IID level-of-care criteria as set out in 12 VAC 30-120-530 et seq.;

3. The services that are delivered shall be consistent with the Individual Support Plan, service limits and requirements, and provider requirements of each service; and

4. Services shall be recommended by the support coordinator/case manager based on his documentation of the need for each specific service and as reflected in a current SIS assessment or for children younger than five years of age, an alternative industry assessment instrument approved by DBHDS, such as the Early Learning Assessment Profile.

C. Assessment and enrollment.

1. Home and community-based waiver services shall be considered only for individuals eligible for admission to an ICF/IID due to their diagnoses of DD. For the support coordinator/case manager to make a recommendation for these waivers' services, the services shall be determined to be an appropriate service alternative to delay or avoid placement in an ICF/IID, or to promote exiting from an ICF/IID or other institutional placement provided that a viable discharge plan has been developed.

2. The support coordinator/case manager shall confirm diagnostic and functional eligibility for individuals with input from the individual and the individual's family/caregiver, as appropriate, and service/support providers involved in the individual's support prior to DMAS assuming payment responsibility of home and community-based waiver services. This shall be accomplished through the completion of the following:

a. The required level-of-care determination through the Virginia Intellectual Developmental Disabilities Eligibility Survey (VIDES) appropriate to the individual according to his age, completed no more that six months prior to waiver enrollment and

b. A psychological or other evaluation of the individual that affirms that the individual meets the diagnostic criteria for developmental disability as defined in § 37.2-100 of the Code of Virginia.

3. The individual who has been found to be eligible for these services shall be given, by the support coordinator/case manager, his choice of either institutional placement or receipt of home and community based waiver services.

4. If the individual chooses home and community based waiver services, the support coordinator/case manager shall recommend the individual for home and community-based waiver services.

5. If the individual selects waiver services and a slot is available, then the support coordinator/case manager shall enroll the individual in the waiver. If no slot is available, the support coordinator/case manager shall place the individual on the DD waivers waiting list consistent with criteria established for these waivers in 12VAC30-120-580, until such time as a slot becomes available. The CSB/BHA shall only enroll the individual following electronic confirmation by DBHDS that a slot is available.

a. Once the individual's name has been placed on the DD waivers waiting list, the support coordinator/case manager shall notify the individual in writing within 10 business days of his placement on the DD waiting list and his assigned prioritization level, and offer appeal rights.

b. The support coordinator/case manager shall document contact with the individual at least annually while the individual is on the waiting list to provide the choice between institutional placement and waiver services.

D. Waiver approval process: authorizing and accessing services.

1. The support coordinator/case manager shall electronically submit enrollment information to DBHDS to confirm level-of-care eligibility once he has determined (i) an individual meets the functional criteria for these waiver services, (ii) that a slot is available, and (iii) the individual has chosen waiver services.

2. Once the individual has been notified of an available waiver slot by the CSB/BHA, the support coordinator/case manager shall submit a DMAS-225 along with a computer-generated confirmation of level-of-care eligibility to the local department of social services to determine financial eligibility for Medicaid and for the waiver program and any patient pay responsibilities.

3. After the support coordinator/case manager has received written notification of Medicaid eligibility from the local departments of social services, the support coordinator/case manager shall inform the individual, submit information to DMAS or its designee to enroll the individual in the waiver, and permit the development of the Individual Support Plan.

a. The individual and the individual's family/caregiver, as appropriate, shall meet with the support coordinator/case manager within 30 calendar days of the waiver enrollment date to discuss the individual's needs and existing supports, obtain a medical examination (which shall have been completed no earlier than 12 months prior to the initiation of waiver services), begin to develop the Personal Profile, and schedule the completion of the SIS®.

b. The support coordinator/case manager shall provide the individual with choice of needed services available in the assigned waiver, alternative settings, and providers. Once the service providers are chosen, a planning meeting shall be arranged by the support coordinator/case manager to develop the Individual Support Plan based on the individual's assessed needs and the preferences of the individual and the individual's family/caregiver's, as appropriate.

c. Persons invited by the support coordinator/case manager to participate in the person-centered planning meeting shall include the individual, service providers, and others as desired by the individual. During the person-centered planning meeting, the services to be rendered to individuals, the frequency of services, the type of service provider or providers, and a description of the services to be offered are identified and included in the ISP. The individual enrolled in the waiver, or the family/caregiver as appropriate, and support coordinator/case manager shall sign the ISP.

4. The individual, family/caregiver or support coordinator/case manager shall contact chosen service providers so that services can be initiated within 30 calendar days of receipt of confirmation of waiver enrollment. (Enrollment occurs once the support coordinator/case manager submits the DMAS-225 form and the computer-generated confirmation of level of care eligibility to the local department of social services.) If the services are not initiated by the provider within 30 days, the support coordinator/case manager shall notify the local department of social services so that re-evaluation of the individual's financial eligibility can be made.

5. In the case of an individual being referred back to a local department of social services for a re-determination of eligibility and in order to retain the designated slot, the support coordinator/case manager shall electronically submit information to DBHDS requesting retention of the designated slot pending the initiation of services. A copy of the request shall be provided to the individual and the individual's family/caregiver, as appropriate. DBHDS shall have the authority to approve the slot-retention request in 30-day extensions, up to a maximum of four consecutive extensions or deny such request to retain the waiver slot for the individual. DBHDS shall provide an electronic response to the support coordinator/case manager indicating denial or approval of the slot extension request. DBHDS shall submit this response to the support coordinator/case manager within ten working days of the receipt of the request for extension. The support coordinator/case manager shall notify the individual in writing of any denial of the slot extension request and the individual's right to appeal.

6. The service providers, in conjunction with the individual and the individual's family/caregiver, as appropriate, and the support coordinator/case manager shall develop a Plan for Supports for each service. Each service provider shall submit a copy of his plan to the support coordinator/case manager. The Plan for Supports from each service provider shall be incorporated into the ISP, along with the steps for risk mitigation as indicated by the risk assessment. The support coordinator/case manager shall review and ensure the provider-specific Plan for Supports meet the established service criteria for the identified needs prior to electronically submitting these along with the results of the comprehensive assessment and a recommendation for the final determination of the need for ICF/IID level of care to DMAS or its designee for service authorization. DMAS or its designee shall, within 10 working days of receiving all supporting documentation, review and approve, suspend for more information, or deny the individual service requests. DMAS or its designee shall communicate electronically to the support coordinator/case manager whether the recommended services have been approved and the amounts and types of services authorized or if any services have been denied. Only waiver services authorized on the ISP by the state-designated agency or its designee according to DMAS policies shall be reimbursed by DMAS.

7. When the support coordinator/case manager obtains the DMAS-225 form from a local department of social services, the support coordinator/case manager shall designate and inform in writing a service provider to be the collector of patient pay, when applicable. The designated provider shall monitor monthly the DMAS-designated system for changes in patient pay obligations and adjust billing, as appropriate, with the change documented in the record in accordance with DMAS policy. When the designated collector of patient pay is the consumer-directed personal or respite assistant or companion, the support coordinator/case manager shall forward a copy of the DMAS-225 form to the employer of record along with the support coordinator's/case manager's provider designation. In such cases, the support coordinator/case manager shall be required to perform the monthly monitoring of the patient pay system and shall notify the EOR of all changes.

8. DMAS shall not pay for any home and community-based waiver services delivered prior to the authorization date approved by DMAS or its designee if service authorization is required.

9. Waiver services shall be approved and authorized by the DMAS designee only if:

a. The individual is Medicaid eligible as determined by the local department of social services;

- b. The individual, including a child, has a diagnosis of DD, as defined by § 37.2-100 of the Code of Virginia, and would, in the absence of waiver services, require the level of care provided in an ICF/IID which would be reimbursed under the Plan;
- c. The individual's ISP is cost effective and can be safely rendered in the community; and
- d. The contents of the providers' Plan for Supports are consistent with the ISP requirements, limitation, units, and documentation requirements of each service.

12VAC30-120-530. Level of functioning standards for FIS, CL, and BI Waivers' eligibility (Virginia Individual Developmental Disabilities Eligibility Survey (VIDES)).

A. 42 C.F.R. § 441.302 mandates that DMAS ensure that individuals who are found to be eligible for § 1915 (c) of the *Social Security Act* waivers demonstrate, at least annually, their need for the level of care provided in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). These waiver services shall be provided for the individuals diagnosed with a developmental disability, as defined in § 37.2-100 of the Code of Virginia, who have been determined to require the level of care provided in an ICF/IID:

B. The VIDES assessment tools shall be administered by support coordinators/case managers.

C. The results of an individual's VIDES determination shall be one element of determining if the individual qualifies for the FIS (12 VAC 30-120-700 et seq.), CL (12 VAC 30-120-1000 et seq.), or BI (12 VAC 30-120-1500 et seq.) waivers.

D. The Commonwealth shall use Virginia Individual Disabilities Eligibility Survey (VIDES) forms to establish the level of care required for its DD Waivers.

1. VIDES for Infants shall be used for the evaluation of individuals who are younger than three years of age (DMAS-P235).
2. VIDES for Children shall be used for the evaluation of individuals who are three to 18 years of age (DMAS-P-236).
3. VIDES for Adults shall be used for the evaluation of individuals who are 18 years of age and older (DMAS-P237).

12VAC30-120-540. SIS® requirements; Virginia Supplemental Questions, and supports packages.

A. The Supports Intensity Scale (SIS®) requirements.

1. The Supports Intensity Scale ® (SIS®) is an assessment tool that evaluates the practical supports required by individuals to live successfully in their communities. The SIS® shall be used to assess individuals' patterns and intensity of needed supports across life activities, such as home living activities, community living activities, lifelong learning, employment, health and

safety, social activities, as well as protection and advocacy and medical and behavioral support needs. It shall be used with the Virginia supplemental questions to determine individual support levels.

2. The SIS® shall be administered and analyzed by qualified, trained interviewers designated by DBHDS.

3. The SIS® also assesses what is important to and important for individuals who are enrolled in a waiver.

B. The Virginia Supplemental Questions (VSQ) shall identify individuals who have unique needs falling outside of the needs captured by the SIS® instrument. It shall also be administered and analyzed by the same qualified, trained interviewers designated by DBHDS.

C. Establishment of service mix packages. (RESERVED)

Statutory Authority

12VAC30-120-570. Tiers of reimbursement.

A. Waiver services shall be reimbursed on a prospective, fee-for-service basis. There shall be no designated formal schedule for annual cost of living or other adjustments and any adjustments to provider rates shall be subject to available funding and approval by the General Assembly.

B. There shall be up to four tiers of reimbursement for some services. The approved reimbursement tier for an individual shall be based on resultant scores of the SIS ® and Virginia Supplemental Questions. DBHDS shall verify the scores and levels of the individuals, as appropriate.

C. Levels of supports. The following seven levels of supports shall be applied by DMAS or its designee in the FIS, CL and BI waivers: (i) Level 1 means low support needs; (ii) Level 2 means low to moderate support needs; (iii) Level 3 means moderate support needs plus some behavior challenges; (iv) Level 4 means moderate to high support needs; (v) Level 5 means maximum support needs; (vi) Level 6 means significant support needs due to medical challenges; and (vii) Level 7 means significant support needs due to behavioral challenges.

D. Tiers of reimbursement. There shall be four as follows:

1. Tier 1 shall be used for individuals having Level 1 support needs.

2. Tier 2 shall be used for individuals having Level 2 support needs.

3. Tier 3 shall be used for individuals having either: (i) Level 3 support needs, or (ii) Level 4 support needs.

4. Tier 4 shall be used for individuals having: (i) Level 5 support needs; (ii) Level 6 support needs, or; (iii) Level 7 support needs.

12VAC30-120-580. Waiting list priorities; assignment process.

A. There shall be a single, statewide waiting list, called the DD waiting list, for the DD Waivers. This waiting list shall be created and maintained by DBHDS.

B. Criteria. In order to be assigned to one of the categories below, the individual shall meet one of these criteria, as appropriate:

1. Priority One shall be assigned to individuals determined to meet one the following criteria and require a waiver service within one year:

a. An immediate jeopardy exists to the health and safety of the individual due to the unpaid primary caregiver having a chronic or long-term physical or psychiatric condition or conditions that significantly limit the ability of the primary caregiver or caregivers to care for the individual; there are no other unpaid caregivers available to provide supports.

b. There is immediate risk to the health or safety of the individual, primary caregiver, or other person living in the home due to either of the following conditions:

(1) The individual's behavior or behaviors, presenting a risk to himself or others, cannot be effectively managed by the primary caregiver or unpaid provider even with support coordinator/case manager-arranged generic or specialized supports; or

(2) There are physical care needs or medical needs that cannot be managed by the primary caregiver even with support coordinator/case manager-arranged generic or specialized supports;

c. The individual lives in an institutional setting and has a viable discharge plan; OR

d. The individual is a young adult who is no longer eligible for IDEA services and is transitioning to independent living. After individuals attain 27 years of age, this criterion shall no longer apply.

2. Priority Two shall be assigned to individuals who meet one of the following criteria and a waiver service will be needed in one to five years:

a. The health and safety of the individual is likely to be in future jeopardy due to

i. The unpaid primary caregiver or caregivers having a declining chronic or long-term physical or psychiatric condition or conditions that significantly limit his ability to care for the individual;

ii. There are no other unpaid caregivers available to provide supports; and

iii. The individual's skills are declining as a result of lack of supports;

b. The individual is at risk of losing employment supports;

c. The individual is at risk of losing current housing due to a lack of adequate supports and services; or

d. The individual has needs or desired outcomes that with adequate supports will result in a significantly improved quality of life.

3. Priority Three shall be assigned to individuals who meet one of the following criteria and will need a waiver slot in five years or longer as long as the current supports and services remain

a. The individual is receiving a service through another funding source that meets current needs;
b. The individual is not currently receiving a service but is likely to need a service in five or more years; or

c. The individual has needs or desired outcomes that with adequate supports will result in a significantly improved quality of life.

C. Individuals and family/caregivers shall have the right to appeal the application of the prioritization criteria (in the event that such application results in a reduction of access to services), emergency criteria, or reserve criteria to their circumstances pursuant to 12 VAC 30-110, All notifications of appeal shall be submitted to DMAS.

D. Slot allocation. Individuals who are in Priority 1 category who are determined to be most in need of supports at the time a slot is available are reviewed by the independent waiver slot assignment committee for the area in which the slot is available. The individual who has the highest need as designated by the committee will be recommended for the available waiver slot. The DMAS designee shall make the final determination for slot allocation.

E. Emergency access. Eligibility criteria for emergency access to either the FIS (12 VAC 30-120-700 et seq.), CL (12 VAC 30-120-1000 et seq.), or BI (12 VAC 30-120-1500 et seq.) waiver.

1. Subject to available funding and a finding of eligibility under 12VAC30-120-530, individuals shall meet at least one of the emergency criteria of this subdivision to be eligible for immediate access to waiver services without consideration to the length of time they have been waiting to access services. The criteria shall be one of the following:

a. Child Protective Services has substantiated abuse/neglect against the primary caregiver and has removed the individual from the home; or for adults where 1) Adult Protective Services has found that the individual needs and accepts protective services, or 2) abuse/neglect has not been founded, but corroborating information from other sources (agencies) indicate that there is an inherent risk present and there are no other caregivers available to provide support services to the individual.

b. Death of primary caregiver or lack of alternative caregiver coupled with the individual's inability to care for himself and danger to self or others without supports.

2. Requests for emergency slots shall be forwarded by the CSB/BHA to DBHDS.

a. Emergency slots may be assigned by DBHDS to individuals until the total number of available emergency slots statewide reaches ten percent of the emergency slots funded for a given fiscal year, or a minimum of three slots. At that point, the next non-emergency waiver slot that becomes available at the CSB in receipt of an emergency slot shall be reassigned to the emergency slot pool in order to ensure emergency slots remain to be assigned to future emergencies within the Commonwealth's fiscal year.

b. Emergency slots shall also be set aside for those individuals not previously identified but newly known as needing supports resulting from an emergent situation.

F. Reserve slots.

1. Reserve slots may be used for transitioning an individual who, due to documented changes in his support needs, requires a move from the DD waiver in which he is presently enrolled into another of the DD waivers to access necessary services.

a. An individual who needs to transition between the DD waivers shall not be placed on the DD waiting list.

b. A documented change in an individual's assessed needs, which requires a service or services that is or are not available in the DD waiver in which the individual is presently enrolled, shall exist for an individual to be considered for a reserve slot.

c. CSBs shall document and notify DBHDS in writing when an individual meets the criteria in subsection b within three business days of knowledge of need. The assignment of reserve slots shall be managed by DBHDS which will maintain a chronological list of individuals in need of a reserve slot in the event that the reserve slot supply is exhausted.

2. The waiver slot belonging to the individual who vacates one of the DD waivers to utilize the reserve slot to enroll in another DD waiver shall be assigned to an individual on that CSB's/BHA's part of the statewide waiting list by DBHDS, after review and recommendations from the local Waiver Slot Assignment Committee.

G. If the individual determines at any time that he no longer wishes to be on the waiver waiting list, he may contact his support coordinator/case manager to request removal from the waiting list. The support coordinator/case manager shall notify DBHDS so that the individual's name can be removed from the waiting list.

Part VIII
Family and Individual Supports (FIS) Waiver

Article 1
General Requirements

12VAC30-120-700. Definitions.

"Activities of daily living" or "ADL" means the same as defined in 30-120-1000.

"Appeal" means the same as defined in 12VAC30-120-1000.

"Assistive technology" means the same as defined in 30-120-1000.

"Barrier crime" means the same as defined in 12VAC30-120-1000.

"Behavioral health authority" or "BHA" means the same as defined in § 37.2-100 of the Code of Virginia.

"Case manager" means the same as defined in 12VAC30-120-1000.

"Center-based crisis support services" means the same as defined in 12VAC30-120-1000.

"Centers for Medicare and Medicaid Services" or "CMS" means the same as defined in 12VAC30-120-1000.

"Challenging behavior" means the same as defined in 12VAC30-120-1000.

"Community-based crisis supports services" means the same as defined in 12VAC30-120-1000.

"Community coaching" means the same as defined in 12VAC30-120-1000.

"Community engagement" means the same as defined in 12VAC30-120-1000.

"Community services board" or "CSB" means the same as defined in §37.2-100 of the Code of Virginia.

"Companion" means, the same as defined in 12VAC30-120-1000.

"Companion services" means the same as defined in 12VAC30-120-1000.

"Comprehensive assessment" means the same as defined in 12VAC30-120-510.

"Consumer-directed employee" "or CD employee" means the same as the term "consumer-directed attendant," defined in 12VAC30-120-1000.

"Consumer-direction" means the same as defined in 12VAC30-120-1000.

"CPR" means Cardiopulmonary Resuscitation.

"Crisis support services" means the same as defined in 12VAC30-120-1000.

"DARS" means the Department for Aging and Rehabilitative Services.

"Date of need" means the date of the initial eligibility determination assigned to reflect that the individual is diagnostically and functionally eligible for the waiver and is willing to begin services within 30 calendar days of the date of need. The date of need shall not be changed unless the individual is subsequently found to be ineligible, either functionally or financially, or withdraws his request for services.

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

"DBHDS staff" means employees of DBHDS who provide technical assistance, conduct service authorizations and review individual level of care criteria.

"Developmental disability" or "DD" means the same thing as set out in §37.2-100 of the Code of Virginia.

"Direct marketing" means the same as defined in 12VAC30-120-1000.

"Direct support professionals" or "DSPs" means the same as defined in 12VAC30-120-1000.

"DMAS" means the Department of Medical Assistance Services.

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

"DSS" means the Department of Social Services.

"Electronic home-based supports" means the same as defined in 12VAC30-120-1000.

"Employer of record" or "EOR" means the same as defined in 12VAC30-120-1000.

"Enroll" means the same as defined in 12VAC30-120-510.

"Environmental modifications" the same as defined in 12VAC30-120-1000.

"EPSDT" means the same as defined in 12VAC30-120-1000.

"Face-to-face visit" means the same as defined in 12VAC30-120-1000.

"Family" means the same as defined in 12VAC30-120-510.

"Family and Individual Supports Waiver" means the waiver that supports individuals living with their families, friends, or in their own homes. It will support individuals with some medical or behavioral needs and will be available to both children and adults..

"Fiscal employer agent" means the same as defined in 12VAC30-120-1000.

"Freedom of choice" means the same as defined in §1902(a)(23) of the Social Security Act.

"General supports" means the same as defined in 12VAC30-120-1000.

"Group day services" means the same as defined in 12VAC30-120-1000.

"Group supported employment services" means the same as defined in 12VAC30-120-1000.

"Habilitation" means services and supports that help an individual keep, learn, or improve skills and functioning for daily living.

"Health, safety, and welfare standard" means the same as defined in 12VAC30-120-1000.

"Home" means, an apartment or single family dwelling in which no more than four individuals who require services live, with the exception of siblings living in the same dwelling with family. This does not include an assisted living facility or group home.

"Home and community-based waiver services" means the same as defined in 12VAC30-120-1000.

"ICF/IID" means the same as defined in 12VAC30-120-1000.

"IDEA" means the federal Individuals with Disabilities Education Act of 2004, 20 USC § 1400 et seq.

"In-home support services" means the same as defined in 12VAC30-120-1000.

"Individual" means the same as defined in 12VAC30-120-510.

"Individual and family/caregiver training" means training and counseling services provided to individuals, families or caregivers of individuals receiving services in the FIS waiver.

"Individual supported employment" means the same as defined in 12VAC30-120-1000.

"Individual Support Plan" or "ISP" means the same as defined in 12VAC30-120-1000.

"Instrumental activities of daily living" means the same as defined in 12VAC30-120-1000.

"LDSS" means the local Department of Social Services.

"Licensed Practical Nurse" means the same as defined in 12VAC30-120-1000.

"LMHP" means the same as defined in 12VAC30-50-130.

"LMHP-resident" or "LMHP-R" means the same as defined in 12VAC30-50-130.

"LMHP-resident in psychology" or "LMHP-RP" means the same as defined in 12VAC30-50-130.

"LMHP-supervisee in social work" or "LMHP-S" means the same as defined in 12VAC30-50-130.

"Medically necessary" means the same as defined in 12VAC30-120-1000.

"Participating provider" means the same as defined in 12VAC30-120-1000.

"Pend" means the same as defined in 12VAC30-120-1000.

"Person-centered planning" means the same as defined in 12VAC30-120-1000.

"Personal assistance services" means the same as defined in 12VAC30-120-1000.

"Personal assistant" means the same as defined in 12VAC30-120-1000.

"Personal care provider" means a participating provider that renders services to prevent or reduce inappropriate institutional care by providing eligible individuals with personal assistants to provide personal assistance services.

"Personal emergency response system" or "PERS" means the same as defined in 12VAC30-120-1000.

"Personal profile" means the same as defined in 12VAC30-120-1000.

"Plan for Supports" means the same as defined in 12VAC30-120-1000.

"Positive behavior support" means the same as defined in 12VAC30-120-1000.

"Primary caregiver" means the same as defined in 12VAC30-120-1000.

"Private duty nursing" means the same as defined in 12VAC30-120-1000.

"Qualified developmental disabilities professional" means the same as defined in 12VAC30-120-1000.

"Registered Nurse" means the same as defined in 12VAC30-120-1000.

"Respite services" means the same as defined in 12VAC30-120-1000.

"Risk assessment" means the same as defined in 12VAC30-120-1000.

"Routine supports" means the same as defined in 12VAC30-120-1000.

"Safety supports" means the same as defined in 12VAC30-120-1000.

"Service authorization" means the same as defined in 12VAC30-120-1000.

"Services facilitation" means the same as defined in 12VAC30-120-1000.

"Services facilitator" means the same as defined in 12VAC30-120-1000.

"Shared living" means the same as defined in 12VAC30-120-1000.

"Significant change" means the same as defined in 12VAC30-120-1000.

"Skilled nursing services" means the same as defined in 12VAC30-120-1000.

"Slot" means the same as defined in 12VAC30-120-510.

"State Plan for Medical Assistance" the same as defined in 12VAC30-120-1000.

"Support coordination/case management" means the same as defined in 12VAC30-50-455(D).

"Support coordinator/case manager" means the same as defined in 12VAC30-120-510.

"Supported living residential services" means the same as defined in 12VAC30-120-1000.

"Supports" means the same as defined in 12VAC30-120-1000.

"Supports Intensity Scale®" the same as defined in 12VAC30-120-510.

"Supports level" means" the level (1-7) to which an individual is assigned as a result of the utilization of the SIS® score and results of the Virginia Supplemental Questions. The level of support is derived from a calculation using the SIS® score and the results of the Virginia Supplemental Questions and correlates to an individual's support needs.

"Therapeutic consultation" means the same as defined in 12VAC30-120-1000.

"Transition services" means the same as defined in 12VAC30-120-2010.

"VDH" means the Virginia Department of Health.

"Workplace assistance services" means the same as defined in 12VAC30-120-1000.

12VAC30-120-710. Covered services and provider requirements for Family and Individual Supports (FIS) waiver services.

A. Except for the exclusions outlined in this subsection, individuals who are enrolled in this waiver may choose between the agency-directed model of service delivery or the consumer-directed model for the following services: (i) personal assistance services; (ii) respite services; and (iii) companion services. The support coordinator/case manager shall collaborate with the individual, family/caregiver, and other persons desired by the individual, to determine if consumer-directed services may be appropriate for the individual. Exclusions include instances where:

1. The individual who is enrolled in the waiver is younger than 18 years of age, except for emancipated minors, or is unable to be the employer of record and no one else can assume this role in the consumer-directed model of service delivery;
2. The health, safety, or welfare of the individual enrolled in the waiver cannot be ensured via the consumer-directed model of service delivery or a back-up emergency plan cannot be developed; or
3. The individual enrolled in the waiver has medication or nursing needs or medical/behavioral conditions that cannot be safely met via the consumer-directed model of service delivery.

B. Covered services.

1. Covered services shall include assistive technology, center-based crisis supports services, community-based crisis supports services, community coaching, community engagement, companion services (both consumer-directed and agency-directed), crisis support services, electronic home-based supports, environmental modifications, group day services, group supported employment, individual supported employment, in-home support services, individual and family/caregiver training, personal assistance services (both consumer-directed and agency-directed), personal emergency response systems (PERS), private duty nursing, respite services (both consumer-directed and agency-directed), services facilitation (only for consumer-directed services), shared living, skilled nursing services, supported living residential, therapeutic consultation, transition services, and workplace assistance services.

C. Core Competency Requirements for Direct Support Professionals (DSPs) and their supervisors in programs licensed by DBHDS shall be the same as those set forth in 12VAC30-120-515 (A).

D. Core Competency Requirements for Support Coordinators/Case Managers (RESERVED)

E. Core Competency Requirements for QDDPs. (RESERVED)

F. Advanced Core Competency requirements for DSPs and DSP supervisors serving individuals with developmental disabilities with the most intensive needs shall be the same as those set forth in 12VAC30-120-515 (D).

G. Provider enrollment requirements and provider participation standards shall be the same as those set forth in 12VAC30-120-514.

H. Documentation requirements shall be the same as those set forth in 12VAC30-120-514(Q).

I. Reevaluation of service need requirements shall be the same as those set forth in 12VAC30-120-515(F).

J. Utilization review (UR) requirements shall be the same as those set forth in 12VAC30-120-515(G).

12VAC30-120-735

12VAC30-120-735. Enrollment and voluntary/involuntary disenrollment of consumer-directed services.

A. Enrollment.

1. Individuals who are enrolled in the FIS waiver may choose between the agency-directed model of service delivery or the consumer-directed model of service delivery, or a combination of both, when DMAS makes the consumer-directed model available for care. The only services provided in this waiver that permit the consumer-directed model of service delivery shall be: (i) personal assistance services; (ii) respite services; or (iii) companion services for which an individual is eligible. An individual enrolled in the waiver shall not be able to choose consumer-directed services if any of the following conditions exists:

(a) The individual enrolled in the waiver is younger than 18 years of age except for emancipated minors or is unable to be the employer of record and no one else can assume the role of EOR;

(b) The health, safety, or welfare of the individual enrolled in the waiver cannot be ensured or a back-up emergency plan cannot be developed; or

(c) The individual enrolled in the waiver has medication or skilled nursing needs or medical/behavioral conditions that cannot be safely met via the consumer-directed model of service delivery.

2. The support coordinator/case manager shall make a determination if (a) through (c) above apply. Individuals shall have the right to appeal, pursuant to 12 VAC 30-110, the decision if they are denied their choice of the consumer-directed service delivery model based on items described in (a) through (c) above.

B. Either voluntary or involuntary disenrollment of the individual from consumer-directed services may occur. In either voluntary or involuntary situations, the individual who is enrolled in the waiver shall be permitted to select an agency from which to receive his personal assistance, respite, or companion services. If the individual refuses to make his own selection,

then either the support coordinator/case manager or the services facilitator shall make the choice for him.

1. An individual who has chosen consumer-direction may choose, at any time, to change to the agency-directed services model as long as he continues to qualify for personal assistance, respite, or companion services. The services facilitator or support coordinator/case manager, as appropriate, shall assist the individual with the change of services from consumer-directed to agency-directed.

2. The services facilitator or support coordinator/case manager, as appropriate, shall initiate involuntary disenrollment from consumer-direction of the individual who is enrolled in the waiver when any of the following conditions occur:

a. The health, safety, or welfare of the individual enrolled in the waiver is at risk;

b. The individual or EOR, as appropriate, demonstrates consistent inability to hire and retain an assistant or companion; or

c. The individual or EOR, as appropriate, is consistently unable to manage the assistant or companion, as may be demonstrated by, but not limited to, a pattern of serious discrepancies with timesheets.

3. Prior to involuntary disenrollment, the services facilitator or support coordinator/case manager, as appropriate, shall:

a. Verify that essential training has been provided to the individual or EOR, as appropriate, to improve the problem condition or conditions;

b. Document in the individual's record the conditions creating the necessity for the involuntary disenrollment and actions taken by the services facilitator or support coordinator/case manager, as appropriate;

c. Discuss with the individual or the EOR, as appropriate, the agency-directed option that is available and the actions needed to arrange for such services while providing a list of potential providers; and

d. Provide written notice to the individual and EOR, as appropriate, of the right to appeal, pursuant to 12VAC30-110, such involuntary termination of consumer direction. Except in emergency situations in which the health or safety of the individual is at serious risk, such notice shall be given at least 10 business days prior to the effective date of the termination of consumer direction. In cases of an emergency situation, notice of the right to appeal shall be given to the individual but the requirement to provide notice at least 10 business days in advance shall not apply.

4. If the services facilitator initiates the involuntary disenrollment from consumer-direction, then he shall inform the support coordinator/case manager.

12VAC30-120-750. In-home support services, supported living residential.

A. In-home support services.

1. Service description. The service description shall be the same as that set forth in 12VAC30-120-1028(A).
2. Criteria. The criteria shall be the same as those set forth in 12VAC30-120-1028(B).
3. Service units and service limitations. The service units and service limits shall be the same as those set forth in 12VAC30-120-1028(C).
4. Allowable activities shall be the same as those set forth in 12VAC30-120-1028(D).
5. Provider requirements shall be the same as those set forth in 12VAC30-120-1028(E).

B. Supported living residential.

1. Description. The service description shall be the same as set forth in 12VAC30-120-1036(A)(1).
2. Criteria. The criteria shall be the same as those set forth in 12VAC30-120-1036(A)(2).
3. Units and limits. Service units and limits shall be the same as those set forth in 12VAC30-120-1036(A)(3).
4. Provider requirements. Provider requirements shall be the same as those set forth in 12VAC30-120-1036(A)(4).

12VAC30-120-751. Shared living.

1. Service description. The service description shall be the same as that set forth in 12VAC30-120-1034(A)(1).
2. Criteria for covered services. The criteria shall be the same as those set forth in 12VAC30-120-1034(A)(2).
3. Allowable activities. Allowable activities shall be the same as those set forth in 12VAC30-120-1034(A)(3).
4. Covered services units and limits. Service units and limits shall be the same as those set forth in 12VAC30-120-1034(A)(4).
5. Provider requirements. Provider requirements shall be the same as those set forth in 12VAC30-120-1034(A)(5) and 12VAC30-120-1560(Q).

12VAC30-120-752. Group day services.

- A. Service description. The service description shall be the same as that set forth in 12VAC30-120-1026(A)(1).

- B. Criteria. The criteria shall be the same as those set forth in 12VAC30-120-1026(A)(2).
- C. Allowable activities shall be the same as those set forth in 12VAC30-120-1026(A)(3).
- D. Service units and service limitations. The service units and limits shall be the same as those set forth in 12VAC30-120-1026(A)(4).
- E. Provider requirements. Provider requirements shall be the same as those set forth in 12VAC30-120-1026(A)(5) and 12VAC30-120-500 et seq.

12VAC30-120-754. Group supported employment services; individual supported employment; workplace assistance services.

A. Group supported employment

- 1. Service description. The service description shall be the same as set forth in 12VAC30-120-1035(A).
- 2. Criteria for receipt of services. The criteria shall be the same as set forth in 12VAC30-120-1035(B)
- 3. Allowable activities shall be the same as those set forth in 12VAC30-120-1035(C).
- 4. Service units and service limitations. Service units and limits shall be the same as set forth in 12VAC30-120-1035(D).
 - a. The unit of service shall be one hour. Services shall not exceed 66 hours per week. The 66 hour weekly limit may include a combination of the following: group supported employment services, individual supported employment, community engagement, community coaching, workplace assistance services or group day services.
- 5. Group supported employment provider requirements. The provider requirements shall be the same as set forth in 12VAC30-120-1035(E).

B. Individual supported employment services.

- 1. Service description. The service description shall be the same as that set forth in 12VAC30-120-1035(A).
- 2. Criteria for receipt of services. The criteria shall be the same as those set forth in 12VAC30-120-1035(B).
- 3. Allowable activities. The allowable activities shall be the same as those set forth in 12VAC30-120-1035(C)
- 3. Service units and service limitations. The service units and limitations shall be the same as those set forth in 12VAC30-120-1035(D).
- 4. Provider requirements. The provider requirements shall be the same as those set forth in 12VAC30-120-500 et seq. and 12VAC30-120-1035(E).

C. Workplace assistance services.

1. Service description. The service description shall be the same as set forth in 12VAC30-120-1039(A).
2. Service criteria. The service criteria shall be the same as those set forth in 12VAC30-120-1039(B).
3. Allowable activities. The allowable activities shall be the same as those set forth in 12VAC30-120-1039(C).
3. Service units and service limitations. Service units and limits shall be the same as those set forth in 12VAC30-120-1039(D).
4. Provider requirements. Provider requirements shall be the same as those set forth in 12VAC30-120-500 et seq. and 12VAC30-120-1039(E).

12VAC30-120-755

12VAC30-120-755. [Reserved] [Benefits planning for 2017].

12VAC30-120-756. Therapeutic consultation.

- A. Service description. The service description shall be the same as that set forth in 12VAC30-120-1037(A).
- B. Criteria. The criteria shall be the same as those set forth in 12VAC30-120-1037(B).
- C. Service units and limits. Service units and limits shall be the same as those set forth in 12VAC30-120-1037(C).
- D. Allowable activities. Allowable activities shall be the same as those set forth in 12VAC30-120-1037(D).
- E. Provider requirements. Provider requirements shall be the same as those set forth in 12VAC30-120-1037(E).

12VAC30-120-758. Environmental modifications. (EM)

- A. Service description. The service description shall be the same as set forth in 12VAC30-120-1025(B)(1).
- B. Criteria. The criteria shall be the same as those set forth in 12VAC30-120-1025(B)(2).
- C. Service units and service limitations. The service units and limits shall be the same as those set forth in 12VAC30-120-1025(B)(3).

D. Provider requirements. Provider requirements shall be the same as those set forth in 12VAC30-120-1025(B)(4).

12VAC30-120-759. Services Facilitation.

A. Covered services; limits on covered services.

1. Services facilitation and consumer-directed service model. Service description. Individuals enrolled in the waiver may be approved to select the consumer-directed (CD) model of service delivery, absent any of the specified conditions that precludes such a choice, and may also receive support from a services facilitator. This shall be a separate waiver service to be used in conjunction with consumer-directed personal assistance, respite, or companion services and shall not be covered for an individual absent one of these consumer directed services.

a. Services facilitators shall train individuals enrolled in the waiver, family/caregiver, or EOR, as appropriate, to direct (such as select, hire, train, supervise, and authorize timesheets of) their own assistants who are rendering personal assistance, respite services, and companion services.

b. The services facilitator shall assess the individual's particular needs for a requested consumer-directed service, assist in the development of the Plan for Supports, provide management training for the individual or the EOR, as appropriate, on his responsibilities as employer, and provide ongoing support of the consumer-directed model of services. The service authorization for receipt of consumer directed services shall be based on the approved Plan for Supports.

c. The services facilitator shall make an initial comprehensive home visit to collaborate with the individual and the individual's family/caregiver, as appropriate, to identify the individual's needs, assist in the development of the Plan for Supports with the individual and the individual's family/caregiver, as appropriate, and provide employer management training to the individual and the family/caregiver, as appropriate, on his responsibilities as an employer, and provide ongoing support of the consumer-directed model of services. Individuals or EORs who are unable to receive employer management training at the time of the initial visit shall receive management training within seven days of the initial visit.

(1) The initial comprehensive home visit shall be completed only once upon the individual's entry into the consumer-directed model of service regardless of the number or type of consumer-directed services that an individual requests.

(2) If an individual changes services facilitators, the new services facilitator shall complete a reassessment visit in lieu of a comprehensive visit.

(3) The employer management training shall be completed before the individual or EOR may hire an assistant who is to be reimbursed by DMAS.

(4) After the initial visit, the services facilitator shall continue to monitor the individual's Plan for Supports quarterly (i.e., every 90 days) and more often as-needed. If consumer-directed respite services are provided, the services facilitator shall review the utilization of consumer-directed respite services either every six months or upon the use of 240 respite services hours, whichever comes first.

d. A face-to-face meeting shall occur between the services facilitator and the individual at least every six months to reassess the individual's needs and to ensure appropriateness of any consumer-directed services received by the individual. During these visits with the individual, the services facilitator shall observe, evaluate, and consult with the individual, EOR, and the individual's family/caregiver, as appropriate, for the purpose of documenting the adequacy and appropriateness of consumer-directed services with regard to the individual's current functioning and cognitive status, medical needs, and social needs. The services facilitator's written summary of the visit shall include, but shall not necessarily be limited to:

- (1) Discussion with the individual and EOR or family/caregiver, as appropriate, whether the particular consumer directed service is adequate to meet the individual's needs;
- (2) Any suspected abuse, neglect, or exploitation and to whom it was reported;
- (3) Any special tasks performed by the assistant/companion and the assistant's/companion's qualifications to perform these tasks;
- (4) Individual's and EOR's or family/caregiver's, as appropriate, satisfaction with the assistant's/companion's service;
- (5) Any hospitalization or change in medical condition, functioning, or cognitive status;
- (6) The presence or absence of the assistant/companion in the home during the services facilitator's visit; and
- (7) Any other services received and the amount.

e. The services facilitator, during routine visits, shall also review and verify timesheets as needed to ensure that the number of hours approved in the Plan for Supports is not exceeded. If discrepancies are identified, the services facilitator shall discuss these with the individual or the EOR to resolve discrepancies and shall notify the fiscal/employer agent. If an individual is consistently identified as having discrepancies in his timesheets, the services facilitator shall contact the support coordinator/case manager to resolve the situation. Failure to review and verify timesheets and maintain documentation of such reviews shall subject the provider to recovery of payments made by DMAS in accordance with 12VAC30-80-130.

f. The services facilitator shall maintain a record of each individual containing elements as set out in 12VAC30-120-770.

g. The services facilitator shall be available during standard business hours to the individual or EOR by telephone.

h. If a services facilitator is not selected by the individual, the individual or the family/caregiver serving as the EOR shall perform all of the duties and meet all of the requirements, including documentation requirements, identified for services facilitation. However, the individual or family/caregiver shall not be reimbursed by DMAS for performing these duties or meeting these requirements.

i. If an individual enrolled in consumer-directed services has a lapse in services facilitator duties for more than 90 consecutive days, and the individual or family/caregiver is not willing or able to assume the service facilitation duties, then the support coordinator/case manager shall notify

DMAS or its designated service authorization contractor and the consumer-directed services shall be discontinued once the required 10 days notice of this change has been observed. The individual whose consumer-directed services have been discontinued shall have the right to appeal this discontinuation action pursuant to 12VAC30-110. The individual shall be given his choice of an agency for the alternative personal care, respite, or companion services that he was previously obtaining through consumer direction.

j. The consumer-directed services facilitator, who is to be reimbursed by DMAS, shall not be the individual enrolled in the waiver, the individual's support coordinator/case manager, a direct service provider, the individual's spouse, a parent, including stepparents and legal guardians, of the individual who is a minor child, or the EOR who is employing the assistant/companion.

k. The services facilitator shall document what constitutes the individual's back-up plan in case the assistant/companion does not report for work as expected or terminates employment without prior notice.

l. Should the assistant/companion not report for work or terminate his employment without notice, then the services facilitator shall, upon the individual's or EOR's request, provide management training to ensure that the individual or the EOR is able to recruit and employ a new assistant/companion.

m. The limits and requirements for individuals' selection of consumer directed services shall be as follows:

(1) In order to be approved to use the consumer-directed model of services, the individual enrolled in the waiver, or if the individual is unable, the designated EOR, shall have the capability to hire, train, and fire his own assistants/companions and supervise the assistants'/companions' performance. Support coordinators/case managers shall document in the Individual Support Plan the individual's choice for the consumer-directed model and whether or not the individual chooses services facilitation. The support coordinator/case manager shall document in this individual's record that the individual can serve as the EOR or if there is a need for another person to serve as the EOR on behalf of the individual.

(2) An individual enrolled in the waiver who is younger than 18 years of age shall be required to have an adult responsible for functioning in the capacity of an EOR.

(3) Specific employer duties shall include checking references of assistants/companions, determining that assistants/companions meet specified qualifications, timely and accurate completion of hiring packets, training the assistants/companions, supervising assistants'/companions' performance, and submitting complete and accurate timesheets to the fiscal/employer agent on a consistent and timely basis.

B. Participation standards for provision of services; providers' requirements.

1. To be enrolled as a Medicaid CD services facilitator and maintain provider status, the services facilitator provider shall have sufficient resources to perform the required activities, including the ability to maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided. All CD services facilitators, whether employed by or contracted with a DMAS enrolled services facilitator provider, shall meet all of the qualifications set out in this subsection. To be enrolled, the

services facilitator shall also meet the combination of work experience and relevant education set out in this subsection that indicate the possession of the specific knowledge, skills, and abilities to perform this function. The services facilitator shall maintain a record of each individual containing elements as set out in this section.

a. If the services facilitator is not an RN, then, within 30 days from the start of such services, the services facilitator shall inform the primary health care provider for the individual enrolled in the waiver that consumer-directed services are being provided and request skilled nursing or other consultation as needed by the individual. Prior to contacting the primary health care provider, the services facilitator shall obtain the individual's written consent to make such contact or contacts. All such contacts and consultations shall be documented in the individual's medical record. Failure to document such contacts and consultations shall be subject to DMAS' recovery of payments made.

b. Prior to enrollment by DMAS as a consumer-directed services facilitator, applicants shall possess, at a minimum, either (i) an associate's degree from an accredited college in a health or human services field or be a registered nurse currently licensed to practice in the Commonwealth and two years of satisfactory direct care experience supporting individuals with disabilities or older adults or children or (ii) a bachelor's degree in a non-health or human services field and a minimum of three years of satisfactory direct care experience supporting individuals with disabilities or older adults or children.

c. All consumer-directed services facilitators, shall:

(1) Have a satisfactory work record as evidenced by two references from prior job experiences from any human services work; such references shall not include any evidence of abuse, neglect, or exploitation of the elderly or persons with disabilities or children;

(2) Submit to a criminal background check within 15 days of employment. The results of such check shall contain no record of conviction of barrier crimes as set forth in § 32.1-162.9:1 of the Code of Virginia. Proof that the criminal record check was conducted shall be maintained in the record of the services facilitator. In accordance with 12VAC30-80-130, DMAS shall not reimburse the provider for any services provided by a services facilitator who has been convicted of committing a barrier crime as set forth in § 32.1-162.9:1 of the Code of Virginia;

(3) Submit to a search of the DSS Child Protective Services Central Registry yielding no founded complaint; and

(4) Not be debarred, suspended, or otherwise excluded from participating in federal health care programs, as listed on the federal List of Excluded Individuals/Entities (LEIE) database at <http://www.olg.hhs.gov/fraud/exclusions/exclusions%20list.asp>.

d. The services facilitator shall not be compensated for services provided to the waiver individual after the initial or a subsequent background check verifies that the services facilitator (i) has been convicted of a barrier crime described in § 32.1-162.9:1 of the Code of Virginia; (ii) has a founded complaint confirmed by the VDSS Child Protective Services Central Registry; or (iii) is found to be listed on the LEIE.

e. All consumer-directed services facilitators providers and staff employed by consumer-directed services facilitator providers to function as a consumer-directed services facilitator shall

complete the DMAS-approved consumer-directed services facilitator training and pass the corresponding competency assessment with a score of at least 80% prior to being approved as a consumer-directed services facilitator or being reimbursed for working with waiver individuals. The competency assessment and all corresponding competency assessments shall be kept in the employee's record.

f. Failure to complete the competency assessment within the 90-day time limit and meet all other requirements shall result in a retraction of Medicaid payment or the termination of the provider agreement, or both.

g. As a component of the renewal of the provider agreement, all consumer-directed services facilitators shall take and pass the competency assessment every five years and achieve a score of at least 80%.

h. The consumer-directed services facilitator shall have access to a computer with secure Internet access that meets the requirements of 45 CFR Part 164 for the electronic exchange of information. Electronic exchange of information shall include, for example, checking individual eligibility, submission of service authorizations, submission of information to the fiscal employer agent, and billing for services.

i. All consumer-directed services facilitators shall possess a demonstrable combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills and abilities shall be documented on the application form, found in supporting documentation, or be observed during the job interview. Observations during the interview shall be documented. The knowledge, skills and abilities include:

(1) Knowledge of:

(a) Types of functional limitations and health problems that may occur in individuals with intellectual disability or individuals with other developmental disabilities, as well as strategies to reduce limitations and health problems;

(b) Physical assistance that may be required by individuals with developmental disabilities, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

(c) Equipment and environmental modifications that may be required by individuals with developmental disabilities that reduce the need for human help and improve safety;

(d) Various long-term care program requirements, including nursing home and ICF/IID placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal assistance, respite, and companion services;

(e) DD Waivers requirements, as well as the administrative duties for which the services facilitator will be responsible;

(f) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in service planning;

(g) Interviewing techniques;

(h) The individual's right to make decisions about, direct the provisions of, and control his consumer-directed personal assistance, companion and respite services, including hiring, training, managing, approving timesheets, and firing an assistant/companion;

(i) The principles of human behavior and interpersonal relationships; and

(j) General principles of record documentation.

(2) Skills in:

(a) Negotiating with individuals and the individual's family/caregivers, as appropriate, and service providers;

(b) Assessing, supporting, observing, recording, and reporting behaviors;

(c) Identifying, developing, or providing services to individuals with developmental disabilities; and

(d) Identifying services within the established services system to meet the individual's needs.

(3) Abilities to:

(a) Report findings of the assessment or onsite visit, either in writing or an alternative format, for individuals who have visual impairments;

(b) Demonstrate a positive regard for individuals and their families;

(c) Be persistent and remain objective;

(d) Work independently, performing position duties under general supervision;

(e) Communicate effectively, orally and in writing; and

(f) Develop a rapport and communicate with individuals of diverse cultural backgrounds.

3. The services facilitator's record about the individual shall contain:

a. Documentation of all employer management training provided to the individual enrolled in the waiver and the EOR, as appropriate, including the individual's or the EOR's, as appropriate, receipt of training on their responsibility for the accuracy and timeliness of the assistant's/companion's timesheets; and

b. All documents signed by the individual enrolled in the waiver or the EOR, as appropriate, which acknowledge their legal responsibilities as the employer.

12VAC30-120-760. Skilled nursing services; private duty nursing services.

A. Skilled nursing services.

1. Service description. The service description shall be the same as that set forth in 12VAC30-120-1031(A)(1).

2. Services criteria. The criteria shall be the same as that set forth in 12VAC30-120-1031(A)(2).
3. Allowable activities. Allowable activities shall be the same as that set forth in 12VAC30-120-1031(A)(3).
4. Skilled nursing services units and limits. Service units and limits shall be the same as that set forth in 12VAC30-120-1031(A)(4).
5. Skilled nursing services provider requirements. Provider requirements shall be the same as that set forth in 12VAC30-120-1031(A)(5).

B. Private duty nursing services.

1. Service description. The service description shall be the same as that set forth in 12VAC30-120-1031(B)(1).
2. Private duty nursing services criteria. The criteria shall be the same as those set forth in 12VAC30-120-1031(B)(2).
3. Private duty nursing services allowable activities. Allowable activities shall be the same as those set forth in 12VAC30-120-1031(B)(3).
4. Private duty nursing services service units and limits. Service units and limits shall be the same as those set forth in 12VAC30-120-1031(B)(4).
5. Private duty nursing services provider requirements. Provider requirements shall be the same as those set forth in 12VAC30-120-1031(B)(5).

12VAC30-120-761. Community engagement; community coaching; community guide (RESERVED).

A. Community engagement

1. Service description. The service description shall be the same as that set forth in 12VAC30-120-1022(A)(1).
2. Community engagement criteria. Criteria shall be the same as those set forth in 12VAC30-120-1022(A)(2).
3. Community engagement allowable activities. Allowable activities shall be the same as those set forth in 12VAC30-120-1022(A)(3).
4. Community engagement service units and service limits. Service units and limits shall be the same as those set forth in 12VAC30-120-1022(A)(4).
5. Community engagement provider requirements. Provider requirements shall be the same as those set forth in 12VAC30-120-1022(A)(5) and 12VAC30-120-1065(A).

B. Community coaching.

1. Service description. The service description shall be the same as that set forth in 12VAC30-120-1022(B)(1).
 2. Criteria. The criteria shall be the same as those set forth in 12VAC30-120-1022(B)(2).
 3. Allowable activities. The allowable activities shall be the same as those set forth in 12VAC30-120-1022(B)(3).
 4. Service units and limits. The service units and limits shall be the same as those set forth in 12VAC30-120-1022(B)(4).
 5. Provider requirements. The provider requirements shall be the same as those set forth in 12VAC30-120-1022(B)(5) and 12VAC30-120-1065(B).
- C. [RESERVED for community guide.]

12VAC30-120-762. Assistive technology. (AT)

- A. Service description. The service description is the same as set forth in 12VAC30-120-1021(A).
- B. Criteria. The criteria are the same as set forth in 12VAC30-120-1021(A)(1).
- C. Service units and service limitations. Service units and limitations are the same as those set forth in 12VAC30-120-1021(A)(2).
- D. Service requirements. Service requirements are the same as those set forth in 12VAC30-120-1021(A)(3).
- E. Provider requirements. Provider requirements are the same as those set forth in 12VAC30-120-1021(A)(4) and 12VAC30-120-1061(A) and (B).

12VAC30-120-764. Crisis support services (such as prevention, intervention, stabilization); center-based crisis supports; community-based crisis supports.

A. Service description.

1. Crisis support services. The service definition shall be the same as that set forth in 12VAC30-120-1024(A)(1).
 - a. Crisis prevention. The service description shall be the same as that set forth in 12VAC30-120-1024(A)(1)(a).
 - b. Crisis intervention. The service definition shall be the same as that set forth in 12VAC30-120(A)(1)(b).
 - c. Crisis stabilization. The service description shall be the same as that set forth in 12VAC30-120-1024(A)(1)(c) .

2. Center-based crisis supports. The service definition shall be the same as set forth in 12VAC30-120-1024(A)(2).

3. Community-based crisis supports. The service definition shall be the same as set forth in 12VAC30-120-1024(A)(3).

B. Criteria.

1. Crisis support services. The criteria shall be the same as those set forth in 12VAC30-120-1024(B)(1).

2. Center-based crisis supports. The criteria shall be the same as those set forth in 12VAC30-120-1024(B)(2).

3. Community-based crisis supports. The criteria shall be the same as those set forth in 12VAC30-120-1024(B)(3).

C. Allowable activities.

1. Crisis support services. Allowable activities shall be the same as those set forth in 12VAC30-120-1024(C)(1) through (C)(2).

2. Center-based crisis supports. Allowable activities shall be the same as those set forth in 12VAC30-120-1024(C)(3).

3. Community-based crisis supports. Allowable activities shall be the same as those set forth in 12VAC30-120-1024(C)(4).

D. Service units and limitations.

1. Crisis support services. Service units and limits shall be the same as those set forth in 12VAC30-120-1024(D)(1).

2. Center-based crisis supports. Service units and limits shall be the same as those set forth in 12VAC30-120-1024(D)(2).

3. Community-based crisis supports. Service units and limits shall be the same as those set forth in 12VAC30-120-1024(D)(3).

E. Provider requirements. Provider requirements shall be the same as those set forth in 12VAC30-120-1024 and 12VAC30-120-1063.

12VAC30-120-766. Personal assistance, respite services, and companion services.

A. Personal Assistance Services.

1. Service description. The service description for personal assistance services shall be the same as that set forth in 12VAC30-120-1029(B).

2. Criteria. The criteria for personal assistance services shall be the same as those set forth in 12VAC30-120-1029(C).

3. Allowable activities. Allowable activities for personal assistance services are the same as those set forth in 12VAC30-120-1029(C)(3).

4. Service units and limits. Service units and limits for personal assistance are the same as those set forth in 12VAC30-120-1029(D).

5. Provider requirements. Provider requirements for personal assistance are the same as those set forth in 12VAC30-120-1029(E) and 12VAC30-120-1062.

B. Respite Services.

1. Service description. The service description shall be the same as that set forth in 12VAC30-120-1032(A).

2. The criteria for respite services shall be the same as those set forth in 12VAC30-120-1032(B).

3. Allowable activities for respite services shall be the same as those set forth in 12VAC30-120-1032(C).

4. Service units and limits. Service units and limits for respite services shall be the same as those set forth in 12VAC30-120-1032(D).

5. Provider requirements for respite services shall be the same as those set forth in 12VAC30-120-1032(E) and 12VAC30-120-1062.

C. Companion Services

1. Service description. The service description shall be the same as that set forth in 12VAC30-120-1023(A).

2. Criteria. The criteria shall be the same as those set forth in 12VAC30-120-1023(B).

3. Service units and service limitations. The service units and limits shall be the same as those set forth in 12VAC30-120-1023(C).

4. Provider requirements. The provider requirements shall be the same as those set forth in 12VAC30-120-1023(D) and 12VAC30-120-1062.

12VAC30-120-770. Consumer-directed model of service delivery.

A. Criteria.

1. The FIS Waiver has three services, companion, personal care, and respite services, that may be provided through a consumer-directed model.
2. Individuals who are eligible for consumer-directed services must have the capability to hire, train, and fire their consumer-directed employees and supervise the employee's work performance. If an individual is unable to direct his own care or is younger than 18 years of age, a family/caregiver may serve as the employer on behalf of the individual.
3. Responsibilities as employer. The individual, or if the individual is unable, then a family/caregiver, is the employer in this service and is responsible for hiring, training, supervising, and firing employees. Specific duties include checking references of employees, determining that employees meet basic qualifications, training employees, supervising the employees' performance, and submitting timesheets to the fiscal agent on a consistent and timely basis. The individual or his family/caregiver, as appropriate, must have an emergency back-up plan in case the employee does not show up for work.
4. DMAS shall contract for the services of a fiscal agent for consumer-directed personal care, companion, and respite care services. The fiscal agent will be paid by DMAS to perform certain tasks as an agent for the individual/employer who is receiving consumer-directed services. The fiscal agent will handle responsibilities for the individual for employment taxes. The fiscal agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services in order to fulfill all of these duties.
5. Individuals choosing consumer-directed services must receive support from a CD services facilitator. Services facilitators assist the individual or his family/caregiver, as appropriate, as they become employers for consumer-directed services. This function includes providing the individual or his family/caregiver, as appropriate, with management training, review and explanation of the Employee Management Manual, and routine visits to monitor the employment process. The CD services facilitator assists the individual/employer with employer issues as they arise. The services facilitator meeting the stated qualifications may also complete the assessments, reassessments, and related supporting documentation necessary for consumer-directed services if the individual or his family/caregiver, as appropriate, chooses for the CD services facilitator to perform these tasks rather than the case manager. Services facilitation services are provided on an as-needed basis as determined by the individual, family/caregiver, and CD services facilitator. This must be documented in the supporting documentation for consumer-directed services and the services facilitation provider bills accordingly. If an individual enrolled in consumer-directed services has a lapse in consumer-directed services for more than 60 consecutive calendar days, the case manager shall notify DBHDS so that consumer-directed services may be discontinued and the option given to change to agency-directed services.

B. Provider qualifications. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, services facilitators providers must meet the following qualifications:

1. To be enrolled as a Medicaid CD services facilitation provider and maintain provider status, the CD services facilitation provider must operate from a business office and have sufficient qualified staff who will function as CD services facilitators to perform the service facilitation and support activities as required. It is preferred that the employee of the CD services facilitation provider possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth. In addition, it is preferable that the CD services facilitator has two years of satisfactory experience in the human services field working with individuals with related conditions.

2. The CD services facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills, and abilities must be documented on the application form, found in supporting documentation, or be observed during the job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

a. Knowledge of:

(1) Various long-term care program requirements, including nursing home, ICF/IID, and assisted living facility placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal care services;

(2) DMAS consumer-directed services requirements, and the administrative duties for which the individual will be responsible;

(3) Interviewing techniques;

(4) The individual's right to make decisions about, direct the provisions of, and control his consumer-directed services, including hiring, training, managing, approving time sheets, and firing an employee;

(5) The principles of human behavior and interpersonal relationships; and

(6) General principles of record documentation.

(7) For CD services facilitators who also conduct assessments and reassessments, the following is also required. Knowledge of:

(a) Types of functional limitations and health problems that are common to different disability types and the aging process as well as strategies to reduce limitations and health problems;

(b) Physical assistance typically required by people with developmental disabilities, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

(c) Equipment and environmental modifications commonly used and required by people with developmental disabilities that reduces the need for human help and improves safety; and

(d) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in care planning.

b. Skills in:

- (1) Negotiating with individuals or their family/caregivers, as appropriate, and service providers;
- (2) Observing, recording, and reporting behaviors;
- (3) Identifying, developing, or providing services to persons with developmental disabilities; and
- (4) Identifying services within the established services system to meet the individual's needs.

c. Abilities to:

- (1) Report findings of the assessment or onsite visit, either in writing or an alternative format for persons who have visual impairments;
- (2) Demonstrate a positive regard for individuals and their families;
- (3) Be persistent and remain objective;
- (4) Work independently, performing position duties under general supervision;
- (5) Communicate effectively, orally and in writing;
- (6) Develop a rapport and communicate with different types of persons from diverse cultural backgrounds; and
- (7) Interview.

3. If the CD services facilitator is not an RN, the CD services facilitator must inform the primary health care provider that services are being provided and request skilled nursing or other consultation as needed.

4. Initiation of services and service monitoring.

a. If the services facilitator has responsibility for individual assessments and reassessments, these must be conducted as specified in 12VAC30-120-766 and 12VAC30-120-776.

b. Management training.

(1) The CD services facilitation provider must make an initial visit with the individual or his family/caregiver, as appropriate, to provide management training. The initial management training is done only once upon the individual's entry into the service. If an individual served under the waiver changes CD services facilitation providers, the new CD services facilitator must bill for a regular management training in lieu of initial management training.

(2) After the initial visit, two routine visits must occur within 60 days of the initiation of care or the initial visit to monitor the employment process.

(3) For personal care services, the CD services facilitation provider will continue to monitor on an as needed basis, not to exceed a maximum of one routine visit every 30 calendar days but no less than the minimum of one routine visit every 90 calendar days per individual. After the initial

visit, the CD services facilitator will periodically review the utilization of companion services at a minimum of every six months and for respite services, either every six months or upon the use of 300 respite care hours, whichever comes first.

5. The CD services facilitator must be available to the individual or his family/caregiver, as appropriate, by telephone during normal business hours, have voice mail capability, and return phone calls within 24 hours or have an approved back-up CD services facilitator.

6. The CD services fiscal contractor for DMAS must submit a criminal record check within 15 calendar days of employment pertaining to the consumer-directed employees on behalf of the individual or family/caregiver and report findings of the criminal record check to the individual or his family/caregiver, as appropriate.

7. The CD services facilitator shall verify bi-weekly timesheets signed by the individual or his family caregiver, as appropriate, and the employee to ensure that the number of plan of care approved hours are not exceeded. If discrepancies are identified, the CD services facilitator must contact the individual to resolve discrepancies and must notify the fiscal agent. If an individual is consistently being identified as having discrepancies in his timesheets, the CD services facilitator must contact the case manager to resolve the situation.

8. Consumer-directed employee registry. The CD services facilitator must maintain a consumer-directed employee registry, updated on an ongoing basis.

9. Required documentation in individuals' records. CD services facilitators responsible for individual assessment and reassessment must maintain records as described in 12VAC30-120-766 and 12VAC30-120-776. For CD services facilitators conducting management training, the following documentation is required in the individual's record:

a. All copies of the plan of care, all supporting documentation related to consumer-directed services, and all DMAS-225 forms.

b. CD services facilitator's notes recorded and dated at the time of service delivery.

c. All correspondence to the individual, to others concerning the individual, and to DMAS and DBHDS.

d. All training provided to the consumer-directed employees on behalf of the individual or his family/caregiver, as appropriate.

e. All management training provided to the individuals or his family/caregivers, as appropriate, including the responsibility for the accuracy of the timesheets.

f. All documents signed by the individual or his family/caregiver, as appropriate, that acknowledge the responsibilities of the services.

12VAC30-120-773. Electronic-based home supports (EBHS).

A. Service description. The service description shall be the same as that set forth in 12VAC30-120-1025(A)(1).

B. Criteria. The criteria shall be the same as those set forth in 12VAC30-120-1025(A)(2).

C. Service limits and service limitations. The service limits and units shall be the same as those set forth in 12VAC30-120-1025(A)(3).

D. Provider requirements. The provider requirements shall be the same as those set forth in 12VAC30-120-1025(A)(4).

12VAC30-120-774. Personal emergency response system (PERS).

A. Service description. The service description shall be the same as set forth in 12VAC30-120-1030(A)(1).

B. Criteria. The criteria shall be the same as set forth in 12VAC30-120-1030(A)(2).

C. Service units and service limitations. Service units and limits shall be the same as set forth in 12VAC30-120-1030(A)(3).

D. Provider requirements. Provider requirements shall be the same as those set forth in 12VAC30-120-1030(A)(4) and 12VAC30-120-1560(P).

12VAC30-120-775. Transition services.

Transition services shall be consistent with the requirements and limits set out in 12VAC30-120-1038, 12VAC30-120-2000 and 12VAC30-120-2010 .

12VAC30-120-777. Companion services (both consumer-directed and agency-directed).

A. Service description. The service description shall be the same as that set forth in 12VAC30-120-1023(A).

B. Criteria. The criteria shall be the same as those set forth in 12VAC30-120-1023(B).

C. Service units and limits. The service units and limits shall be the same as those set forth in 12VAC30-120-1023(C).

D. Provider requirements. The provider requirements shall be the same as those set forth in 12VAC30-120-1023(D) and 12VAC30-120-1062.

12 VAC 30-120-778. [RESERVED for non-medical transportation.]

12VAC30-120-779. Individual and family/caregiver training.

A. Service description. This service provides training and counseling services to individuals, families, or caregivers of individuals enrolled in the waiver including participation in education opportunities designed to improve the family's or caregiver's ability to care for and support the individual enrolled in the waiver. This service shall also provide educational opportunities for the individual to better understand his disability, and increase his self-determination and self-advocacy.

B. Criteria. Any individuals who are enrolled in this waiver and their family/caregivers, as appropriate, may participate in this service. DMAS shall cover this service as authorized by the individual's Plan for Supports.

C. Service units and limits.

1. This service may be authorized for up to 80 hours per ISP year.
2. Travel and room and board expenses shall not be covered.

D. Provider requirements.

1. Providers shall have a signed, current provider participation agreement with DMAS in order to be reimbursed for providing individual and family/caregiver training.
2. Providers shall have the necessary licensure/certification as required for their profession (i.e., RNs shall have a current license to practice nursing in the Commonwealth or hold a multi-state licensure privilege).
3. This service shall be provided by enrolled provider entities with expertise in, experience in, or demonstrated knowledge of the training topic set out in the Plan for Supports.
4. This service may be provided through seminars and conferences organized by the enrolled provider entities.
5. This service may also be provided by individual practitioners who have experience in or demonstrated knowledge of the training topics. This may include psychologists, teachers/educators, social workers, medical personnel, personal care providers, therapists, and providers of other services such as day and residential supports.
6. Qualified provider types include:
 - a. Staff of home health agencies;
 - b. Staff of community developmental disabilities services agencies;
 - c. Staff of developmental disabilities residential providers;
 - d. Staff of community mental health centers;
 - e. Staff of public health agencies, hospitals, clinics, or other agencies/organizations;
 - f. Individual practitioners including licensed or certified personnel such as RNs, LPNs, psychologists, speech/language therapists, occupational therapists, physical therapists, licensed clinical social workers, licensed behavior analysts (BCBAs), and persons with other education,

training, or experience directly related to the specified needs of the individual as set out in the ISP.

12VAC30-120-782. Payment for services.

A. All shared living, supported living residential, in-home supports, group day services, community engagement, community coaching, workplace assistance services, personal assistance (both agency-directed and consumer-directed), respite services (both agency directed and consumer directed), skilled nursing, private duty nursing, therapeutic consultation, center-based crisis support services, community-based crisis support services, crisis support services, PERS, environmental modifications, assistive technology, companion (both agency-directed and consumer-directed), individual and family/caregiver training, consumer-directed services facilitation, and transition services provided in this waiver shall be reimbursed consistent with DMAS' service limits and payment amounts as set out in the fee schedule.

B. Reimbursement rates for individual supported employment shall be the same as set by the Department for Aging and Rehabilitative Services for the same services. Reimbursement rates for group supported employment shall be as set by DMAS.

C. All EHBS, AT and EM covered procedure codes provided in the FIS Waiver shall be reimbursed as a service limit of one. The maximum Medicaid funded expenditure per individual for all AT and EM covered procedure codes (combined total of AT and EM items and labor related to these items) shall be \$5,000 each for AT and \$5,000 for EM per calendar year. The maximum expenditure for EHBS shall be \$5,000 per calendar year. No additional provider mark-ups shall be permitted.

D. Duplication of services.

1. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the ADA (42 USC §§ 12131 through 12165), the Rehabilitation Act of 1973, the Virginians with Disabilities Act, or any other applicable statute.

2. Payment for services under the ISP shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

3. Payment for services under the ISP shall not be made for services that are duplicative of each other.

4. Payments for services shall only be provided as set out in the individuals' ISPs.

12VAC30-120-1000

Part X

Community Living (CL) Waiver

Article 1

Definitions and General Requirements

12VAC30-120-1000. Definitions.

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

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

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

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

"Assistive technology" or "AT" means specialized medical equipment and supplies, including those devices, controls, or appliances specified in the Individual Support Plan but not available under the State Plan for Medical Assistance, which enable individuals to increase their abilities to perform ADLs, or to perceive, control, or communicate with the environment in which they live, or that are necessary to the proper functioning of the specialized equipment.

"Barrier crime" means those crimes listed in §§ 32.1-162.9:1, 37.2-314, 37.2-416, 37.2-506, 37.2-607, and 63.2-1719 of the Code of Virginia.

"Behavioral health authority" or "BHA" means same as defined in § 37.2-100 of the Code of Virginia.

"Case manager" means the person who delivers the support coordination/case management services set out in 12 VAC 30-50-455.

"Center-based crisis support services" means crisis prevention and stabilization in a crisis therapeutic home using planned and emergency admissions. They are designed for those individuals who need on-going crisis supports.

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

"Challenging behavior" means culturally abnormal behaviors of such intensity, frequency, and duration that the physical safety of the individual or others is placed in serious jeopardy or that the behavior limits access to ordinary community facilities. These behaviors include withdrawal, self-injury, injury to others, aggression, or self-stimulation.

Community-based crisis support services" means services to individuals who are experiencing crisis events putting them at risk for homelessness, incarceration, hospitalization or danger to themselves or others. This service shall provide ongoing supports to individuals in their homes and in community settings.

"Community coaching" means a service designed for individuals who need one-to-one support in order to develop a specific skill to address barriers preventing that individual from participating in the community engagement services.

"Community engagement" means services that support and foster individuals' abilities to acquire, retain, or improve skills necessary to build positive social behavior, interpersonal competence, greater independence, employability, and personal choice necessary to access typical activities and functions of community life such as those chosen by the general population.

"Community Living" or "CL" waiver means the waiver set out in 12 VAC 30-120-1000 et. seq.

"Community services board" or "CSB" means the same as defined in §37.2-100 of the Code of Virginia.

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

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

"Consumer-directed attendant" or "CD attendant" means a person who provides via the consumer-directed model of services, person assistance services, companion services, or respite services, or any combination of these three services, and who is also exempt from workers' compensation.

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

"Crisis support services" means intensive supports by trained and, where applicable, licensed staff in crisis prevention, crisis intervention, and crisis stabilization to an individual who is experiencing an episodic behavioral or psychiatric event in the community which has the potential to jeopardize the current community living situation.

"DARS" means the Department for the Aging and Rehabilitative Services.

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

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

"Developmental disability" or "DD" means the same as defined in §37.2-100 of the Code of Virginia.

"Direct marketing" means either (i) conducting directly or indirectly door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; (ii) mailing directly; (iii)

paying "finders' fees"; (iv) offering financial incentives, rewards, gifts, or special opportunities to eligible individuals and the individual's family/caregivers, as appropriate, as inducements to use the providers' services; (v) continuous, periodic marketing activities to the same prospective individual and the individual's family/caregiver - for example, monthly, quarterly, or annual giveaways as inducements to use the providers' services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of the providers' services or other benefits as a means of influencing the individual's and the individual's family/caregivers use of the providers' services.

"Direct support professional" or "DSP" means staff members identified by the provider as having the primary role of assisting an individual on a day-to-day basis with routine personal care needs, social support, and physical assistance in a wide range of daily living activities so that the individual can lead a self-directed life in his own community.

"DMAS" means the Department of Medical Assistance Services.

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

"DSS" means the Virginia Department of Social Services.

"Electronic home-based supports" or "EHBS" means goods and services based on current technology, such as Smart Home ©, and includes purchasing electronic devices, software, services and supplies not otherwise covered through other benefits in this waiver or through the State Plan that allows individuals to use technology in their residences to achieve greater independence, self-determination and reduce the need for human intervention.

"Employer of record" or "EOR" means the person who performs the functions of the employer in the consumer directed model of service delivery. The EOR may be the individual enrolled in the waiver, a family member, a caregiver or another designated person.

"Enroll" means the same as defined in 12VAC30-120-510.

"Environmental modifications" or "EM" means physical adaptations to the individual's home or primary vehicle, that are necessary to ensure the individual's health and welfare or enable functioning with greater independence.

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

"Face-to-face visit" means an in-person meeting between the support coordinator/case manager and individual, and family/caregiver, as appropriate, for the purpose of assessing the individual's status and determining satisfaction with services, including the need for additional services and supports.

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

"Freedom of choice" means the same as defined in §1902(a)(23) of the Social Security Act.

"General supports" means staff presence to ensure that appropriate action is taken in an emergency or an unanticipated event and includes: (i) awake staff during nighttime hours; (ii) routine bed checks; (iii) oversight of unstructured activities; (iv) asleep staff at night on premises for security or safety reasons, or both, or; (v) on-call staff.

"Group day services" means services for the individual to acquire, retain, or improve skills of self-help, socialization, community integration, employability and adaptation via opportunities for peer interactions, community integration, and enhancement of social networks.

"Group home residential services" means skill-building, routine supports, general supports, and safety supports that are provided primarily in a licensed residence which enable the individual to acquire, retain, or improve skills necessary to successfully live in the community.

"Group supported employment services" means continuous support provided by staff in a naturally occurring place of employment to groups of two to eight individuals with developmental disabilities and involves interactions with the public and coworkers who do not have developmental disabilities.

"Health, safety, and welfare standard" means the standard that is applied when an individual who is enrolled in a DD waiver requests additional waiver services. It is the standard applied to ensure that an individual's right to receive a waiver service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria and a written, approved individual Plan for Supports, and that services can be safely provided in the community.

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

"ICF/IID" means a facility or distinct part of a facility licensed by DBHDS and meeting the federal certification regulations for an Intermediate Care Facility for Individuals with Intellectual Disabilities and individuals with related conditions and that addresses the total needs of the residents individuals, which include physical, intellectual, social, emotional, and habilitation, ~~providing~~ and provides active treatment as defined in 42 CFR 483.440.

"Individual" means the same as defined in 12VAC30-120-510.

"Individual supported employment" means one-on-one ongoing supports that enable individuals, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, to work in an integrated setting.

"Individual Support Plan" or "ISP" means a comprehensive, person-centered plan that sets out the supports and actions to be taken during the year by each service provider, as detailed in ~~the~~ each service provider's Plan for Supports, which are part of the ISP, to achieve desired outcomes. The Individual Support Plan shall be developed collaboratively by the individual enrolled in the waiver, the individual's family/caregiver, as appropriate, other service providers, the support coordinator/case manager, and other interested parties chosen by the individual, and shall contain the DMAS-approved ISP components.

"In-home support services" means residential services that take place in the individual's home, family home, or community settings that typically supplement the primary care provided by the individual, family, or other unpaid caregiver and are designed to ensure the health, safety and welfare of the individual.

"Instrumental activities of daily living" or "IADLs" means complex skills needed to successfully live independently such as meal preparation, shopping, housekeeping, laundry, and money management.

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

"LMHP" means a licensed mental health professional as defined in 12 VAC 35-105-20.

"LMHP-resident" means the same as defined in 12 VAC 30-50-130.

"LMHP-RP" means the same as defined in 12 VAC 30-50-130.

"LMHP-supervisee" means the same as defined in 12 VAC 30-50-130.

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

"Medically necessary" means an item or service provided for the diagnosis or treatment of an individual's condition consistent with community standards of medical practice as determined by DMAS and in accordance with Medicaid policy.

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

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

"Pend" means delaying the consideration of an individual's request for authorization of services until all required information is received by DMAS or its designee.

"Person-centered planning" means a fundamental process that focuses on what is important to and for an individual, and on the needs and preferences of the individual to create an Individual Support.

"Personal assistance services" means direct support with ADLs, IADLs, access to the community, monitoring of self-administration of medication or other medical needs, and the monitoring of health status and physical condition or work or post-secondary school related personal assistance.

"Personal assistant" means a person who provides personal assistance services employed by a provider agency.

"Personal emergency response system" or "PERS" means an electronic device and monitoring service that enable certain individuals at high risk of institutionalization to secure help in an emergency.

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

"Plan for Supports" means each service provider's plan for supporting the individual enrolled in the waiver in achieving his desired outcomes and facilitating the individual's health and safety. The Plan for Supports is one component of the Individual Support Plan.

"Positive behavior support" means an applied science that uses educational methods to expand an individual's behavior repertoire and systems change methods to redesign an individual's living environment to enhance the individual's quality of life and minimize his challenging behaviors.

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

"Private duty nursing services" means individual and continuous nursing care to individuals that may be provided, concurrently with other services, due to the medical nature of supports required by individuals who have a serious medical condition or complex health care needs, or both, and which has been certified by a physician as medically necessary to enable the individual to remain at home rather than in a hospital, nursing facility, or ICF/IID.

"Progressive condition" means disease or health condition that gets worse over time, resulting in general decline in health or function, including aging.

"Qualified developmental disabilities professional" or "QDDP" means a professional who (i) possesses at least one year of documented experience working directly with individuals who have developmental disabilities; (ii) is one of the following: a doctor of medicine or osteopathy, a registered nurse, a provider holding at least a bachelor's degree in a human service field including, but not limited to, sociology, social work, special education, rehabilitation engineering, counseling, or psychology, or a provider who has documented equivalent qualifications; and (iii) possesses the required Virginia or national license, registration, or certification in accordance with his profession, if applicable.

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

"Respite services" means temporary, substitute care that is normally provided by the family or other unpaid, primary caregiver who resides in the same home as the individual. Services shall be provided on a short-term basis due to the emergency absence of or need for routine or periodic relief of the primary caregiver.

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

"Routine supports" means supports that assist the individual with daily activities.

"Safety supports" means specialized assistance that is required to ensure an individual's health and safety.

"Service authorization" means the process to approve specific services for an enrolled Medicaid individual by a DMAS service authorization designee prior to service delivery and reimbursement in order to validate that the service requested is medically necessary and meets DMAS requirements for reimbursement. Service authorization does not guarantee payment for the service.

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

"Services facilitator" means a DMAS-enrolled provider or DMAS-designated entity or one who is employed by or contracts with a DMAS-enrolled services facilitator, who is responsible for supporting the individual or EOR, as appropriate, by ensuring the development and monitoring of the Plans for Support for consumer-directed model of services, providing employee management training, and completing ongoing review activities as required by the DMAS-approved consumer-directed model of services. "Services facilitator" shall be deemed to mean the same thing as "consumer-directed services facilitator."

"Shared living" means an arrangement in which a roommate resides in the same household as the individual receiving waiver services and provides an agreed-upon, limited amount of supports. In exchange for providing the agreed-upon support, a portion of the total cost of rent, food, and utilities that can be reasonably attributed to the live-in roommate is reimbursed to the individual.

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

"Skill building supports" means those supports that help the individual gain new skills and abilities and was previously called training.

"Skilled nursing services" means nursing services (i) listed in the plan of care that do not meet home health criteria, (ii) required to prevent institutionalization, (iii) not otherwise available under the State Plan for Medical Assistance, (iv) provided within the scope of the state's Nursing Act (§ 54.1-3000 et seq. of the Code of Virginia) and Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia), and (v) provided by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse who is licensed to practice in the state. Skilled

nursing services are to be used to provide training, consultation, nurse delegation as appropriate, and oversight of direct care staff as appropriate.

"Sponsored residential services" means residential services that consist of skill-building, routine supports, general supports, and safety supports provided in the homes of families or persons (sponsors) providing supports under the supervision of a DBHDS-licensed provider that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community settings.

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

"Support coordination/case management" means the same as defined in 12VAC30-50-455(D).

"Support coordinator/case manager" means the person who provides support coordination/case management services to an individual in accordance with 12VAC30-50-455.

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

"Supported living residential services" means a service taking place in an apartment setting operated by a DBHDS-licensed provider that consist of skill-building, routine supports, general supports, and safety supports that enable the individual to acquire, retain, or improve self-help, socialization, and adaptive skills necessary to successfully live in home and community settings.

"Supporting documentation" means the same as defined in 12VAC30-120-510.

"Supports Intensity Scale®" or "SIS" means the same as defined in 12VAC30-120-510.

"Therapeutic consultation" means professional consultation provided by members of psychology, social work, rehabilitation engineering, behavioral analysis, speech therapy, occupational therapy, psychiatry, psychiatric clinical nursing, therapeutic recreation, physical therapy, or behavior consultation disciplines that are designed to assist individuals, parents, family members, and any other providers of support services with implementing the Individual Support Plan.

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

"Transition services" means the same as defined in 12VAC30-120-2010.

"Workplace assistance services" means supports provided to an individual who has completed job development and has completed or nearly completed job placement training (i.e., supported employment) but requires more than typical job coach services to maintain stabilization in their employment.

12VAC30-120-1005. Waiver service population and provider requirements.

A. Waiver service populations. These waiver services shall be provided for the following individuals who have been determined to require the level of care provided in an ICF/IID:

1. Individuals with DD.

B. Core competency requirements for direct support professionals (DSPs) and their supervisors in programs licensed by DBHDS shall be the same as those set forth in 12VAC30-120-515 (A).

C. Core competency requirements for support coordinators/case managers (RESERVED)

D. Core competency requirements for QDDPs. (RESERVED)

E. Advanced core competency requirements for DSPs and DSP supervisors serving individuals with developmental disabilities with the most intensive needs as identified by assignment to levels 5, 6, or 7 shall be the same as those set forth in 12VAC30-120-515 (D).

F. Provider enrollment requirements shall be the same as those set forth in 12VAC30-120-514.

G. Documentation requirements shall be the same as those set forth in 12VAC30-120-514(Q).

H. Reevaluation of service need requirements shall be the same as those set forth in 12VAC30-120-515(F).

I. Utilization review requirements shall be the same as those set forth in 12VAC30-120-515(G).

12VAC30-120-1020. Covered services: list of covered services.

A. Covered services in the CL Waiver include: assistive technology, center-based crisis supports services, community-based crisis support services, community coaching, community engagement, companion services (both consumer-directed and agency-directed), crisis support services, electronic home-based supports (EHBS), environmental modifications, group day services, group home residential services, group supported employment, individual supported employment, in-home support services, personal assistance services (both consumer-directed and agency-directed), personal emergency response systems (PERS), private duty nursing, respite services (both consumer-directed and agency-directed), services facilitation (only for consumer-directed services), shared living, skilled nursing services, sponsored residential services, supported living residential services, therapeutic consultation, transition services, and workplace assistance services.

12VAC30-120-1021. Covered services: assistive technology (in FIS, CL, BI) and RESERVED FOR benefits planning (in FIS, CL, BI).

A. Assistive technology (AT). Service description. This service shall entail the provision of specialized medical equipment and supplies including those devices, controls, or appliances, specified in the Individual Support Plan but which are not available under the State Plan for Medical Assistance, that (i) enable individuals to increase their abilities to perform activities of daily living (ADLs); (ii) enable individuals to perceive, control, or communicate with the

environment in which they live; or (iii) are necessary for life support, including the ancillary supplies and equipment necessary to the proper functioning of such items.

1. Criteria. In order to qualify for these services, the individual shall have a demonstrated need for equipment for remedial or direct medical benefit primarily in the individual's primary home, primary vehicle, community activity setting, or day program to specifically improve the individual's personal functioning. AT shall be covered in the least expensive, most cost-effective manner. The equipment and activities shall include:

- a. Specialized medical equipment, ancillary equipment, and supplies necessary for life support;
- b. Durable or non-durable medical equipment and supplies that are not otherwise available through the State Plan for Medical Assistance;
- c. Adaptive devices, appliances, and controls which enable an individual to be independent in areas of personal care and ADLs; and
- d. Equipment and devices which enable an individual to communicate more effectively.

2. Service units and service limitations. AT shall be available to individuals who are receiving at least one other waiver service and may be provided in a setting described above in subparagraph (A)(1). Only the AT services set out in the ISP shall be covered by DMAS. AT shall be service authorized by the state-designated agency or its designee for each calendar year with no carry-over of unspent funds across calendar years.

a. The maximum funded expenditure per individual for all AT covered procedure codes (combined total of AT items and labor related to these items) shall be \$5,000 per calendar year. The service unit shall always be one for the total cost of all AT being requested for a specific timeframe.

b. AT shall not be approved for purposes of convenience of the caregiver or restraint of the individual.

3. Service requirements.

a. An independent professional consultation to determine the level of need, that is not performed by the AT provider, shall be obtained from staff knowledgeable of that item for each AT request prior to approval by the state-designated agency or its designee. Equipment, supplies, or technology not available as durable medical equipment through the State Plan may be purchased and billed as AT as long as the request for such equipment, supplies, or technology is documented and justified in the individual's ISP, recommended by the support coordinator/case manager, service authorized by the state-designated agency or its designee, and provided in the least expensive, most cost-effective manner possible.

b. All AT items to be covered shall meet applicable standards of manufacture, design, and installation.

c. The AT provider shall obtain, install, and demonstrate, as necessary, such service authorized AT prior to submitting his claim to DMAS for reimbursement. The provider shall provide all warranties or guarantees from the AT's manufacturer to the individual and family/caregiver, as appropriate.

- d. AT providers shall not be the spouse or parents of the individual enrolled in the waiver.
- e. Requests for AT services shall be denied if waiver services are available for children under EPSDT (12VAC30-50-130). No duplication of payment for AT services shall be permitted between the waiver and services covered for adults that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act, and the Rehabilitation Act.

4. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-500 et seq., and 12VAC30-120-1061(A) and (B).

B. Benefits planning. [RESERVED]

12VAC30-120-1022. Covered services: community engagement; community coaching; [RESERVED for community guide].

A. Community engagement service description.

1. Community engagement means services which support and foster individuals' abilities to acquire, retain, or improve skills necessary to build positive social behavior, interpersonal competence, greater independence, employability, and personal choices necessary to access typical activities and functions of community life such as those chosen by the general population. These may include community education or training and volunteer activities. Community engagement provides a wide variety of opportunities to facilitate and build relationships and natural supports in the community, while utilizing the community as a learning environment. These activities are conducted at naturally occurring times and in a variety of natural settings in which the individual actively interacts with persons without disabilities (other than those paid to support the individual). The activities enhance the individual's involvement with the community and facilitate the development of natural supports. This service shall be provided in the least restrictive and most integrated settings possible according to the individual's Plan for Supports and individual choice. Community engagement is a tiered service for reimbursement purposes.

2. Community engagement criteria. Individuals who are authorized for community engagement shall have a Plan for Supports.

3. Community engagement allowable activities include:

a. Skill building, education, support and monitoring that assists the individual with the acquisition and retention of skills in the following areas: (i) activities and public events in the community; (ii) community educational activities and events; (iii) interests and activities that encourage therapeutic use of leisure time; (iv) volunteer experiences; and (vi) maintaining contact with family and friends.

b. Skill building and education in self-direction designed to enable the individual to achieve one or more of the following outcomes particularly through community collaborations and social connections developed by the provider (e.g., partnerships with community entities such as senior centers, arts councils, etc.): (i) development of self-advocacy skills; (ii) exercise of civil rights;

(iii) acquisition of skills that promote the ability to exercise self-control and responsibility over services and supports received or needed; (iv) acquisition of skills that enable the individual to become more independent, integrated, or productive in the community; (v) development of communication skills and abilities; (vi) furthering spiritual practices; (vii) participation in cultural activities; (viii) developing skills that enhance career planning goals in the community; (ix) development of living skills; (x) promotion of health and wellness; (xi) development of orientation to the community, mobility, and the ability to achieve the desired destination; (xii) access to and utilization of public transportation; or (xiii) interaction with volunteers from the community in program activities.

4. Community engagement service units and service limits. Service authorization shall be required.

a. The unit of service shall be one hour.

b. Community engagement services alone or in combination with group day, community coaching, workplace assistance services, or supported employment services shall not exceed 66 hours per week.

c. This service shall be delivered in the community and shall not take place in a licensed residential setting nor in the individual's residence.

d. This service shall be provided at a ratio of no more than one staff to three individuals.

e. Community engagement may include planning community activities with the individual, although this shall be limited to no more than 10 percent of the total number of authorized hours per month.

f. Providers shall only be reimbursed for the tier to which the individual has been assigned based on the individual's assessed needs.

5. Community engagement provider requirements.

a. Community engagement providers shall be licensed by DBHDS as a provider of day support services.

b. Providers shall meet all of the requirements set forth in 12VAC30-120-500 et seq. and 12VAC30-120-1065(A).

B. Community coaching.

1. Community coaching service description. Community coaching means services which are designed for individuals who need one to one support in a variety of community settings in order to build a specific skill or set of skills to address a particular barrier or barriers preventing an individual from participating in activities of community engagement. In addition to skill building, this service includes safety supports.

2. Community coaching criteria. This service may be provided to individuals who require 1:1 support to address identified barriers in their Plan for Supports that prevent them from participating in the Community Engagement service.

3. Community coaching allowable activities.

- a. Individuals who are authorized for community coaching shall have a Plan for Supports. Community coaching activities and supports shall be contained in the Plan for Supports and be sensitive to the individual's age, abilities, and personal preferences.
 - b. One-on-one skill-building and coaching to facilitate participation in community activities and opportunities such as: (i) activities and public events in the community; (ii) community education, activities, and events, and; (iii) use of public transportation.
 - c. Skill building and support in positive behavior, relationship building and social skills.
 - d. Support with the individual's self-management, eating and personal care needs in the community.
4. Community coaching service units and service limits.
- a. The unit of service shall be one hour.
 - b. Community coaching, alone or in combination with community engagement, group day, workplace assistance services, or supported employment services shall not exceed 66 hours per week.
 - c. This service shall be provided at a ratio of no more than one staff to one individual.
 - d. Community coaching cannot be provided prior to service authorization.
5. Community coaching provider requirements.
- a. Community coaching providers shall be licensed by DBHDS as a provider of day support services.
 - b. Providers shall meet all of the requirements set forth in 12VAC30-120-500 et seq. and 12VAC30-120-1065(B).

C. Community guide services [RESERVED].

12VAC30-120-1023. Covered services: companion (agency-directed and consumer-directed).

A. Service description.

1. This service provides nonmedical care, socialization, or general support to adults (18 years of age or older). These services shall be provided in either the individual's home or at various locations in the community. It may be coupled with residential support services as needed.
2. Companions may assist or support the individual enrolled in the waiver with IADLs (including meal preparation, community access and activities, laundry, and shopping) but companions do not perform these activities as discrete services. Companions may also perform light housekeeping tasks (including bed-making, dusting and vacuuming, grocery shopping) when such services are specified in the individual's Plan for Supports and essential to the individual's health and welfare in the context of providing nonmedical care, socialization, or support, as may

be needed in order to maintain the individual's home environment in an orderly and clean manner. Companions shall provide safety supports.

3. Companion services shall be provided in accordance with the ISP to meet an assessed need of the individual and shall not be purely recreational in nature.

4. This service may be provided and reimbursed either through an agency-directed or a consumer-directed model.

a. Consumer-direction involves hiring, training, supervising, and terminating persons serving as companions by either the individual in the waiver or the EOR.

b. Individuals choosing to receive companion services through the consumer-directed model may choose a services facilitator to provide the training and ongoing guidance necessary to be the employer.

c. An individual who is unable to independently manage his own consumer-directed companion services may designate an adult family member/caregiver or some other person who agrees to fulfill the required duties to serve as the Employer of Record on behalf of the individual.

B. Criteria.

1. In order to qualify for companion services, the individual enrolled in the waiver shall have demonstrated a need for assistance with IADLs, community access, reminders for medication self-administration, or support to ensure his safety.

2. Individuals choosing the consumer-directed option shall meet requirements for consumer direction as described in 12 VAC 30-120-1062.

C. Service units and service limitations.

1. The unit of service for companion services shall be one hour and the amount that may be included in the Plan for Supports shall not exceed eight hours per 24-hour day regardless of whether it is an agency-directed or consumer-directed service model, or combination of both.

2. A companion shall not be permitted to provide nursing care procedures including care of ventilators, tube feedings, suctioning of airways, external catheters, or wound care. A companion shall not provide routine support with ADLs.

3. The hours that may be authorized shall be based on documented individual need. No more than two unrelated individuals who are receiving waiver services and who live in the same home shall be permitted to share the authorized work hours of the companion. Providers shall not bill for more than one individual at the same time.

4. Companion services shall not be provided by adult foster care providers or any other paid caregivers for an individual residing in that foster care home.

D. Provider requirements for companion services shall be the same as those set forth in 12VAC30-120-500 et seq. and 12VAC30-120-1062.

12VAC30-120-1024. Covered services: crisis support services (such as prevention, intervention, stabilization); center-based crisis supports; community-based crisis supports.

A. Service description.

1. Crisis support services shall provide intensive supports to an individual who has a history of or is experiencing an episodic behavioral or psychiatric crisis in the community. These services are designed to prevent the individual from experiencing an episodic crisis which has the potential to jeopardize his current community living situation, to intervene in such a crisis, or to stabilize the individual after the crisis. This service shall prevent escalation of a crisis, maintain safety, stabilize the individual and strengthen the current living situation so the individual can be supported in the community beyond the crisis period. Crisis support services may include as appropriate and necessary:

a. Crisis prevention services provide ongoing assessment of an individual's medical, cognitive, and behavioral status as well as predictors of self-injurious, disruptive, or destructive behaviors, with initiation of positive behavior supports to resolve and prevent future occurrence of crisis situations. Crisis prevention shall also encompass supporting the family and individual through team meetings, revising the behavior plan/guidelines, and other activities as the behavior support plan changes are implemented and residual concerns from the crisis situation are addressed.

b. Crisis intervention services shall be used during a crisis to prevent further escalation of the situation and to maintain the immediate personal safety of those involved. This shall be a short term service providing highly structured intervention that can include, for example, temporary changes to the person's residence, changes to the person's daily routine, and emergency referral to other care providers.

c. Crisis stabilization services begin once the acuity of the situation has resolved and there is no longer an immediate threat to the health and safety of the individual or others. Crisis stabilization services shall be geared toward gaining a full understanding of all of the factors that precipitated the crisis and may have maintained it until trained staff from outside the immediate situation arrived.

2. Center-based crisis support means planned crisis prevention and emergency crisis stabilization services in a crisis therapeutic home using planned and emergency admissions. They are designed for those individuals who will need on-going crisis supports. Planned admissions shall be provided to individuals receiving crisis services and who need temporary, therapeutic interventions outside of their home setting to maintain stability. Emergency admissions shall be provided to individuals who are experiencing an identified behavioral health need or behavior challenge that is preventing them from reaching stability within their home settings.

3. Community-based crisis supports means services to individuals experiencing crisis events which put them at risk for homelessness, incarceration, hospitalization, or danger to self or others. This service shall provide ongoing supports to individuals in their homes and other community settings. These services provide temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement. This service shall be designed to stabilize the individual and strengthen the current living situation so the individual can be maintained during and beyond the crisis period.

B. Criteria.

1. Crisis support services are designed for individuals experiencing circumstances such as the following: (i) marked reduction in psychiatric, adaptive, or behavioral functioning; (ii) an increase in emotional distress; (iii) needing continuous intervention to maintain stability; or (iv) causing harm to himself or others.

2. Center-based crisis supports are designed for individuals with a history of at least one of the following: (i) psychiatric hospitalization(s); (ii) incarceration; (iii) residential/day placement(s) that were terminated; or (iv) his behavior(s) have significantly jeopardized placement. In addition, the individual shall meet at least one of the following: (i) is experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning; (ii) is experiencing an increase in emotional distress; (iii) needs continuous intervention to maintain stability; or (iv) is causing harm to himself or others. The individual shall also: (i) be at risk of psychiatric hospitalization; (ii) be at risk of emergency ICF/IID placement; (iii) be at immediate risk of loss of community service due to severe situational reaction; or (iv) be actually causing harm to himself or others.

3. Community-based crisis supports are ongoing supports to the individual who may have (i) a history of multiple psychiatric hospitalizations, frequent medication or setting changes; or (ii) a history of requiring enhanced staffing due to his mental health or behavioral issues. They are designed for those individuals who will need on-going crisis supports. In order to be approved to receive this service, the individual shall have a history of at least one of the following: (i) previous psychiatric hospitalization or hospitalizations; (ii) previous incarceration; (iii) residential/day placement or placements that were terminated; or (iv) his behavior or behaviors have significantly jeopardized placement. In addition, the individual shall meet at least one of the following: (i) is experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning; (ii) is experiencing an increase in extreme emotional distress; (iii) needs continuous intervention to maintain stability; or (iv) is actually causing harm to himself or others. The individual shall also: (i) be at risk of psychiatric hospitalization; (ii) be at risk of emergency ICF/IID placement; (iii) be at immediate threat of loss of community service due to a severe situational reaction; or (iv) is actually causing harm to himself or others.

C. Allowable activities.

1. Crisis support services prevention allowable activities.

a. The crisis support provider shall train and mentor staff or family members who support the individual long-term once the crisis has stabilized in order to minimize or prevent recurrence of the crisis. Crisis support staff shall deliver support in such a way that maintains the individual's typical routine to the maximum extent possible.

b. Crisis prevention entails ongoing assessment of an individual's medical, cognitive, and behavioral status including predictors of self-injurious, disruptive or destructive behaviors with use of positive behavior supports. This service shall also include providing training to family/caregivers to avert further crises and maintain the individual's typical routine to the maximum extent possible.

c. Crisis stabilization entails gaining a full understanding of the factors which contributed to the crisis once the immediate threat has resolved. These services result in the development of new plans which may include environmental modifications, interventions to enhance communication skills, or changes to the individual's daily routine or structure. Crisis stabilization staff shall train

family/caregivers and other persons significant to the individual in techniques and interventions to avert future crises.

2. Crisis support services intervention allowable activities. Crisis support staff providing crisis intervention shall model verbal de-escalation techniques including active listening, reflective listening, validation and suggestions for immediate changes to the situation.

3. Center-based crisis supports allowable activities: (i) a variety of types of face-to-face assessments (psychiatric, neuropsychiatric, psychological, behavioral) and stabilization techniques; (ii) medication management and monitoring; (iii) behavior assessment and positive behavior support; (iv) intensive care coordination with other agencies/providers to maintain the individual's community placement; (v) training family members/caregivers and service providers in positive behavior supports; (vi) skill building related to the behavior creating the crisis such as self-care/ADLs, independent living skills, self-esteem, appropriate self-expression, coping skills, and medication compliance, and; (vi) supervising the individual in crisis to ensure his safety and that of other persons in the environment.

4. Community-based crisis supports allowable activities shall be provided in either the individual's home or in community settings, or both. Crisis staff shall work directly with the individual, his current support provider and his family/caregiver, or both. Services are provided using: (i) coaching; (ii) teaching; (iii) modeling; (iv) role-playing; (v) problem solving; or (vi) direct assistance. Activities include: (i) psychiatric, neuropsychiatric psychological, and behavioral assessments and stabilization techniques; (ii) medication management and monitoring; (iii) behavior assessment and positive behavior support; (iv) intensive care coordination with agencies/providers to maintain the individual's community placement; (v) family/caregiver training in positive behavioral supports to maintain the individual in the community; (vi) skill building related to the behavior creating the crisis such as self-care/ADLs, independent living skills, self-esteem, appropriate self-expression, coping skills, and medication compliance, and; and (vii) supervision to ensure the individual's safety and the safety of others in the environment.

D. Service units and service limitations.

1. Crisis support services shall be authorized or re-authorized following a documented face-to-face assessment conducted by a QDDP.

a. Crisis Prevention: The unit of the service shall be one hour and billing may occur up to 24 hours per day if necessary. Medically necessary crisis prevention may be authorized for up to 60 days per ISP year. Crisis prevention services include supports during the provision of any other waiver service and may be billed concurrently (same dates and times).

b. Crisis Intervention: The unit of the service shall be one hour and billing may occur up to 24 hours per day if necessary. 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. Crisis intervention services include supports during the provision of any other waiver service and may be billed concurrently (same dates and times).

c. Crisis Stabilization: The unit of the service shall be one hour and billing may occur up to 24 hours per day if necessary. 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. Crisis stabilization

services include supports during the provision of any other waiver service and may be billed concurrently (same dates and times).

2. Center-based crisis supports shall be limited to six months per ISP year and shall be authorized in increments of up to a maximum of 30 days with each authorization. Center-based crisis supports shall not be provided during the provision of the following waiver services and shall not be billed concurrently (same dates and times): Group Home Residential, Sponsored Residential, Supported Living, Agency Directed or Consumer-Directed Respite.

3. Community-based crisis supports is an hourly service unit and may be authorized for up to 24 hours per day if necessary in increments of no more than 15 days at a time. The annual limit is 1080 hours. Requests for additional community-based crisis supports services in excess of the 1080 hour annual limit will be considered if justification of medical necessity is provided.

E. Provider requirements. In addition to the general conditions and requirements for home and community-based waiver services participating providers as specified in 12VAC30-120-500 et seq. and 12VAC30-120-1063, the following provider requirements apply:

1. Providers of all crisis support services, center-based crisis support services, community-based crisis support services shall have current signed participation agreements with DMAS and shall directly provide the services and bill DMAS for Medicaid reimbursement. These providers shall renew their participation agreements as directed by DMAS.

2. Crisis support services shall be provided by entities licensed by DBHDS as providers of outpatient crisis stabilization services, residential crisis stabilization services or non-residential crisis stabilization services. Providers shall employ or utilize QDDPs, licensed mental health professionals or other qualified personnel licensed to provide clinical or behavioral interventions.

3. Center-based crisis support providers shall be licensed by DBHDS as providers of group home residential services and either emergency services or residential crisis stabilization services. Center-based crisis supports shall be provided by a Licensed Mental Health Professional (LMHP), LMHP-supervisee, LMHP-resident, LMHP-RP, certified pre-screener, QDDP, or DSP under the supervision of one of the professionals listed in this subsection.

4. Community-based crisis support providers shall be licensed by DBHDS as providers of emergency services, outpatient crisis stabilization services, residential crisis stabilization services or non-residential crisis stabilization services. Community-based crisis support services shall be provided by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a certified pre-screener, or QDDP.

5. Provider documentation requirements.

a. Supporting documentation shall be developed (or revised, in the case of a request for an extension) and submitted to the support coordinator/case manager for authorization within 72 hours of the face-to-face assessment or reassessment.

b. Documentation indicating the dates and times of crisis services, the amount and type of service provided, and specific information about the individual's response to the services and supports in the supporting documentation shall be recorded in the individual's record.

c. Documentation of provider qualifications shall be maintained for review by DMAS or DBHDS staff and shall be provided upon request from either agency.

12VAC30-120-1025. Covered services: electronic home-based supports (EHBS); environmental modifications (EM).

A. Electronic Home-Based Supports (EHBS).

1. Service description. This service shall provide devices, equipment, or supplies, based on current technology, such as Smart Home © technology, to enable the individual to live in his community and participate in his community more safely while decreasing the need for other services such as staff supports. The equipment/devices shall be purchased for the individual and shall be typically installed in the individual's home. Portable hand-held devices may be used by the individual at home or in the community. These devices and services shall support the individual's greater independence and self-reliance in the community. This service may also include ongoing electronic monitoring, which is the provision of oversight and monitoring within the home through off-site monitoring.

2. Criteria.

a. In order to qualify for this service, the individual shall be at least 18 years of age and shall be physically capable of using the equipment provided via this service.

b. A preliminary needs assessment shall be completed by a technology specialist to determine the best type and use of technology and overall cost effectiveness of various options. This assessment shall be submitted to DMAS' designee for service authorization prior to the delivery of any goods and services and prior to the submission of any claims for Medicaid reimbursement. The technology specialist conducting the preliminary assessment may be an occupational therapist, or other similarly credentialed specialist, who is licensed or certified by the Commonwealth and specializes in assistive technologies, mobile technologies, and current accommodations for individuals with developmental disabilities.

c. The service shall support training in the use of these goods and services, ongoing maintenance, and monitoring services to address an identified need in the individual's ISP (including improving and maintaining the individual's opportunities for full participation in the community).

d. Items or services purchased through EBHS shall be designed to decrease the need for other Medicaid services (such as reliance on staff supports); promote inclusion in the community; or increase the individual's safety in the home environment.

3. Service units and limits.

a. The annual ISP year limit for this service shall be \$5,000. No unspent funds from one plan year shall be accumulated and carried over to subsequent plan years.

b. Receipt of this service shall not be tied to the receipt of any other covered waiver or Medicaid services. Equipment/supplies already covered by any other Medicaid covered service shall be excluded from coverage by this waiver service. This service shall not be covered for individuals

who are receiving residential supports which are reimbursed on a daily basis, such as group home, sponsored or supported living residential services.

4. Provider requirements.

a. An EHBS provider shall be one of the following: (i) a Medicaid-enrolled personal care agency; (ii) a Medicaid-enrolled durable medical equipment provider; (iii) a CSB; (iv) a Center for Independent Living; (v) a licensed and Medicaid-enrolled home health provider; or (vi) a PERS manufacturer that is Medicaid-enrolled and has the ability to provide electronic home-based equipment, direct services (i.e., installation, equipment maintenance, and service calls), and monitoring services.

b. The provider of ongoing monitoring systems shall provide an emergency response center with fully trained operators who are capable of receiving signals for help from an individual's equipment 24-hours a day, 365, or 366, days per year as appropriate, of determining whether an emergency exists, and of notifying the appropriate responding organization or an emergency responder that the individual needs help.

c. The EHBS provider shall have the primary responsibility to furnish, install, maintain, test, and service the equipment, as required, to keep it fully operational. The provider shall replace or repair the device within 24 hours of the individual's notification of a malfunction of the unit or device.

d. The EHBS provider shall properly install all equipment and shall furnish all supplies necessary to ensure that the system is installed and working properly.

e. An EHBS provider shall install, test, and demonstrate to the individual and family/caregiver, as appropriate, the unit or device before submitting his claim for services to DMAS. The provider responsible for installation of devices shall document the date of installation and training in their use.

f. The provider of off-site monitoring shall document each instance of action being taken on behalf of the individual. This documentation shall be maintained in this provider's record for the individual and shall be provided to either DMAS or DBHDS upon demand.

g. Providers shall meet all of the requirements set forth in 12VAC30-120-500 et seq., and 12VAC30-120-1061.

B. Environmental modifications (EM).

1. Service description. This service shall be defined, as set out in 12VAC30-120-1000. Adaptations may include, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the individual. Modifications may be made to a primary automotive vehicle in which the individual is transported if it is owned by the individual, a family member with whom the individual lives or has consistent and ongoing contact, or a nonrelative who provides primary long-term support to the individual and is not a paid provider of services.

2. Criteria. In order to qualify for these services, the individual enrolled in the waiver shall have a demonstrated need for equipment or modifications of a remedial or medical benefit offered in

an individual's primary home or the primary vehicle used by the individual, to specifically improve the individual's personal functioning. This service shall encompass those items not otherwise covered in the State Plan for Medical Assistance or through another program.

3. Service units and service limitations.

a. Environmental modifications shall be provided in the least expensive manner possible that will accomplish the modification required by the individual enrolled in the waiver and shall be completed within the calendar year consistent with the Plan of Supports' requirements.

b. The maximum funded expenditure per individual for all EM covered procedure codes (combined total of EM items and labor related to these items) shall be \$5,000 per calendar year for individuals regardless of waiver for which EM is approved. The service unit shall always be one, for the total cost of all EM being requested for a specific timeframe.

c. EM shall be available to individuals enrolled in the waiver who are receiving at least one other waiver service. EM shall be service authorized by the state-designated agency or its designee for each calendar year with no carry-over of authorized unspent funds across calendar years.

d. Providers of EM services shall not be the spouse or parents (natural, adoptive, or foster parents) or legal guardians of the individual enrolled in the waiver.

e. Modifications shall not be used to bring a substandard dwelling up to minimum habitation standards.

f. Providers shall be reimbursed for their actual cost of material and labor and no additional mark-ups shall be permitted.

g. Excluded from coverage under this waiver service shall be those adaptations or improvements to the home that are of general utility and that are not of direct medical or remedial benefit to the individual enrolled in the waiver, including carpeting, roof repairs, and central air conditioning. Also excluded shall be modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act, and the Rehabilitation Act. Adaptations that add to the total square footage of the home shall be excluded from this service. Except when EM services are furnished in the individual's own home, such services shall not be provided to individuals who receive residential support services.

h. Modifications shall not be service authorized or covered to adapt living arrangements that are owned or leased by providers of waiver services or those living arrangements that are sponsored by a DBHDS-licensed provider. Specifically, provider-owned or leased settings where residential support services are furnished shall already be compliant with the Americans with Disabilities Act.

i. Modifications to a primary vehicle that shall be specifically excluded from this benefit shall be:

(1) Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual;

(2) Purchase or lease of a vehicle; and

(3) Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications that were covered under this waiver benefit.

4. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-500 et seq., and 12VAC30-120-1061. If a provider has previously made environmental modifications, that previous work shall have been completed satisfactorily in order to be authorized for future jobs. These providers shall perform all servicing and repairs that the modification may require for the individual's successful use.

12VAC30-120-1026. Covered services: group day services.

A. Group day services.

1. Service description. Group day services means services for the individual to acquire, retain, or improve skills of self-help, socialization, community integration, career planning and adaptation via opportunities for peer interactions, community integration, and enhancement of social networks. These services shall be typically offered in a nonresidential. Supports may be provided for the purpose of Medicaid reimbursement. Skill building shall be a component of this service unless the individual has a documented progressive condition in which case group day services may focus on maintaining skills and functioning and preventing or slowing regression rather than acquiring new skills or improving existing skills. Group day services is a tiered service for reimbursement purposes. Providers shall only be reimbursed for the individual's assigned level and tier.

2. Criteria. For group day services, an individual shall demonstrate the need for skill-building or supports offered primarily in settings other than the individual's own residence that allows him an opportunity for being a productive and contributing member of his community. In addition, group day services shall be available for individuals who can benefit from supported employment services, but who need these services as an appropriate alternative or in addition to supported employment services.

3. Allowable activities shall include, as may be appropriate for the individual as documented in his Plan for Supports:

a. Developing problem-solving, sensory, gross and fine motor, communication and personal care skills;

b. Developing self, social, and environmental awareness skills;

c. Developing skills as needed in positive behavior, using community resources, community safety and positive peer interactions, volunteering and educational programs in integrated settings, forming community connections or relationships;

d. Supporting older adults in participating in meaningful retirement activities in their communities, i.e., clubs and hobbies; and

e. Career planning and resume developing based on career goals, personal interests, and community experiences.

f. Group day services shall be coordinated with the therapeutic consultation plan, as applicable.

4. Service units and service limitations.

a. This service unit shall be one hour. Group day services, alone or in combination with (but not at the same time as) community engagement, community coaching, workplace assistance, or supported employment services shall not exceed 66 hours per week. Group day services occur one or more hours per day on a regularly scheduled basis for one or more days per week in settings that are separate from the individual's home.

b. Group day services shall be billed according to the DMAS fee schedule.

c. Group day staffing ratios shall be based on the activity and the individual's needs, as set out in his Plan for Supports, and shall be limited to a ratio of a maximum of one staff to seven individuals.

d. Service providers shall be reimbursed only for the amount of group day services that are rendered as established in the individual's approved Plan for Supports based on the setting, intensity, and duration of the service to be delivered.

5. Provider Requirements. Documentation shall confirm the individual's attendance, the amount of the individual's time in services, and provide specific information regarding the individual's response to various settings and supports. Observation of the individual's responses to the services shall be available in a daily progress note.

a. The provider shall review the supporting documentation with the individual or his family/caregiver, as appropriate, and submit a written summary of this review support coordinator/case manager at least quarterly with the Plan for Supports modified as appropriate. For the annual review and anytime the supporting documentation is updated, the supporting documentation shall be reviewed with the individual or his family/caregiver, as appropriate, and such review shall be documented.

b. An attendance log or similar document shall be maintained that indicates the date, type of services rendered, and the number of hours and units provided (including specific time frame).

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

d. Supervision of direct service staff shall be provided by a qualified developmental disabilities professional.

e. Providers shall ensure that individuals providing group day services meet provider competency training requirements as specified in 12VAC30-120-1005.

f. Providers shall meet all of the requirements set forth in 12VAC30-120-500 et seq.

12VAC30-120-1027. Covered services: group home residential services.

A. Service description. Group home residential services shall consist of skill-building, routine supports, general supports, and safety supports that are provided to enable an individual to acquire, retain, or improve skills necessary to successfully live the community. These services shall be provided to individuals who are living in (i) a group home or (ii) the home of an adult foster care provider, and services shall be provided in a licensed or foster care approved residence. Group home residential is a tiered service for reimbursement purposes (as described in 12VAC30-120-500) based on the individual's assigned level and tier and licensed bed capacity of the home. Group home residential services shall be provided to the individual as continuous services (up to 24 hours per day) performed by paid staff who shall be physically present with the individual. These supports may be provided either individually or simultaneously to more than one individual living in that home, depending on the required support. Providers shall only be reimbursed for the individual's assigned level and tier and based on the licensed bed capacity of the group home.

B. Criteria. Only individuals who are on the CL waiver shall be eligible for group home residential services.

C. Allowable activities. The allowable activities shall include, as may be appropriate for the individual as documented in his Plan for Supports:

1. Skill-building and providing routine supports related to ADLs and IADLs;
2. Skill-building and providing routine supports and safety supports related to the use of community resources (transportation, shopping, restaurant dining, and participating in social and recreational activities) (the cost of participation in the actual social or recreational activity shall not be reimbursed);
3. Supporting the individual in replacing challenging behaviors with positive, accepted behavior for home and community environments;
4. Monitoring the individual's health and physical condition and providing supports with medication and other medical needs;
5. Providing routine supports and safety supports with transportation to and from training sites and community resources;
6. Providing general supports, as needed; and
7. Providing safety supports to ensure the individual's health and safety.

D. Service units and limitations.

1. The unit of service shall be a day.
2. Group home residential services shall be authorized for Medicaid reimbursement only when the individual requires these services and they are set out in the Plan for Supports. These services shall be service authorized.

12VAC30-120-1028. Covered services: in-home support services.

A. In-home support service description. In-home support services means residential services that take place in the individual's home, family home, or community settings that typically supplement the primary care provided by the individual, family, or other unpaid caregiver and are designed to ensure the health, safety and welfare of the individual. This service shall consist of: skill-building and routine supports, general supports, and safety supports that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. In-home support services require the presence of a skills development (formerly called training) component, along with the provision of supports. In-home support services is not a tiered service but shall be reimbursed according to the number of individuals served.

B. Criteria. To be eligible for in-home support services, individuals shall:

1. Be enrolled in the FIS or CL waiver, and
2. Be living in their own home or family home.

C. Units and limits. The unit shall be one hour. These services shall not typically be provided 24 hours per day but may be authorized for brief periods up to 24 hours a day when medically necessary. This service shall not be covered for the individual simultaneously with the coverage of group home residential, supported living residential, or sponsored residential services. Individuals may have in-home supports, personal assistance, and respite services in their ISP but shall not receive these Medicaid-reimbursed services simultaneously.

D. Allowable activities include:

1. Skill-building and providing routine supports and safety supports related to personal care activities (ADLs);
2. Skill-building and providing routine supports and safety supports related to the use of community resources (transportation, shopping, dining at restaurants, participating in social and recreational activities);
3. Supporting the individual in replacing challenging behaviors with positive, accepted behaviors for home and community environments;
4. Monitoring the individual's health and physical condition and providing general supports and safety supports with medication or other medical needs;
5. Providing supports with ADLs and IADLs and using community resources;
6. Providing supports with transportation to and from training sites and community resources; or
7. Providing safety supports to ensure the individual's health and safety.

E. Provider requirements.

1. All providers of this service shall have current, signed participation agreements with DMAS. The provider designated in this agreement shall directly submit claims to DMAS for reimbursement.
2. Provider documentation shall confirm the individual's amount of time in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the plan for supports. Data shall be collected as described in the Plan for Supports, summarized, and then necessary changes shall be added to the supporting documentation. Provider documentation shall be available in a daily progress note.
3. The supporting documentation shall be reviewed by the provider with the individual and family/caregiver as appropriate, and written summary of this review submitted to the support coordinator/case manager, at least quarterly, with desired outcomes, support activities, and strategies modified as appropriate.
4. Providers of in-home support services shall be licensed by DBHDS as providers of supportive in-home services.
5. The individual shall have a back-up plan for times when in-home supports cannot occur as regularly scheduled.

12VAC30-120-1029. Covered services: non-medical transportation; personal assistance services (agency-directed and consumer-directed).

A. Non-medical transportation activities [RESERVED]

B. Personal assistance services. Service description. These services may be provided either through an agency-directed or consumer-directed (CD) model.

1. Personal assistance services means direct support with ADLs, IADLs, access to the community, monitoring of self-administration of medication or other medical needs, and the monitoring of health status and physical condition or work or post-secondary school-related personal assistance. Personal assistance services substitute for the absence, loss, diminution, or impairment of a physical, behavioral, or cognitive function.
2. When specified in the Plan for Supports, personal assistance services may include assistance with IADLs. Assistance with IADLs shall be documented in the Plan for Supports as essential to the health and welfare of the individual, rather than for the individual's family/caregiver's comfort.
3. An additional component to personal assistance is work or post-secondary school-related personal assistance which allows the personal assistance provider to provide assistance and supports to individuals in the workplace and postsecondary educational institutions. Work or post-secondary school-related personal assistance shall not be provided if they are services that should be provided by DARS, under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act, the Virginians with Disabilities Act, or § 504 of the Rehabilitation Act. Work-related personal assistance services shall not duplicate services provided under supported employment.

C. Personal Assistance Services Criteria.

1. In order to qualify for personal assistance services, the individual shall demonstrate a need for assistance with activities of daily living, reminders to take medication, or other medical needs, or monitoring health status or physical condition.
2. Individuals choosing the consumer-directed option for personal assistance services may receive support from a services facilitator and shall meet requirements for consumer direction as described in 12VAC30-120-759 and 12VAC30-120-770.
3. For personal assistance services, allowable activities include: (i) support with ADLs; (ii) support with monitoring of health status/physical condition; (iii) support with prescribed use of medication and other medical needs; (iv) support with preparation and eating of meals; (v) support with housekeeping (such as bed making, cleaning, individual's laundry) activities; (vi) support with participation in social, recreational and community activities; (vii) assistance with bowel/bladder care needs, range of motion activities, non-sterile technique routine wound care, and external catheters when supervised by an RN; (ix) accompanying the individual to appointments or meetings; and (x) safety supports.

D. Service units and service limitations.

1. The unit of service for personal assistance services shall be ~~is~~ one hour. The hours to be authorized shall be based on the individual's assessed and documented need as reflected in the Plan for Supports.
2. Individuals may receive a combination of personal assistance, respite, and in-home support services as documented in their Plan for Supports but shall not receive in-home supports services and personal assistance or respite services at the same time.
3. The provider of personal assistance shall have a back-up plan in case the personal assistant or consumer-directed (CD) employee does not report for work as expected or terminates employment without prior notice.
4. Individuals must need assistance with ADLs in order to receive IADL care through personal care services.
5. Individuals shall be permitted to share personal assistance service hours with one other individual (receiving waiver services) who lives in the same home.
6. This service does not include skilled nursing (neither practical nor professional nursing) services with the exception of skilled nursing tasks that ~~may be~~ are delegated in accordance with 18VAC90-20-420 through 18VAC90-20-460. No more than two unrelated individuals who live in the same home shall be permitted to share the authorized work hours of the personal assistant.
7. Services may be provided for Medicaid reimbursement by the individual's relative or legal guardian. Services shall not be reimbursed by Medicaid when they are provided by the individual's spouse or, if the individual is a minor child, by his parent or parents (natural, adoptive, foster, or step-parent).

8. Personal assistance shall not be reimbursed by DMAS for individuals who receive group home residential services, sponsored residential services, supported living residential services or who live in assisted living facilities, or receive comparable services from another program or service.

12VAC30-120-1030. Covered services: personal emergency response systems.

A. Personal Emergency Response System (PERS).

1. Service description. PERS is an electronic device and monitoring service that enables certain individuals at risk of institutionalization to secure help in an emergency. PERS services shall be limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time and who would otherwise require supervision.

2. Criteria. PERS may be authorized when there is no one else in the home with the individual enrolled in the waiver who is competent or continuously available to call for help in an emergency.

3. Service units and service limitations.

a. The one-time installation of the unit shall include installation, account activation, individual and caregiver instruction, and removal of PERS equipment. A unit of service is the one-month rental price set by DMAS.

b. PERS services shall be capable of being activated by a remote wireless device and shall be connected to the individual's telephone system. The PERS console unit shall provide hands-free voice-to-voice communication with the response center. The activating device shall be waterproof, automatically transmit to the response center an activator low battery alert signal prior to the battery losing power, and be able to be worn by the individual.

c. PERS services shall not be used as a substitute for providing adequate supervision for the individual enrolled in the waiver.

d. Physician-ordered medication monitoring units shall be provided simultaneously with PERS services.

e. PERS shall not be covered for individuals who are simultaneously receiving group home residential services, sponsored residential services, or supported living residential services.

4. Provider requirements. Providers shall meet all requirements of 12VAC30-120-500 et seq., 12VAC30-120-1061(A) and (E) and 12VAC30-120-1560(P).

12VAC30-120-1031. Covered services: skilled nursing and private duty nursing.

A. Skilled nursing services.

1. Services description. This service shall provide part-time or intermittent care that may be provided concurrently with other services due to the medical nature of the supports provided. These services shall be provided for individuals enrolled in the waiver having serious medical conditions and complex health care needs who do not meet home health criteria but who require specific skilled nursing services which cannot be provided by non-nursing personnel.

2. Services criteria. The individuals who are authorized to receive this service shall require specific skilled nursing services which cannot be provided by non-nursing personnel as documented in the Plan for Supports. This service shall be rendered to the individual in his residence or other community settings on a regularly scheduled or intermittent basis in accordance with the Plan for Supports.

3. Allowable activities shall be ordered and certified as medically necessary by a Virginia-licensed physician. The ordered services may include:

a. Consultation, assistance to direct support staff, and nurse delegation;

b. Training of family and other caregivers;

c. Monitoring an individual's medical status;

d. Administering medications and other medical treatment; or

e. Assurance that all items listed above in (a) through (d) are carried out in accordance with the Individual Support Plan.

4. Service units and limits.

a. Skilled nursing services shall be ordered by a physician and shall be medically necessary.

b. This service shall be rendered and billed in quarter hour increments. Individuals receiving this service shall not be required to meet the criteria for the receipt of home health services. Skilled nursing services shall not be limited by the acute, time-limited standards for home health services as contained in the State Plan for Medical Assistance.

c. Individuals enrolled in the waiver shall not be authorized to receive waiver skilled nursing services concurrently with private duty nursing services or personal assistance services. Waiver skilled nursing services shall not be authorized or covered if the necessary service is available under EPSDT for an individual who is a child.

d. Foster care providers shall not be the skilled nursing services providers for the same individuals for whom they provide foster care.

e. The support coordinator/case manager shall assist an individual who has short-term, acute, and limited in nature skilled nursing needs in accessing the home health services benefit under the State Plan for Medical Assistance. Such short-term State Plan services shall be accessed from a licensed home health services provider that is a DMAS-enrolled provider.

f. The support coordinator/case manager shall assist an individual who has skilled nursing needs that are expected to be longer-term, but intermittent in nature, with accessing skilled nursing services.

g. Skilled nursing services providers shall not be reimbursed while the individual enrolled in the waiver is receiving care in an emergency room or is receiving inpatient services in either an acute care hospital, nursing facility, rehabilitation facility, ICF/IID or any other type of facility, or during emergency transport of the individual to such facilities.

5. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-500 et seq., and 12VAC30-120-1067(A).

B. Private duty nursing services.

1. Service description. Private duty nursing services means individual and continuous nursing care that may be provided, concurrently with other services, due to the medical nature of supports required by individuals who have a serious medical condition or complex health care needs, or both, and which has been certified by a physician as medically necessary to enable the individual to remain at home rather than in a hospital, nursing facility, or ICF/IID. This service shall be rendered to the individual in his residence or other community settings.

2. Criteria.

a. The individual shall require these services as certified by a Virginia-licensed physician as medically necessary to enable the individual to remain at home or otherwise in the community rather than in a hospital, nursing facility, an ICF/IID, or any other type of institution.

b. The medical need for these services shall be documented in the individual's ISP. Once the medical need no longer exists, this service shall be terminated.

c. Individuals enrolled in the waiver shall not be authorized to receive private duty nursing services concurrently with skilled nursing services.

3. Allowable activities.

a. Monitoring of an individual's medical status;

b. Administering medications or other medical treatment.

4. Service units and limits.

a. Private duty nursing services shall be ordered by a Virginia-licensed physician and shall be medically necessary.

b. The unit of service shall be a quarter hour.

5. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-500 et seq., and 12VAC30-120-1067(B).

12VAC30-120-1032. Covered services: respite (agency-directed; consumer-directed).

Respite services. Respite services may be provided either through an agency-directed or consumer-directed (CD) model. Refer to 12 VAC 30-120-759 and 12VAC30-120-770 for consumer-directed requirements.

A. Service description.

1. Respite services are temporary, substitute care that is normally provided by the family or other unpaid, primary caregiver who resides in the same home as the individual. Services shall be provided on a short-term basis due to the emergency absence of or need for routine or periodic relief of the primary caregiver.

2. Respite services may be provided to individuals to provide assistance in the areas of activities of daily living (ADLs), instrumental activities of daily living (IADLs), access to the community, monitoring of self-administered medications or other medical needs, and monitoring of health status and physical condition in the absence of the primary caregiver or to relieve the primary caregiver from the duties of care-giving. Such services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. When specified in the Plan for Supports, such supportive services may include assistance with IADLs. Respite assistance shall not include either practical or professional nursing services or those practices regulated in Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia, as appropriate. This service shall not include skilled nursing services with the exception of skilled nursing tasks that are delegated pursuant to 18VAC90-20-420 through 18VAC90-20-460.

B. Criteria.

1. In order to qualify for respite services, the individual shall demonstrate a need for assistance with ADLs, community access, self-administration of medications or other medical needs, or monitoring of health status or physical condition.

2. The need for respite services shall be documented in the Plan for Supports.

C. Allowable activities shall include: (i) assistance with ADLs and IADLs; (ii) support with monitoring health status and physical condition; (iii) support with medication and medical needs; (iv) safety supports; (v) support to participate in social, recreational, or community activities; (vi) accompanying the individual to appointments or meetings, and; (vii) assistance with bowel/bladder programs, range of motion exercises, routine wound care that does not include sterile technique, and external catheter care when trained and supervised by an RN.

D. Service units and service limitations.

1. The unit of service shall be one hour. Respite services shall be limited to 480 hours per individual per state fiscal year. If an individual changes waiver programs, this same maximum number of respite hours shall apply. No additional respite hours beyond the 480 maximum limit shall be approved for payment. Individuals who are receiving respite services in this waiver through both the agency-directed and CD models shall not exceed 480 hours per year combined.

2. Each provider shall have a back-up plan for the individual's care in case the respite assistant does not report for work as expected or terminates employment without prior notice.

3. Respite services shall not be provided to relieve staff of either group homes or sponsored residential, as defined by 12VAC35-105-20, or assisted living facilities, as defined by 22VAC40-72-10, where residential supports are provided in shifts. Respite services shall not be provided for DMAS reimbursement by adult foster care providers for an individual residing in that foster home.

4. Skill development shall not be provided with respite services.
 5. The hours to be authorized shall be based on the individual's need. No more than two unrelated individuals who live in the same home shall be permitted to share the authorized work hours of the respite assistant.
 6. Consumer-directed and agency-directed respite services shall meet the same standards for service limits and authorizations.
- E. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-500 et seq., and 12VAC30-120-1062.

12VAC30-120-1033. Covered services: services facilitation; consumer-directed model.

Services facilitation and consumer-directed service model.

A. Service description. The requirements for services facilitation shall be the same as those set forth in 12VAC30-120-759 and 12VAC30-120-770.

12VAC30-120-1034. Covered services: shared living.

A. Shared living.

1 Service description. Shared living means Medicaid coverage of a portion of the total cost of rent, food, and utilities that can be reasonably attributed to a roommate who has no legal responsibility to financially support the individual who is enrolled in the waiver. The types of assistance provided are expected to vary from individual to individual and may include: (i) fellowship; (ii) safety supports; and (iii) limited ADL/IADL help. This service shall require the use of an administrative provider that shall be responsible for directly coordinating the services and directly billing DMAS for reimbursement.

2. Criteria.

a. The individual, who shall be at least 18 years of age, shall select his roommate and, together through a planning process, they shall determine the assistance to be provided by the roommate based on the individual's needs and preferences. The individual shall reside in his own home or in a residence leased by the individual. Reimbursable room and board for the roommate shall be established through the service authorization process per the CMS-approved rate methodology, published on the DBHDS website.

b. The individual shall be receiving at least one other waiver service in order to receive Medicaid coverage of shared living.

3. Allowable activities include help with ADLs/IADLs, which shall account for no more than 20% of the anticipated roommate time and may include: (i) help with meal preparation, light housework, and reminders to take medications; and (ii) routine prompting or intermittent direct assistance with ADLs.

4. Covered services units and limits. The unit of service shall be a month or may be a partial month for months in which the service begins or ends.

a. The roommate shall complete and pass background checks, including criminal registry checks required by §§ 37.2-416, 37.2-506, and 37.2-607 of the Code of Virginia.

b. The roommate shall successfully meet the training requirements set out in the ISP including CPR training, safety awareness, fire safety and disaster planning, and conflict management and resolution.

c. Shared living services shall not be covered for individuals who are simultaneously receiving group home residential, sponsored residential services, or supported living residential services.

d. The roommate shall not have the responsibility for providing skill-building or medical services. The roommate shall not be the spouse; parent, (biological, adoptive, foster, or step-parent); or legal guardian of the individual.

5. Provider requirements. Shared living administrative providers shall meet all of the requirements set forth in 12VAC30-120-500 et seq., 12VAC30-120-1069, and 12VAC30-120-1560(Q).

12VAC30-120-1035. Covered services: supported employment services.

Supported employment services.

A. Service description. This service may be performed for a single individual (as in individual supported employment) or in small groups (as in group supported employment) of individuals (two to eight individuals). These services shall consist of ongoing supports that enable individuals to be employed in an integrated work setting and may include assisting the individual, either as a sole individual or in small groups, to locate a job or develop a job on behalf of the individual, as well as activities needed to sustain paid work by the individual or individuals including skill-building supports and safety supports on a job site.

1. These services shall be provided in work settings where persons without disabilities are employed. Supported employment services shall be especially designed for individuals with developmental disabilities who face impediments to employment due to the nature and complexity of their disabilities, irrespective of age or vocational potential (i.e., the individual's ability to perform work).

2. Supported employment services shall be available to individuals for whom competitive employment at or above the minimum wage is unlikely without ongoing supports and who because of their disabilities need ongoing support to perform in a work setting. The individual's assessment and Plan for Supports shall clearly reflect the individual's need for employment-related skill building.

3. Supported employment shall be provided in one of two models: individual or group.

a. Individual supported employment shall be defined as one-on-one ongoing supports that enable individuals, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, to work in an integrated setting. The outcome of this service shall be

sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals. For this service, reimbursement of supported employment shall be limited to actual documented interventions or collateral contacts by the provider as required by the individual receiving waiver services but not for the supervisory activities rendered as a normal part of the regular business setting, and not the amount of time the individual enrolled in the waiver is in the supported employment situation.

b. Group supported employment shall be defined as continuous support provided by staff in a naturally occurring place of employment to groups of two to eight individuals with disabilities and involves interactions with the public and coworkers who do not have disabilities. This service shall be provided in a community setting that promotes integration into the workplace and interaction between participants and people without disabilities in the workplace. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in the community.

B. Criteria.

1. Only job development tasks that specifically pertain to the individual shall be allowable activities under the ~~HD~~ Waiver supported employment service and DMAS shall cover this service only after determining that this service is not available from DARS for the individual enrolled in the waiver.

2. In order to qualify for these services, the individual shall have demonstrated that competitive employment at or above the minimum wage is unlikely without ongoing supports and, that because of his disability, he needs ongoing support to perform in a work setting.

3. The Plan for Supports shall document the amount of supported employment required by the individual.

C. Allowable activities for both individual and group supported employment include the following job development tasks, supports, and training. The individual shall be present unless otherwise noted below.

1. Vocational/job-related discovery or assessment;

2. Person-centered employment planning which results in employment related outcomes;

3. Individualized job development, with or without the individual present, that produces an appropriate job match for the individual and the employer to include job analysis or determining job tasks, or both (this element is for individual supported employment only, and is not permitted for group supported employment);

4. Negotiation with prospective employers, with or without the individual present;

5. On-the-job training in work skills required to perform the job;

6. Ongoing evaluation, supervision, and monitoring of the individual's performance on the job but which do not include supervisory activities rendered as a normal part of the business setting;

7. Ongoing support services necessary to ensure job retention, with or without the individual present;

8. Supports to ensure the individual's health and safety;
9. Development of work-related skills essential to obtaining and retaining employment, such as the effective use of community resources and break/lunch areas and transportation systems; and
10. Staff provision of transportation between the individual's place of residence and the workplace when other forms of transportation are unavailable or inaccessible. The job coach shall be present with the individual during the provision of transportation.

D. Service units and service limitations.

1. Service providers shall be reimbursed only for the amount and type of supported employment included in the individual's ISP.
2. The unit of service for individual supported employment shall be one hour and the service shall be limited to 40 hours per week per individual. The unit of service for group supported employment shall be one hour and the service shall be limited to 40 hours per week per individual.
3. Group supported employment is based on the size of the group. Individual supported employment shall be billed according to the DARS fee schedule.
4. Supported employment services alone or in combination with community engagement, community coaching, workplace assistance or group day services shall not exceed 66 hours per week. Supported employment services shall take place in non-residential settings separate from the individual's home.
5. For time-limited and service authorized periods (not to exceed 40 hours) individual supported employment may be provided in combination with day services or residential services for purposes of job discovery.

E. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-500 et seq., and 12VAC30-120-1066(A) and (B).

12VAC30-120-1036. Covered services: supported living residential; sponsored residential.

A. Supported living residential.

1. Service description. Supported living residential shall take place in an apartment setting that shall be operated by a DBHDS-licensed provider of supervised living residential services. These services shall consist of skill-building, routine and general supports, and safety supports, that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Service providers shall be reimbursed only for the amount and type of supported living residential services that are included in the individual's ISP. Supported living residential services shall be authorized for Medicaid reimbursement in the Plan for Supports only when the individual requires these services. Supported living residential is a tiered service for reimbursement purposes. Providers shall only be reimbursed for the individual's assigned level and tier. Supported living residential

services shall be provided to the individual in the form of around-the-clock availability of paid provider staff who have the ability to respond in a timely manner. These services may be provided individually or simultaneously to more than one individual living in the apartment, depending on the required support or supports.

2. Criteria. This service shall be provided to individuals who require (i) skills development related to personal care activities (such as ADLs, communication, and IADLs); (ii) help to replace challenging behaviors with positive, accepted behaviors for home and community-based environments; (iii) monitoring of health and physical conditions and the provision of supports with medication or other medical needs; (iv) transportation to and from training sites and community resources/activities; (v) general supports as needed, and; (vi) safety supports to ensure the individual's health and safety.

3. Units and limits.

a. The unit of service shall be one day and billing shall not exceed 344 days per ISP year.

b. Total billing shall not exceed the amount authorized in the ISP. The provider shall maintain documentation of the dates that services have been provided, and specific circumstances that prevented provision of all of the scheduled services, should that occur. This service shall be provided on an individual-specific basis according to the ISP and service setting requirements;

c. Supported living residential services shall not be provided to any individual enrolled in the waiver who receives personal assistance services or other residential services under the CL waiver, such as group home residential services, shared living, in-home support services, or sponsored residential services, that provide a comparable level of care.

d. Room and board shall not be components of this service;

e. Supported living residential services shall not be used solely to provide routine or emergency respite care for the family/caregiver with whom the individual lives; and

f. Medicaid reimbursement shall be available only for supported living residential services provided when the individual is present and when an enrolled Medicaid provider is providing the services.

4. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-500 et seq., and 12VAC30-120-1064.

B. Sponsored Residential Services.

1. Service description. Sponsored residential services means residential services that consist of skill-building, routine supports, general supports, and safety supports that are provided in the homes of families or persons (sponsors) providing supports under the supervision of a DBHDS-licensed provider, that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community settings. This service shall include skills development with the provision of supports, as needed. After January 1, 2017, sponsored living residential services shall be a tiered service for reimbursement purposes. After January 1, 2017, providers shall only be reimbursed for the individual's assigned level and tier.

2. Criteria. This service shall only be authorized for Medicaid reimbursement when, through the person-centered planning process, this service is determined necessary to meet the individual's needs. These services may be provided individually or simultaneously to up to two individuals living in the same home, depending on the required support.

3. Allowable activities shall include: (i) skill-building and routine supports related to personal care activities, (such as ADLs), communication and IADLs; (ii) skill-building and routine and safety supports related to the use of community resources; (iii) replacing challenging behaviors with positive, accepted behaviors; (iv) monitoring and supporting health and physical conditions, and the provision of supports with medication management and other medical needs; (v) routine and safety supports with transportation to and from training sites and community resources/activities, and; (vi) providing general supports and safety supports.

4. Units and limits.

a. The unit of service shall be one day and billing shall not exceed 344 days per ISP year, as indicated in the Plan for Supports of the individuals who are authorized to receive this service.

b. This service shall not be covered for individuals who are simultaneously receiving shared living services, supported living services, in-home support services, or group home residential services.

c. DMAS coverage of this service shall be limited to no more than two individuals per residential setting. Providers shall not bill for services rendered to more than two individuals living in the same residential setting.

d. This service shall be provided to individuals up to 24-hours per day by the sponsor family who shall be physically present with the individual.

5. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-500 et seq., and 12VAC30-120-1064.

12VAC30-120-1037. Covered services: therapeutic consultation.

A. Therapeutic consultation. Service description. This service shall provide assessments, development of a therapeutic consultation plan, and teaching in any of the following specialty areas to assist family members, caregivers, and other service providers in assisting the individual enrolled in the waiver. The specialty areas shall be (i) psychology, (ii) behavioral consultation services, (iii) therapeutic recreation, (iv) speech and language pathology, (v) occupational therapy, (vi) physical therapy, and (vii) rehabilitation engineering. The need for any of these services shall be based on the individuals' Individual Support Plan, and shall be provided to an individual for whom specialized consultation is clinically necessary. Therapeutic consultation services may be provided in individuals' homes, and in appropriate community settings (such as licensed or approved homes or day support programs) as long as they are intended to facilitate implementation of individuals' desired outcomes as identified in their Individual Support Plans.

B. Service criteria. In order to qualify for these services, the individual shall have a documented need for consultation in any of these services. Documented need shall indicate that the ISP cannot be implemented effectively and efficiently without such consultation as provided by this covered service and approved through service authorization.

1. The individual's therapeutic consultation plan shall clearly reflect the individual's needs, as documented in the assessment information, for specialized consultation provided to family/caregivers and providers in order to effectively implement the ISP.

2. Other than behavioral consultation, therapeutic consultation services shall not include direct therapy provided to individuals enrolled in the waiver and shall not duplicate the activities of other services that are available to the individual through the State Plan for Medical Assistance. Behavior Consultation Services may include direct behavioral interventions and demonstration to family members/staff of such interventions.

C. Service units and limits.

1. The unit of service shall be one hour.

2. The services shall be explicitly detailed in the ISP.

3. Travel time, written preparation, and telephone communication shall be considered as in-kind expenses within this service and shall not be reimbursed as separate items.

4. Therapeutic consultation shall not be billed solely for purposes of monitoring the individual.

5. Only behavioral consultation in this therapeutic consultation service may be offered in the absence of any other waiver service.

D. Allowable activities shall include:

a. Interviewing the individual, family members, caregivers, and relevant others to identify issues to be addressed and desired outcomes of consultation;

b. Observing the individual in daily activities and natural environments;

c. Assessing the individual's need for an assistive device or modification or adjustment, or both, in the environment or services including reviewing documentation and evaluating the efficacy of assistive devices and interventions identified in the therapeutic consultation plan;

d. Developing data collection mechanisms and collecting baseline data as appropriate for the type of consultation service provided;

e. Observing and assessing the current interventions, support strategies, or assistive devices being used with the individual;

f. Designing a written therapeutic consultation plan detailing the interventions, environmental adaptations, and support strategies to address the identified issues and desired outcomes, including recommendations related to specific devices, technology or adaptation of other training programs or activities including training relevant persons to better support the individual simply by observing the individual's environment, daily routines and personal interactions;

g. Demonstrating specialized, therapeutic interventions, individualized supports, or assistive devices;

h. Training family/caregivers and other relevant persons to assist the individual in using an assistive device, to implement specialized, therapeutic interventions or adjust currently utilized support techniques;

i. Intervening directly, by behavioral consultants, with the individual and demonstrating to family/caregivers/staff such interventions. Such intervention modalities shall relate to the individual's identified behavioral needs as detailed in established specific goals and procedures set out in the ISP.

E. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-500 et seq., and 12VAC30-120-1068(C).

12VAC30-120-1038. Covered services: transition services.

This service shall be the same as set out in 12 VAC 30-120-2000 and 12 VAC 30-120-2010.

12VAC30-120-1039. Covered services: workplace assistance services.

A. Workplace assistance services description. Workplace assistance services means supports provided to an individual who has completed job development and completed or nearly completed job placement training (i.e. supported employment) but requires more than the typical job coach services to maintain stabilization in his employment. These services are supplementary to individual supported employment services.

B. Workplace assistance criteria.

1. The activity shall not be work skill training related which would normally be provided by a job coach;

2. Services shall be delivered in their natural setting, where and when they are needed, and

3. Services shall facilitate the maintenance of and inclusion in an employment situation.

C. Allowable activities include:

1. Habilitative supports related to non-work skills needed for the individual to maintain employment;

2. Habilitative supports to make and strengthen community connections; and

3. Safety supports to ensure the individual's health and safety.

D. Workplace assistance service units and service limitations.

1. A unit shall be one hour. This service may be provided during the time that the individual being served is working, up to and including 40 hours a week. There shall be no annual limit on how long these services may remain authorized.

2. This service shall not be provided simultaneously with work-related personal assistance services. This service shall not be provided solely for the purpose of providing assistance with ADLs to the individual when he is working.

3. The service delivery ratio shall be one staff person to one waiver individual. Workplace assistance services, alone or in combination with community engagement, community coaching, supported employment, or group day services shall not exceed 66 hours per week.

4. The provider shall render on-site habilitative supports related to behavior, health, time management or other skills that otherwise would endanger the individual's continued employment. The provider may provide assistance to the individual with personal care needs as well; however, this cannot be the sole use of workplace assistance services.

E. Provider requirements. Providers shall meet all of the requirements set forth in 12VAC30-120-500 et seq., and 12VAC30-120-1066(C).

12VAC30-120-1059. Provider Requirements: Services Facilitation.

A. Provider Requirements for services facilitation shall be the same as those set forth in 12VAC30-120-759(B) and 12VAC30-120-770(B).

12VAC30-120-1061. Provider requirements for assistive technology (AT), electronic home based services (EHBS), environmental modifications (EM), Personal Emergency Response systems (PERS).

A. The required documentation for assistive technology, environmental modifications (EM), electronic home-based supports (EHBS), and Personal Emergency Response Systems (PERS) shall be as follows:

1. The appropriate service authorization, to be completed by the support coordinator/case manager, may serve as the Plan for Supports for the provision of AT, EM, EHBS, and PERS services. A rehabilitation engineer may be involved for AT, EHBS, PERS, or EM services if disability expertise is required that a general contractor may not have. The Plan for Supports and service authorization shall include justification and explanation if a rehabilitation engineer is needed. The service authorization request shall be submitted to the state-designated agency or its designee in order for service authorization to occur;

2. For these services, written documentation regarding the process and results of ensuring that the item is not covered by the State Plan for Medical Assistance as DME and supplies, and that it is not available from a DME provider;

3. Documentation of the recommendation for the item by an independent professional consultant;

4. Documentation of the date services are rendered and the amount of service that is needed;
5. Any other relevant information regarding the device or modification;
6. Documentation in the support coordination/case management record of notification by the designated individual or individual's representative family/caregiver of satisfactory completion or receipt of the service or item; and
7. Instructions regarding any warranty, repairs, complaints, or servicing that may be needed.

B. Assistive technology (AT). In addition to meeting the service coverage requirements in 12 VAC 30-120-1021 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-500 et seq., AT shall be provided by DMAS-enrolled durable medical equipment (DME) providers or DMAS-enrolled CSBs/BHAs with a signed, current waiver provider agreement with DMAS to provide AT. DME shall be provided in accordance with 12VAC30-50-165.

1. Independent assessments for AT shall be conducted by independent professional consultants. Independent, professional consultants include speech/language therapists, physical therapists, occupational therapists, physicians, behavioral therapists, certified rehabilitation specialists, or rehabilitation engineers.
2. Providers that supply AT for an individual shall not perform assessment/consultation, write specifications, or inspect the AT for that individual. Providers of services shall not be spouses or parents (natural, adoptive, foster, or step-parent)/caregivers of the individual.
3. AT shall be delivered within the ISP year, or within a year from the start date of the authorization.
4. If required, a rehabilitation engineer or certified rehabilitation specialist may be utilized: (i) if the assistive technology will be initiated in combination with environmental modifications involving systems which are not designed to be compatible or (ii) an existing device must be modified or a specialized device must be designed and fabricated.

C. Electronic home-based supports (EHBS).

1. Providers of this service shall have a current, signed participation agreement with DMAS. Providers as designated on this agreement shall render these services directly and shall bill DMAS directly for Medicaid reimbursement. These providers shall be one of the following:
 - a. A licensed personal care agency;
 - b. An Durable Medical Equipment provider;
 - c. A CSB/BHA;
 - d. A Center for Independent Living;
 - e. A licensed home health provider; or
 - f. An EHBS manufacturer that has the ability to provide electronic home-based equipment, direct services (i.e., installation, equipment maintenance, service calls and monitoring services);

2. The EHBS provider shall have the primary responsibility to furnish, install, maintain, test, and service the equipment, as may be required, to keep it fully operational.

3. The EHBS provider shall properly install all authorized equipment and shall furnish all supplies necessary to ensure that the system is properly installed and working.

4. The provider shall replace or repair the device or system within 24-hours of the individual's, or family/caregiver's, notification of a malfunction of the unit or system.

5. The provider of ongoing electronic monitoring systems shall provide an emergency response center with fully trained operators who are capable of receiving signals for help from an individual's EHBS equipment 24-hours a day, 365, or 366, days per year as appropriate, of determining whether an emergency exists, and of notifying an emergency response organization or an emergency responder that the EHBS service individual needs emergency help.

6. The EHBS provider shall install, test, and demonstrate to the individual and family/caregiver, as appropriate, the unit or system before submitting his claim for services to DMAS.

7. An EHBS provider shall maintain a data record for each individual receiving EHBS at no additional cost to DMAS. The record shall document all of the following:

(a) Delivery date and installation date of the EHBS;

(b) The signature of the individual or his family/caregiver, as appropriate, verifying receipt of the EHBS device;

(c) Verification by a test that the EHBS device is operational, monthly or more frequently as needed;

(d) Updated and current individual responder and contact information, as provided by the individual or the individual's care provider, or support coordinator/case manager; and

(e) A case log documenting the individual's utilization of the system and contacts and communications with the individual or his family/caregiver, as appropriate, support coordinator/case manager, or responder.

D. Environmental modifications. In addition to meeting the service coverage requirements in 12VAC30-120-1025 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-500 et seq., environmental modifications shall be provided in accordance with all applicable federal, state, or local building codes and laws by CSBs/BHAs contractors or DMAS-enrolled providers.

E. Personal Emergency Response Systems. In addition to meeting the service coverage requirements in 12VAC30-120-1030 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-500 et seq., PERS providers shall also meet the requirements in 12VAC30-120-1560(P).

12VAC30-120-1062. Provider requirements for companion services, personal assistance, and respite services.

A. Licensure Requirements for Agency Directed Services.

1. For companion, personal assistance, and respite services, the provider shall be licensed by DBHDS as either a residential service provider, supportive in-home residential service provider, day support service provider, or respite service provider or shall meet the DMAS criteria to be a personal care/respite care provider.

B. Supervision Requirements for agency-directed companion, personal assistance and respite services.

1. A supervisor shall provide ongoing supervision of all personal assistants, companions, and respite assistants.

2. For DMAS-enrolled personal assistance and respite providers, the provider shall employ or subcontract with and directly supervise an RN or an LPN who shall provide ongoing supervision of all assistants. The supervising RN or LPN shall have at least one year of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/IID, or nursing facility.

3. For companion service providers, the provider shall employ or subcontract with and directly supervise an RN or an LPN who shall provide ongoing supervision of all companions. The supervising RN or LPN shall have at least one year of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/IID, or nursing facility or shall have a bachelor's degree in a human services field and at least one year of experience working with individuals with developmental disabilities.

4. The supervisor shall make a home visit to conduct an initial assessment prior to the start of services for all individuals enrolled in the waiver requesting, and who have been approved to receive, personal assistance, companion, or respite services. The supervisor shall also perform any subsequent reassessments or changes to the Plan for Supports. All changes that are indicated for an individual's Plan for Supports shall be reviewed with and agreed to by the individual and, if appropriate, the family/caregiver.

5. The supervisor shall make supervisory home visits as often as needed to ensure both quality and appropriateness of services. The minimum frequency of these visits shall be every 30 to 90 days under the agency-directed model, depending on the individual's needs.

6. Based on continuing evaluations of the assistant's/companion's performance and individual's needs, the supervisor shall identify any gaps in the assistant's/companion's ability to function competently and shall provide training as indicated.

C. Service Facilitation Requirements for companion, personal assistance, and respite services shall be the same as those set forth in 12VAC30-120-759(A) and 12VAC30-120-770.

D. Family members as providers in companion, personal assistance, and respite services (agency directed and consumer directed).

1. Individuals paid by DMAS shall not be the parents of individuals enrolled in the waiver who are minor children or the individuals' spouses.

2. Persons rendering services for reimbursement by DMAS shall not be the individual's spouse. Other family members living under the same roof as the individual being served may not provide companion or assistant services unless there is objective written documentation completed by the services facilitator, or the EOR when the individual does not select services facilitation, as to why there are no other providers available to provide services.

3. Family members who are approved to be reimbursed for providing these services shall meet the same qualifications as all other staff providing services.

E. Required Documentation (agency-directed and consumer-directed). In addition to the requirements in 12VAC30-120-500 et seq., the following requirements for personal assistance services, respite services, and companion services apply.

1. Agency-directed providers or the services facilitator, or the EOR in the absence of a services facilitator, shall maintain records regarding each individual who is receiving services.

2. At a minimum, these records shall contain:

a. A copy of the completed DBHDS-approved SIS assessment and, as needed, an initial assessment completed by the supervisor or services facilitator prior to or on the date services are initiated.

b. The provider's Plan for Supports, that contains, at a minimum, the following elements:

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

(2) The individual's support activities to meet the identified outcomes;

(3) Services to be rendered and the frequency of such services to accomplish the above desired outcomes and support activities; and

c. Documentation indicating that the Plan for Supports' desired outcomes and support activities have been reviewed by the provider quarterly, annually, and more often as needed. The results of the review shall be submitted to the support coordinator/case manager. For the annual review and in cases where the Plan for Supports is modified, the Plan for Supports shall be reviewed with and agreed to by the individual enrolled in the waiver and the individual's family/caregiver, as appropriate.

d. The services supervisor or CD services facilitator shall document in the individual's record in a summary note following significant contacts with the assistant/companion and home visits with the individual the following:

(1) Whether services continue to be appropriate;

(2) Whether the Plan for Supports is adequate to meet the individual's needs or changes are needed in the plan;

(3) The individual's satisfaction with the service;

(4) The presence or absence of the assistant/companion during the supervisor's visit;

- (5) Any suspected abuse, neglect, or exploitation and to whom it was reported; and
- (6) Any hospitalization or change in medical condition, functioning, or cognitive status;
- e. All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator/ case manager, DMAS, and DBHDS;
- f. Contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual; and
- g. Documentation provided by the support coordinator/ case manager as to why there are no providers other than family members available to render assistant/companion services if this service is part of the individual's Plan for Supports.

3. The records of individuals enrolled in the waiver who are receiving services shall contain:

- a. The specific services delivered to the individual enrolled in the waiver, dated the day that such services were provided, the number of hours as outlined in the Plan for Supports, the individual's responses, and observations of the individual's physical and emotional condition; and
- b. At a minimum, monthly verification by the residential supervisor of the services and hours rendered and billed to DMAS.

F. Consumer-directed services: enrollment and disenrollment.

1. Individuals enrolled in the waiver may choose between the agency-directed model of service delivery or the consumer-directed model when DMAS makes this alternative model available for care. The only services provided in this waiver that permit the consumer-directed model of service delivery shall be: (i) personal assistance services; (ii) respite services; and (iii) companion services. An individual enrolled in the waiver shall not be able to choose consumer-directed services if any of the following conditions exists:

- a. The individual enrolled in the waiver is younger than 18 years of age or is unable to be the employer of record and no one else can assume this role;
- b. The health, safety, or welfare of the individual enrolled in the waiver cannot be assured or a back-up emergency plan cannot be developed; or
- c. The individual enrolled in the waiver has medication or skilled nursing needs or medical/behavioral conditions that cannot be safely met via the consumer-directed model of service delivery.

2. Voluntary/involuntary disenrollment of consumer-directed services. Either voluntary or involuntary disenrollment of consumer-directed services may occur. In either voluntary or involuntary situations, the individual enrolled in the waiver shall be permitted to select an agency from which to receive his personal assistance, respite, or companion services. If the individual either fails to select an agency or refuses to do so, then one will be selected for him by either the support coordinator/case manager or services facilitator.

- a. An individual who has chosen consumer direction may choose, at any time, to change to the agency-directed services model as long as he continues to qualify for the specific services. The

services facilitator or support coordinator/case manager, as appropriate, shall assist the individual with the change of services from consumer-directed to agency-directed.

b. The services facilitator or support coordinator/case manager, as appropriate, shall initiate involuntary disenrollment from consumer direction of an individual enrolled in the waiver when any of the following conditions occur:

- (1) The health, safety, or welfare of the individual enrolled in the waiver is at risk;
- (2) The individual or EOR, as appropriate, demonstrates consistent inability to hire and retain a personal assistant CD employee; or
- (3) The individual or EOR, as appropriate, is consistently unable to manage the assistant CD employee, as may be demonstrated by, but shall not necessarily be limited to, a pattern of serious discrepancies with timesheets.

c. Prior to involuntary disenrollment, the services facilitator or support coordinator/case manager, as appropriate, shall:

- (1) Verify that essential training has been provided to the individual or EOR, as appropriate, to improve the problem condition or conditions;
- (2) Document in the individual's record the conditions creating the necessity for the involuntary disenrollment and actions taken by the services facilitator or support coordinator/case manager, as appropriate;
- (3) Discuss with the individual or the EOR, as appropriate, the agency directed option that is available and the actions needed to arrange for such services while providing a list of potential providers; and
- (4) Provide written notice to the individual and EOR, as appropriate, of the right to appeal, pursuant to 12VAC30-110, such involuntary termination of consumer direction. Except in emergency situations in which the health or safety of the individual is at serious risk, such notice shall be given at least 10 business days prior to the effective date of the termination of consumer direction. In cases of an emergency situation, notice of the right to appeal shall be given to the individual but the requirement to provide notice at least 10 business days in advance shall not apply.

d. If the services facilitator initiates the involuntary disenrollment from consumer direction, then he shall inform the support coordinator/case manager.

G. Consumer-directed attendant requirements for companion, personal assistance, and respite services.

1. For the consumer-directed model, there shall be a services facilitator (or person serving in this capacity) meeting the requirements found in 12VAC30-120-759(B) and 12VAC30-120-770.

2. Persons functioning as CD attendants/companions shall meet the following requirements:

a. Be at least 18 years of age;

- b. Possess basic math skills and be able to read and write English to the degree required to function in this capacity and create and maintain the required documentation;
- c. Be capable of following a Plan for Supports with minimal supervision and be physically able to perform the required work;
- d. Possess a valid social security number that has been issued by the Social Security Administration;
- e. Be capable of aiding in IADLs;
- f. Receive an annual tuberculosis screening in accordance with guidelines published on the VDH website.
- g. Be willing to attend training at the individual's and the individual family/caregiver's, as appropriate, request;
- h. Understand and agree to comply with the DMAS' waiver requirements as contained in 12VAC30-120-1000 et seq.; and
- i. Not be the EOR who is directing the individual's care.

3. If an individual or his family/caregiver, as appropriate, is consistently unable to hire and retain an employee to provide consumer-directed services, the services facilitator shall contact the support coordinator/case manager and DBHDS to transfer the individual, at the choice of the individual or his family/caregiver, as appropriate, to a provider that provides Medicaid-funded agency-directed personal care assistance or respite care services. The CD services facilitator shall make arrangements with the support coordinator/case manager to have the individual transferred.

H. Requirements for agency-directed companions/assistants.

1. Assistants/companions shall have completed an educational curriculum of at least 40 hours of study related to the needs of individuals who have disabilities, including intellectual/developmental disabilities, as ensured by the provider prior to being assigned to support an individual, and have the required skills and training to perform the services as specified in the individual's Plan for Supports and related supporting documentation.

Assistants'/companions' required training, as further detailed in the applicable provider manual, shall be met in one of the following ways:

- a. Registration with the Board of Nursing as a certified nurse aide;
 - b. Graduation from an approved educational curriculum as listed by the Board of Nursing; or
 - c. Completion of the provider's educational curriculum, as conducted by a licensed RN who shall have at least one year of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/IID, or nursing facility.
2. Assistants/companions shall have a satisfactory work record, as evidenced by two references from prior job experiences, if applicable, including no evidence of possible abuse, neglect, or exploitation of elderly persons, children, or adults with disabilities.

3. Provider inability to render services and substitution of assistants (agency-directed model). When assistants/companions are absent or otherwise unable to render scheduled supports to individuals enrolled in the waiver, the provider shall be responsible for ensuring that services continue to be provided to the affected individuals.

a. The provider may either provide another assistant/companion, obtain a substitute assistant/companion from another provider if the lapse in coverage is to be less than two weeks in duration, or transfer the individual's services to another personal care assistance or respite provider. The provider that has the service authorization to provide services to the individual enrolled in the waiver shall contact the support coordinator/case manager to determine if additional, or modified, service authorization is necessary.

b. If no other provider is available who can supply a substitute assistant/companion, the provider shall notify the individual and the individual's family/caregiver, as appropriate, and the support coordinator/case manager so that the support coordinator/case manager may find another available provider of the individual's choice.

4. During temporary, short-term lapses in coverage that are not expected to exceed approximately two weeks in duration, the following procedures shall apply:

a. The service authorized provider shall provide the supervision for the substitute assistant/companion;

b. The provider of the substitute assistant/companion shall send a copy of the assistant's/companion's daily documentation signed by the assistant/companion, the individual, and the individual's family/caregiver, as appropriate, to the provider having the service authorization; and

c. The service authorized provider shall bill DMAS for services rendered by the substitute assistant/companion.

5. If a provider secures a substitute assistant/companion, the provider agency shall be responsible for ensuring that all DMAS requirements continue to be met including documentation of services rendered by the substitute assistant/companion and documentation that the substitute assistant's/companion's qualifications meet DMAS' requirements. The two providers involved shall be responsible for negotiating the financial arrangements of paying the substitute assistant/companion.

I. Agency-directed documentation requirements:

1. The record for agency-directed service providers shall contain:

a. The specific services delivered to the individual enrolled in the waiver by the assistant/companion, dated the day of service delivery, and the individual's responses;

b. The personal assistant's/companion's arrival and departure times;

c. The personal assistant's/companion's weekly comments or observations about the individual enrolled in the waiver to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and

d. The personal assistant's/companion's and individual's and the individual's family/caregiver's, as appropriate, weekly signatures recorded on the last day of service delivery for any given week to verify that companion services during that week have been rendered.

e. These records shall be separated from those of other non-waiver services, such as home health services. At a minimum these records shall contain:

(1) The most recently updated plan of care for supports and supporting documentation, and all provider documentation;

(2) A copy of the SIS® assessment, the initial assessment by the RN supervisory nurse or support coordinator/case manager/services facilitator completed prior to or on the date services are initiated, subsequent reassessments, and changes to the supporting documentation by the RN supervisory nurse or support coordinator/case manager/services facilitator;

(3) Nurses' or support coordinator/case manager/services facilitator summarizing notes recorded and dated during any contacts with the CD attendant and during supervisory visits to the individual's home;

J. Special Requirements for respite services

1. When respite services are not received on a routine basis, but are episodic in nature, the supervisor or services facilitator shall conduct the initial home visit with the respite assistant immediately preceding the start of services and make a second home visit within the respite service authorization period. The supervisor or services facilitator, as appropriate, shall review the use of respite services either every six months or upon the use of 240 respite service hours, whichever comes first.

2. When respite services are routine in nature, that is occurring with a scheduled regularity for specific periods of time, and offered in conjunction with personal assistance, the supervisory visit conducted for personal assistance may serve as the supervisory visit for respite services. However, the supervisor or services facilitator, as appropriate, shall document supervision of respite services separately. For this purpose, the same individual record shall be used with a separate section for respite services documentation.

12VAC30-120-1063. Provider requirements for crisis support services (including crisis stabilization); center-based crisis supports; community-based crisis supports.

A. Crisis support services. In addition to the service coverage requirements in 12VAC30-120-1024 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-500 et seq., the following crisis support provider qualifications shall apply:

1. Documentation of providers' qualifications shall be maintained for review by DBHDS and DMAS staff or DMAS' designated agent.

2. A Plan for Supports shall be developed (or revised, in case of a request for extension) and submitted to the support coordinator/ case manager for authorization within 72 hours of the requested start date and face-to-face assessment or reassessment for authorization.

3. Provider documentation requirements shall be the same as those set forth in 12VAC30-120-1024(E)(5).

4. Required documentation in the individual's record. The provider shall maintain a record regarding each individual enrolled in the waiver who is receiving crisis support services. At a minimum, the record shall contain the following:

a. Documentation of the face-to-face assessment and any reassessments completed by a QDDP;

b. A Plan for Supports that contains, at a minimum, the following elements:

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

(2) Services to be rendered and the frequency of services to accomplish these desired outcomes and support activities;

(3) A timetable for the accomplishment of the individual's desired outcomes and support activities;

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

(5) The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports; and

B. Center-based crisis supports.

1. Provider documentation requirements shall be the same as those set forth in 12VAC30-120-1024(E)(5).

C. Community-based crisis supports.

1. Provider documentation requirements shall be the same as those set forth in 12VAC30-120-1024(E)(5).

2. Required documentation in the individual's record. The provider shall maintain a record regarding each individual enrolled in the waiver who is receiving community-based crisis support services. At a minimum, the record shall contain the following:

a. Documentation of the face-to-face assessment and any reassessments completed by a QDDP;

b. A plan for supports that contains, at a minimum, the following elements:

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

(2) Services to be rendered and the frequency of services to accomplish these desired outcomes and support activities;

(3) A timetable for the accomplishment of the individual's desired outcomes and support activities;

- (4) The estimated duration of the individual's needs for services; and
- (5) The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports.

12VAC30-120-1064. Provider requirements for group home residential services; sponsored residential; supported living residential.

A. The required documentation for group home residential, sponsored residential, and supported living residential shall be as follows:

1. A completed copy of the DBHDS-approved SIS© assessment form.
2. The provider's Plan for Supports containing, at a minimum, the following elements:
 - a. The individual's strengths, desired outcomes, required or desired supports or both, and skill-building needs;
 - b. The individual's support activities to meet the identified outcomes;
 - c. The services to be rendered and the schedule of such services to accomplish the desired outcomes and support activities;
 - d. A timetable for the accomplishment of the individual's desired outcomes and support activities;
 - e. The estimated duration of the individual's needs for services; and
 - f. The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports.
3. Documentation indicating that the Plan for Supports' desired outcomes and support activities have been reviewed by the provider quarterly, annually, and more often as needed. The results of the review shall be submitted to the support coordinator/ case manager. For the annual review and in cases where the Plan for Supports is modified, the Plan for Supports shall be reviewed with and agreed to by the individual enrolled in the waiver and the individual's family/caregiver, as appropriate.
4. All correspondence to the individual and the individual's family/caregiver, as appropriate, the support coordinator/ case manager, DMAS, and DBHDS.
5. Written documentation of contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.

B. Group home residential services. In addition to meeting the service coverage requirements in 12VAC30-120-1027 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-500 et seq., group home residential providers, shall meet the following additional requirements:

1. The provider of group home residential services for adults (ages 18 years or older) shall be licensed by DBHDS as a provider of group home residential services or a provider approved by the local department of social services as an adult foster care provider (12VAC 35-105-20). Providers of group home residential services for children (ages up to the 18th birthday) shall be licensed by DBHDS as children's residential providers.

2. Provider documentation shall confirm the individual's days in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the Plan for Supports. This documentation shall be available in a daily progress note. Data shall be collected as described in the Plan for Supports, summarized, and then relevant changes should be added to the supporting documentation.

3. The supporting documentation shall be reviewed by the provider with the individual and family/caregiver as appropriate, and this written review submitted to the support coordinator/case manager, at least quarterly, with desired outcomes, support activities, and strategies modified as appropriate.

4. These services shall include a skills development component along with the provision of supports, as needed.

C. Supported living residential services. Service providers shall be licensed by DBHDS as providers of supervised living residential services.

12VAC30-120-1065. Provider requirements for community engagement; community coaching.

A. Community engagement. In addition to meeting the service coverage requirements in 12VAC30-120-1022(A) and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-500 et seq., community engagement providers shall meet the following additional requirements:

1. Community engagement service providers shall be licensed by DBHDS as providers of non-center based day support services.

2. Such providers shall have a current, signed provider participation agreement with DMAS in order to render these services for Medicaid reimbursement. The provider that is designated in this agreement shall render the services directly and shall directly bill DMAS for reimbursement.

3. Prior to rendering these services, community engagement providers shall also ensure that persons rendering these services have received training in the characteristics of developmental disabilities and appropriate interventions, training strategies and other methods of supporting individuals with functional limitations.

a. In addition to receiving such training, these persons shall pass, with at least a score of 80%, an objective, standardized test of knowledge, skills, and abilities in the characteristics of developmental disabilities and appropriate interventions, training strategies and other methods of supporting individuals with functional limitations.

b. This required test shall be administered according to DBHDS' defined procedures.

c. The provider shall maintain documentation of this training and acceptable testing results on all persons employed to render community engagement services. Such documentation shall be provided to DMAS and DBHDS upon request.

B. Community coaching provider requirements.

1. Community coaching service providers shall be licensed by DBHDS as a provider of day support services.
2. Providers shall have a current, signed provider participation agreement with DMAS in order to provide these services. The provider designated in the participation agreement shall directly provide the services and bill DMAS for reimbursement.
3. Providers shall also assure that persons providing community coaching services have received training in the characteristics of developmental disabilities and appropriate interventions, training strategies and other methods of supporting individuals with functional limitations prior to providing waiver services and pass an objective standardized test, with a score of at least 80%, of skills, knowledge, and abilities approved by DBHDS that shall be administered according to DBHDS' defined procedures.
4. The provider shall maintain documentation of the training and acceptable testing results on all persons employed to render community coaching services. Such documentation shall be provided to DMAS and DBHDS upon request.

C. Community guide (RESERVED).

12VAC30-120-1066. Provider requirements for supported employment (individual & group); workplace assistance.

A. Group supported employment services. In addition to meeting the service coverage requirements in 12VAC30-120-1035 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-500 et seq., group supported employment providers shall meet the following additional requirements:

1. Providers of group-supported employment services shall be DARS-contracted providers of supported employment services. DARS shall verify that these providers meet criteria to be providers through a DARS-recognized accrediting body. DARS shall provide the documentation of this accreditation verification to DMAS and DBHDS upon request.
2. Providers shall maintain their accreditation in order to continue to receive Medicaid reimbursement. Providers that lose their accreditation, regardless of the reason, shall not be eligible to receive Medicaid reimbursement and shall have their provider agreement terminated by DMAS. Reimbursements made to such providers after the date of the loss of the accreditation shall be subject to recovery by DMAS.
3. Provider documentation shall confirm the individual's amount of time in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the plan for supports. Assessment results shall be available in at least a daily note or

a weekly summary. Data shall be collected as described in the Plan for Supports, reviewed, summarized, and included in the regular supporting documentation.

4. The supporting documentation shall be reviewed by the provider with the individual and family/caregiver as appropriate, and this written person-centered review submitted to the support coordinator/case manager, at least quarterly, with desired outcomes, support activities, and strategies modified as appropriate.

5. Providers of group-supported employment shall submit employment-related data to DBHDS as requested and no more than quarterly.

B. Individual supported employment services. In addition to meeting the service coverage requirements in 12VAC30-120-1035 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-500 et seq., individual supported employment providers shall meet the following additional requirements:

1. Individual supported employment services providers shall have a current, signed provider participation agreement with DMAS. The provider designated in this agreement shall directly coordinate the services and directly bill DMAS for reimbursement.

2. Providers of individual supported employment services shall be providers of supported employment services with DARS. DARS shall verify that these providers meet criteria to be providers through a recognized accrediting body. DARS shall provide the documentation of this accreditation verification to DMAS and DBHDS upon request.

3. Providers shall maintain their accreditation in order to continue to receive Medicaid reimbursement. Providers that lose their accreditation, regardless of the reason, shall not be eligible to receive Medicaid reimbursement and shall have their provider agreement terminated by DMAS. Reimbursements made to such providers after the date of the loss of the accreditation shall be subject to recovery by DMAS. Providers whose accreditation is restored shall be permitted to re-enroll with DMAS upon presentation of accreditation documentation and a new signed provider participation agreement.

4. Provider documentation shall confirm the individual's amount of time in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the plan for supports. Assessment results shall be available in at least a daily note or a weekly summary. Data shall be collected as described in the plan for supports, reviewed, summarized, and included in the regular supporting documentation.

5. The supporting documentation shall be reviewed by the provider with the individual and family/caregiver as appropriate, and this written person-centered review submitted to the support coordinator/case manager, at least quarterly, with desired outcomes, support activities, and strategies modified as appropriate.

6. Providers of group-supported employment shall submit employment-related data to DBHDS as requested and no more than quarterly.

C. Workplace assistance. In addition to meeting the service coverage requirements in 12VAC30-120-1039 and the general conditions and requirements for home and community-

based participating providers as specified in 12VAC30-120-500 et seq., workplace assistance services providers shall meet the following additional requirements:

1. These providers shall be either:
 - a. Providers of supported employment services with DARS, or
 - b. Be licensed by DBHDS as a provider of non-center-based day support services.
2. Prior to seeking reimbursement for this service from DMAS, these providers shall ensure that staff persons providing workplace assistance services have completed training regarding the principles of supported employment. The documentation of the completion of this training shall be maintained by the provider and shall be provided to DMAS and DBHDS upon request.
3. The direct support professional providing workplace assistance services shall coordinate his service provision with the job coach, if there is one working with the individual, who may be providing individual supported employment services to the individual being supported.

12VAC30-120-1067. Nursing services (skilled and private duty).

A. Skilled nursing services. In addition to meeting the service requirements in 12VAC30-120-1031 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-500 et seq., participating skilled nursing providers shall meet the following requirements:

1. Required documentation. The provider shall maintain a record, for each individual enrolled in the waiver whom he serves, that contains:
 - a. A Plan for Supports that contains, at a minimum, the following elements:
 - (1) The individual's strengths, desired outcomes, and required or desired supports;
 - (2) Services to be rendered and the frequency of services to accomplish the ~~above~~-desired outcomes and support activities;
 - (3) The estimated duration of the individual's needs for services; and
 - (4) The provider staff responsible for the overall coordination and integration of the services specified in the Plan for Supports;
 - b. Documentation of all training, including the dates and times, provided to family/caregivers or staff, or both, including the person or persons being trained and the content of the training. Training of professional staff shall be consistent with the Regulations Governing the Practice of Nursing;
 - c. Documentation of the physician's determination of medical necessity prior to services being rendered;
 - d. Documentation of nursing license/qualifications of providers;

e. Documentation indicating the dates and times of nursing services that are provided and the amount and type of service;

f. Documentation that the Plan for Supports was reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and results of these reviews submitted to the support coordinator/case manager. For the annual review and in cases where the Plan for Supports is modified, the Plan for Supports shall be reviewed with and agreed to by the individual and the family/caregiver, as appropriate; and

g. Documentation that the Plan for Supports has been reviewed by a physician within 30 days of initiation of services, when any changes are made to the Plan for Supports, and also reviewed and approved annually by a physician.

2. Providers shall either employ or subcontract with nurses who are currently licensed as either RNs or LPNs under Chapter 30 of Title 54.1 of the Code of Virginia, or who hold a current multistate licensure privilege to practice nursing in the Commonwealth.

3. Skilled nursing services may be provided by either: (i) a licensed registered nurse (RN) or licensed practical nurse (LPN), who is under the supervision of a licensed RN, employed by a DMAS-enrolled home health provider, or; (ii) a licensed RN or LPN, who is under the supervision of a licensed RN contracted with or employed by a DBHDS-licensed day support, respite, or residential services provider.

B. Private duty nursing services provider requirements. In addition to meeting the service coverage requirements in 12VAC30-120-1031(B) and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-500 et seq., participating private duty nursing providers shall meet the following requirements:

1. If the provider designated in the participation agreement employs LPNs to render direct care, then he shall also employ an RN, or be an RN himself, in order to supervise the LPNs.

2. Private duty nursing services may be provided by either: (i) a licensed registered nurse (RN) or licensed practical nurse (LPN), who is under the supervision of a licensed RN, employed by a DMAS-enrolled home health provider, or; (ii) a licensed RN or LPN, who is under the supervision of a licensed RN contracted with or employed by a DBHDS-licensed day support, respite, or residential services provider.

3. Both RNs and LPNs providing private duty nursing services shall have current licenses issued by the Virginia Board of Nursing or current multi-state licensure privileges to practice nursing in the Commonwealth.

12VAC30-120-1068. Provider requirements for benefits planning; non-medical transportation; therapeutic consultation; transition services.

A. Benefits planning. (RESERVED.)

B. Non-medical transportation. (RESERVED.)

C. Therapeutic consultation. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-1037 and 12VAC30-120-500 et seq., professionals rendering therapeutic consultation services, including behavior consultation services, shall meet all applicable state licensure or certification requirements. Persons providing rehabilitation consultation services shall be rehabilitation engineers or certified rehabilitation specialists.

1. Supporting documentation for therapeutic consultation. The following information shall be required in the supporting documentation:

a. A Plan for Supports, that contains at a minimum, the following elements:

(1) Identifying information;

(2) Desired outcomes, support activities, and time frames; and

(3) Specific consultation activities.

b. A written support plan detailing the recommended interventions or support strategies for providers and family/caregivers to better support the individual enrolled in the waiver in the service.

c. Ongoing documentation of rendered consultative services which may be in the form of contact-by-contact or monthly notes, which must be signed and dated, that identify each contact, what was accomplished, and the professional who made the contact and rendered the service.

d. If the consultation services extend three months or longer, written quarterly reviews are required to be completed by the service provider and shall be forwarded to the support coordinator/case manager. If the consultation service extends beyond one year or when there are changes to the Plan for Supports, the plan shall be reviewed by the provider with the individual and family/caregiver, as appropriate. The Plan for Supports shall be agreed to by the individual and family/caregiver, as appropriate and the support coordinator/case manager and shall be submitted to the support coordinator/case manager. All changes to the Plan for Supports shall be reviewed with and agreed to by the individual and the individual's family/caregiver, as appropriate.

e. A final disposition summary shall be forwarded to the support coordinator/case manager within 30 days following the end of this service and shall include:

(1) Strategies utilized;

(2) Objectives met;

(3) Unresolved issues; and

(4) Consultant recommendations.

2. Professional qualifications.

a. Providers rendering therapeutic consultation services shall meet all applicable state or federal licensure, endorsement, or certification requirements.

b. Behavior consultation shall only be provided by (i) a Board-certified behavioral analyst (BCBA) or a Board-certified associate behavior analyst (BCABA); (ii) a positive behavioral supports facilitator endorsed by a recognized Positive Behavioral Supports Organization; or meet the criteria for psychology consultation.

c. Psychology consultation shall only be provided by the following individuals licensed in the Commonwealth of Virginia (i) a psychologist; (ii) a licensed professional counselor; (iii) a licensed clinical social worker; (iv) psychiatric clinical nurse specialist; or (v) a psychiatrist.

d. Speech consultation shall only be provided by a Speech-language pathologist who is licensed by the Commonwealth of Virginia.

e. Occupational therapy consultation shall only be provided by an occupational therapist who is licensed by the Commonwealth of Virginia.

f. Physical therapy consultation shall only be provided by a physical therapist who is licensed by the Commonwealth of Virginia.

g. Therapeutic recreation consultation shall only be provided by a therapeutic recreation specialist who is certified by the National Council for Therapeutic Recreation Certification.

g. Rehabilitation consultation shall only be provided by a rehabilitation engineer or certified rehabilitation specialist.

D. Transition services. Provider requirements shall be the same as those set out in 12 VAC 30-120-2000 and 12 VAC 30-120-2010.

12VAC30-120-1069. Provider requirements for shared living supports.

In addition to meeting the service coverage requirements in 12VAC30-120-1034 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-500 et seq., participating shared living support providers shall meet the following qualifications and requirements:

A. Shared living support administrative providers shall be licensed by DBHDS to provide services to individuals with DD, and shall manage the administrative aspects of this service, including roommate matching as needed, background checks, training, periodic on-site monitoring, and disbursing funds to the individual. This administrative provider shall be reimbursed a flat fee payment for the completion of these duties. DMAS may audit such provider's records for compliance with these requirements.

B. Administrative providers shall have a current, signed participation agreement with DMAS in order to provide these services. The provider designated in this agreement shall coordinate these services and submit claims directly to DMAS for reimbursement.

C. Administrative providers shall ensure that there is a backup plan in the event that the live-in roommate is unable to provide the agreed to supports.

D. Documentation of the actual amount of rent shall be submitted simultaneously with the request for service authorization.

D. Reimbursement for shared living support services shall be based upon compliance with DMAS' submission requirements for claims and supporting documentation as may be required as proof of service delivery. Claims that are not supported by the required documentation shall be subject to recovery by DMAS of any expenditures that may have been made.

F. For QMR and utilization review purposes, the administrative provider shall be required to maintain and present to DMAS as requested, an agreement that identifies what supports in the individual's Plan for Supports the roommate will provide, and this agreement shall be signed by the individual and the roommate. The individual's support coordinator/case manager shall retain a copy of this signed, executed agreement in his file for the particular individual.

G. The administrative provider shall ensure that there is a back-up plan in place in the event that the roommate is unable or unavailable to provide supports. The administrative provider shall maintain documentation of the actual rent, food, and utilities costs and submit it with the service authorization request for shared living services.

H. The administrative provider shall submit monthly claims for reimbursement based upon the amount determined through the service authorization process.

I. Weekly summaries of supports provided by the roommate and signed by the roommate shall be maintained by the administrative provider.

12VAC30-120-1070. Payment for services.

A. All shared living, group home residential, sponsored residential, supported living residential, in-home support, group day support, community engagement, community coaching, personal assistance (both agency directed and consumer directed), respite (both agency directed and consumer directed), skilled nursing, private duty nursing, therapeutic consultation, crisis support, center-based crisis support, community-based crisis support, PERS, companion (both agency directed and consumer directed), consumer-directed services facilitation, workplace assistance, and transition services provided in this waiver shall be reimbursed consistent with the agency's service limits and payment amounts as set out in the fee schedule.

B. Reimbursement rates for individual supported employment shall be the same as set by the Department for Aging and Rehabilitative Services for the same services. Reimbursement rates for group supported employment shall be as set by DMAS.

C. All AT and EM covered procedure codes provided in the CL waiver shall be reimbursed as a service limit of one. The maximum Medicaid funded expenditure per individual for all AT and EM covered procedure codes shall be \$5,000 each for AT and \$5000 for EM per calendar year. No additional mark-ups, such as in the durable medical equipment rules, shall be permitted.

D. Duplication of services.

1. DMAS shall not duplicate reimbursement for services that are required as a reasonable accommodation as a part of the ADA (42 USC §§ 12131 through 12165), the Rehabilitation Act of 1973, the Virginians with Disabilities Act, or any other applicable statute.
2. Payment for services under the Plan for Supports shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
3. Payment for services under the Plan for Supports shall not be made for services that are duplicative of each other.
4. Payments for services shall only be provided as set out in the individuals' Individual Support Plan.

12VAC30-120-1090. Appeals.

A. Providers shall have the right to appeal actions taken by DMAS or its designee. Provider appeals shall be considered pursuant to § 32.1-325.1 of the Code of Virginia and the Virginia Administrative Process Act (Chapter 40 (§ 2.2-4000 et seq.) of Title 2.2 of the Code of Virginia), and DMAS regulations at 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.

B. Individuals shall have the right to appeal an action taken by DMAS or its designee. Individuals' appeals shall be considered pursuant to 12VAC30-110-10 through 12VAC30-110-370. DMAS shall provide the opportunity for a fair hearing, consistent with 42 CFR Part 431, Subpart E. The individual shall be advised in writing of such denial and of his right to appeal consistent with DMAS client appeals regulations 12VAC30-110-70 and 12VAC30-110-80.

12VAC30-120-1500

Part XV

Building Independence Waiver

12VAC30-120-1500. Definitions.

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

"Appeal" means the same as defined in 12VAC30-120-1000.

"Assistive technology" means the same as defined in 12VAC30-120-1000.

"Barrier crime" means the same as defined in 12VAC30-120-1000.

"Behavioral health authority" or "BHA" means the same as defined in §37.2-100 of the Code of Virginia.

"Building Independence waiver" means the waiver set forth in 12VAC30-120-1500 et seq.

"Case manager" means the same as defined in 12VAC30-120-1000.

"Center-based crisis support services" means the same as defined in 12VAC30-120-1000.

"Centers for Medicare and Medicaid Services" or "CMS" means the same as defined in 12VAC30-120-1000.

"Community-based crisis support services" means the same as defined in 12VAC30-120-1000.

"Community coaching" means the same as defined in 12VAC30-120-1000.

"Community engagement" means the same as defined in 12VAC30-120-1000.

"Community services board" or "CSB" means the same as defined in §37.2-100 of the Code of Virginia.

"Crisis support services" means the same as defined in 12VAC30-120-1000.

"DARS" means the Department for Aging and Rehabilitative Services.

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

"DBHDS staff" means persons employed by the Department of Behavioral Health and Developmental Services.

"Developmental disability" means the same as defined in §37.2-100 of the Code of Virginia.

"Direct marketing" means the same as defined in 12VAC30-120-1000.

"Direct support professionals" or "DSPs" means the same as defined in 12VAC30-120-1000.

"DMAS" means the Department of Medical Assistance Services.

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

"Electronic home-based supports" or "EHBS" means the same as defined in 12VAC30-120-1000.

"Enroll" means the same as defined in 12VAC30-120-510.

"Environmental modifications" means the same as defined in 12VAC30-120-1000.

"EPSDT" means the same as defined in 12VAC30-120-1000.

"Face-to-face visit" means the same as defined in 12VAC30-120-1000.

"Group day services" means the same as defined in 12VAC30-120-1000.

"Group supported employment services" means the same as defined in 12VAC30-120-1000.

"Home and community-based waiver services" means the same as defined in 12VAC30-120-1000.

"ICF/IID" means the same as defined in 12VAC30-120-1000.

"Independent living supports" means a service provided to adults, ages 18 years and older, who have developmental disabilities that offers skill building and assistance necessary to secure a self-sustaining, independent living situation in the community or provides the support necessary to maintain those skills. Individuals authorized to receive this service typically live alone or with roommates in their own homes or apartments.

"Individual" means the same as defined in 12VAC30-120-1000.

"Individual supported employment" means the same as defined in 12VAC30-120-1000.

"LDSS" means the local Department of Social Services.

"LMHP" means a licensed mental health professional as defined in 12 VAC 35-105-20.

"LMHP-resident" means the same as defined in 12VAC30-50-130.

"LMHP-RP" means the same as defined in 12VAC30-50-130

"LMHP-supervisee" means the same as defined in 12VAC30-50-130.

"Medically necessary" means the same as defined in 12VAC30-120-1000.

"Participating provider" means the same as defined in 12VAC30-120-1000.

"Pend" means the same as defined in 12VAC30-120-1000.

"Person-centered planning" means the same as defined in 12VAC30-120-1000.

"Personal emergency response system" or "PERS" means the same as defined in 12VAC30-120-1000.

"Personal profile" means the same as defined in 12VAC30-120-1000.

"Plan for Supports" means the same as defined in 12VAC30-120-1000.

"Positive behavior support" means the same as defined in 12VAC30-120-1000.

"Primary caregiver" means the same as defined in 12VAC30-120-1000.

"Qualified Developmental Disability Professionals" means the same as defined in 12VAC30-120-1000.

"Risk assessment" means the same as defined in 12VAC30-120-1000.

"Routine supports" means the same as defined in 12VAC30-120-1000.

"Safety supports" means the same as defined in 12VAC30-120-1000.

"Service authorization" means the same as defined in 12VAC30-120-1000.

"Shared living" means the same as defined in 12VAC30-120-1000.

"Skill building supports" means the same as defined in 12VAC30-120-1000.

"Slot" means the same as defined in 12VAC30-120-510.

"State Plan for Medical Assistance" means the same as defined in 12VAC30-120-1000.

"Support coordination/case management" means the same as defined in 12 VAC 30-50-455(D).

"Support coordinator/case manager" means the same as defined in 12VAC30-120-1000.

"Supporting documentation" means the same as defined in 12VAC30-120-510.

"Supports" means the same as defined in 12VAC30-120-1000.

"Supports Intensity Scale" or "SIS" means the same as defined in 12VAC30-120-510.

"Transition services" means the same as defined in 12VAC30-120-1000.

"VDSS" means the Virginia Department of Social Services.

12VAC30-120-1510. General coverage and requirements for Building Independence Waiver services.

A. Covered services.

1. Covered services shall include assistive technology, center-based crisis support services, community-based crisis support services, community coaching services, community engagement services, crisis support services, electronic home-based supports, environmental modifications, group day services, group and individual supported employment services, independent living supports, personal emergency response systems (PERS), shared living, and transition services to individuals who have been assigned a Building Independence waiver slot.

B. Core Competency Requirements for Direct Support Professionals (DSPs) and their supervisors in programs licensed by DBHDS shall be the same as those set forth in 12VAC30-120-515 (A).

C. Core Competency Requirements for Support Coordinators/Case Managers (RESERVED)

D. Core Competency Requirements for QDDPs. (RESERVED)

E. Advanced Core Competency requirements for DSPs and DSP supervisors serving individuals with developmental disabilities with the most intensive needs as identified by assignment to levels 5, 6, or 7 shall be the same as those set forth in 12VAC30-120-515 (D).

F. Provider enrollment requirements shall be the same as those set forth in 12VAC30-120-514.

G. Providers shall meet the documentation requirements as specified in 12VAC30-120-514(Q).

H. Reevaluation of service need requirements shall be the same as those specified in 12VAC30-120-515(F).

I. Utilization review requirements shall be the same as those set forth in 12VAC30-120-515(G).

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

A. Participation standards for home and community-based waiver services participating providers are set forth in 12VAC30-120-500 et seq.

12VAC30-120-1552. Covered services; services descriptions.

A. Service descriptions.

1. Assistive technology (AT) service description. The service definition is the same as that set forth in 12VAC30-120-1021(A).

2. Benefits planning (RESERVED)

3. Center-based crisis support. The service description is the same as that set forth in 12VAC30-120-1024(A)(2).

4. Community-based crisis support services. The service description is the same as that set forth in 12VAC30-120-1024(A)(3).

5. Community coaching. The service description shall be the same as that set forth in 12VAC30-120-1022(B)(1).

6. Community engagement. The service description shall be the same as that set forth in 12VAC30-120-1022(A)(1).

7. Community guide (RESERVED).
8. Crisis support services. The service description shall be the same as that set forth in 12VAC30-120-1024(A)(1).
9. Electronic home-based supports (EHBS). The service description shall be the same as that set forth in 12VAC30-120-1025(A)(1).
10. Environmental modifications (EM). The service description shall be the same as that set forth in 12VAC30-120-1025(B)(1).
11. Group day services. The service description shall be the same as that set forth in 12VAC30-120-1026(A)(1).
12. Group supported employment. The service description shall be the same as that set forth in 12VAC30-120-1035(A).
13. Independent living supports means a service provided to adults (18 and over) that offers skill building and assistance necessary to secure a self-sustaining, independent living situation in the community and provide the support necessary to maintain those skills. Individuals receiving this service typically live alone or with roommates in their own homes or apartments. The supports may be provided in the individual's residence or in other community settings. Independent living supports is a tiered service for reimbursement purposes. Providers shall only be reimbursed for the individual's assigned level and tier.
14. Individual supported employment. The service description shall be the same as set forth in 12VAC30-120-1035(A).
15. Non-medical transportation (RESERVED).
16. Personal emergency response systems (PERS). The service description shall be the same as that set forth in 12VAC30-120-1030(A)(1).
17. Shared living. The service description shall be the same as that set forth in 12VAC30-120-1034(A)(1).
18. Transition services. The service description shall be the same as that set forth in 12VAC30-120-1038.

12VAC30-120-1554. Criteria that must be met to receive covered services.

A. Assistive technology criteria shall be the same as those set forth in 12VAC30-120-1021(A)(1).

B. Benefits planning (RESERVED).

C. Center-based crisis supports. Criteria shall be the same as those set forth in 12VAC30-120-1024(B)(2).

D. Community-based crisis supports. Criteria shall be the same as those set forth in 12VAC30-120-1024(B)(3).

E. Community coaching. The criteria shall be the same as those set forth in 12VAC30-120-1022(B)(2).

F. Community engagement. The criteria shall be the same as those set forth in 12VAC30-120-1022(A)(2).

G. Community guide activities (RESERVED).

H. Crisis support services. The criteria shall be the same as those set forth in 12VAC30-120-1024(B)(1).

I. Electronic home-based supports (EHBS). The criteria shall be the same as those set forth in 12VAC30-120-1025(A)(2).

J. Environmental modifications. The criteria shall be the same as those set forth in 12VAC30-120-1025(B)(2).

K. Group day services. The criteria shall be the same as those set forth in 12VAC30-120-1026(A)(2).

L. Group supported employment. The criteria shall be the same as those set forth in 12VAC30-120-1035(B).

M. The need for independent living supports shall be clearly indicated in the ISP. This service provides skill-building to : (i) promote the individual's community participation and inclusion in meaningful activities; (ii) increase socialization skills and maintain relationships; (iii) improve and maintain the individual's health, safety and fitness, as necessary; (iv) promote the individual's decision-making and self-determination skills; and (v) improve and support as needed the individual's skills with ADLs and IADLs. These services shall not be provided in a licensed residential setting.

N. Individual supported employment. The criteria shall be the same as those set forth in 12VAC30-120-1035(B).

O. Non-medical transportation (RESERVED).

P. Personal emergency response system (PERS). The criteria shall be the same as those set forth in 12VAC30-120-1030(A)(2).

Q. Shared living. The criteria shall be the same as those set forth in 12VAC30-120-1034(A)(2).

R. Transition services. The criteria shall be the same as those set forth in 12VAC30-120-1038, 12 VAC 30-120-2000 and 12 VAC 30-120-2010.

12VAC30-120-1556. Allowable activities.

1. Benefits planning activities [RESERVED]

2. Community coaching. Allowable activities shall be the same as those set forth in 12VAC30-120-1022(B)(3).
3. Community engagement. Allowable activities shall be the same as those set forth in 12VAC30-120-1022(A)(3).
4. Community guide [RESERVED]
5. Group day services. The allowable activities shall be the same as those set forth in 12VAC30-120-1026(A)(3).
6. Group supported employment. The allowable activities shall be the same as those set forth in 12VAC30-120-1035(C).
7. Independent living supports allowable activities include skill building and supports to promote: (i) the individual's community participation and inclusion; (ii) socialization skills to develop and maintain relationships; (iii) the individual's health, safety and fitness; (iv) the individual's decision making and self-determination skills; (v) the individual's engagement in meaningful community activities; and (vi) supports related to ADLs and IADLs.
8. Individual supported employment. The allowable activities shall be the same as those set forth in 12VAC30-120-1035(C).
9. Non-medical transportation [RESERVED]
10. Shared living. The allowable activities shall be the same as those set forth in 12VAC30-120-1034(A)(3).
11. Transition services. The allowable activities shall be the same as those set out in 12VAC30-120-1038, 12VAC30-120-2000 and 12VAC30-120-2010.
12. Crisis support services. The allowable activities shall be the same as those set forth in 12VAC30-120-1024(C)(1)-(2).
13. Center-based crisis support services. The allowable activities shall be the same as those set forth in 12VAC30-120-1024(C)(3).
14. Community-based crisis support services. The allowable activities shall be the same as those set forth in 12VAC30-120-1024(C)(4).

12VAC30-120-1558. Units and limits on covered services.

A. Limits on covered services.

1. AT service units and services shall be the same as those set forth in 12VAC30-120-1021(A)(2) and (A)(3).
2. Benefits planning [RESERVED]

3. Center-based crisis supports. Service units and limits shall be the same as those set forth in 12VAC30-120-1024(D)(2).
4. Community-based crisis supports. Service units and limits shall be the same as those set forth in 12VAC30-120-1024(D)(3).
5. Community coaching. Service units and limits shall be the same as those set forth in 12VAC30-120-1022(B)(4).
6. Community engagement. Service units and limits shall be the same as those set forth in 12VAC30-120-1022(A)(4).
7. Community guide **[RESERVED]**
8. Crisis support services. Service units and limits shall be the same as those set forth in 12VAC30-120-1024(D)(1).
9. Environmental modifications. Service units and limits shall be the same as those set forth in 12VAC30-120-1025(B)(3).
10. Group day services. The service units and limits shall be the same as those set forth in 12VAC30-120-1026(A)(4).
11. Group supported employment. The service units and limits shall be the same as those set forth in 12VAC30-120-1035(D).
12. The independent living supports unit of service delivery shall be a month or, when beginning or ceasing the service, may be a partial month. Individuals who have been approved for this service shall receive no more than 21 hours of independent living supports per week (Sunday through Saturday) in the individual's home or in community settings. This service shall not be provided in a licensed residential setting.
13. Individual supported employment. The service units and limits shall be the same as those set forth in 12VAC30-120-1035(D).
14. Non-medical transportation: **[RESERVED]**
15. Personal emergency response systems. The service units and limits shall be the same as those set forth in 12VAC30-120-1030(A)(3).
16. Shared living. Service units and limits shall be the same as those set forth in 12VAC30-120-1034(A)(4).
17. Transition services. Service units and limits shall be the same as those set forth in 12VAC30-120-1038, 12VAC30-120-2000 and 12VAC30-120-2010.

12VAC30-120-1560. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based waiver participating providers as specified in 12VAC30-120-500 et seq., service providers shall meet the following requirements:

A. Assistive technology providers shall meet all of the requirements set forth in 12VAC30-120-1021(A)(4) and 12VAC30-120-1061(A) and (B).

B. Benefits planning. (RESERVED).

C. Center-based crisis support providers shall meet all of the requirements set forth in 12VAC30-120-1024(E) and 12VAC30-120-1063(B).

D. Community-based crisis support providers shall meet all of the requirements set forth in 12VAC30-120-1024(E) and 12VAC 30-120-1063(C).

E. Community coaching providers shall meet all of the requirements set forth in 12VAC30-120-1022(B)(5) and 12VAC30-120-1065(B).

F. Community engagement providers shall meet all of the requirements set forth in 12VAC30-120-1022(A)(5) and 12VAC30-120-1065(A).

G. Community guide services (RESERVED)

H. Crisis support services providers shall meet all of the requirements set forth in 12VAC30-120-1024(E) and 12VAC30-120-1063(A).

I. Electronic home based services providers shall meet all of the requirements set forth in 12VAC30-120-1025(A)(4) and 12VAC30-120-1061.

J. Environmental modification (EM) providers shall meet all of the requirements set forth in 12VAC30-120-1025(B)(4) and 12VAC30-120-1061.

K. Group day services providers shall meet all of the requirements set forth in 12VAC30-120-1026(A)(5).

L. Group supported employment providers shall meet all of the requirements set forth in 12VAC30-120-1035(E) and 12VAC30-120-1066(A) and (B).

M. Independent living supports shall be provided by agencies licensed by DBHDS as providers of supportive in-home services. These providers shall have a signed participation agreement with DMAS. The provider designated on the agreement shall directly provide independent living support services and directly bill DMAS for reimbursement. Providers shall ensure that persons rendering in-home support services have received training in the characteristics of intellectual/developmental disabilities and the appropriate interventions, training strategies, and support methods for individuals with functional limitations prior to providing waiver services. All providers of in-home support services shall pass (with a minimum score of 80%) an objective, standardized test of skills, knowledge, and abilities approved by DBHDS and administered according to DBHDS' defined procedures. (See www.dbhds.virginia.gov for further information.)

N. Individual supported employment providers shall meet all of the requirements set forth in 12VAC30-120-1035(E) and 12VAC30-120-1066(A) and (B).

O. Non-medical transportation providers (RESERVED).

P. Personal emergency response systems provider requirements. In addition to meeting the general conditions and requirements for home and community-based services participating providers as specified in 12VAC30-120-500 et seq., 12VAC30-120-1030(A)(4), and 12VAC30-120-1061(A) and (E), providers shall also meet the following requirements:

1. A PERS provider shall be either a (i) licensed home health or personal care agency, (ii) a durable medical equipment provider, (iii) a hospital, or (iv) a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and service calls), and PERS monitoring.
2. The PERS provider shall have a current, signed provider participation agreement with DMAS. This agreement shall be renewed promptly when requested by DMAS. The provider named on this participation agreement shall directly render these PERS services and shall submit his claims to DMAS for reimbursement.
3. The PERS provider shall provide an emergency response center staff with fully trained operators who are capable of receiving signals for help from an individual's PERS equipment 24 hours a day, 365, or 366 as appropriate, days per year; of determining whether an emergency exists; and of notifying an emergency response organization or an emergency responder that the individual needs emergency help.
4. A PERS provider shall comply with all applicable federal and state laws and regulations, all applicable regulations of DMAS, and all other governmental agencies having jurisdiction over the services to be performed.
5. The PERS provider shall have the primary responsibility to furnish, install, maintain, test, and service the PERS equipment, as required to keep it fully operational. The provider shall replace or repair the PERS device within 24 hours of the individual's or family/caregiver's notification of a malfunction of the console unit, activating devices, or medication-monitoring unit while the original equipment is being repaired.
6. The PERS provider shall properly install all PERS equipment into the functioning telephone line or cellular system of an individual receiving PERS and shall furnish all supplies necessary to ensure that the system is installed and working properly.
7. The PERS installation shall include local seize line circuitry, which guarantees that the unit will have priority over the telephone connected to the console unit should the phone be off the hook or in use when the unit is activated.
8. The PERS provider shall install, test and demonstrate to the individual and family/caregiver, as appropriate, the PERS system before submitting the claim for reimbursement to DMAS.
9. A PERS provider shall maintain all installed PERS equipment in proper working order.
10. A PERS provider shall maintain a data record for each individual receiving PERS at no additional cost to DMAS. The record shall document all of the following:
 - (a) Delivery date and installation date of the PERS;
 - (b) The signature of the individual or his family/caregiver, as appropriate, verifying receipt of PERS device;

(c) Verification by a test that the PERS device is operational, monthly or more frequently as needed;

(d) Updated and current individual responder and contact information, as provided by the individual or the individual's care provider, or support coordinator/case manager; and

(e) A case log documenting the individual's utilization of the system and contacts and communications with the individual or his family/caregiver, as appropriate, support coordinator/case manager, or responder.

11. The PERS provider shall have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.

12. Standards for PERS equipment. All PERS equipment shall be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard Number 1635 for Digital Alarm Communicator System Units and Number 1637, which is the UL safety standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The PERS device shall be automatically reset by the response center after each activation ensuring that subsequent signals can be transmitted without requiring manual reset by the individual enrolled in the waiver or family/caregiver, as appropriate.

13. A PERS provider shall instruct the individual, his family/caregiver, as appropriate, and responders in the use of the PERS service.

14. The emergency response activator shall be activated either by breath, by touch, or by some other means, and shall be usable by persons who have visual or hearing impairments or physical disabilities. The emergency response communicator shall be capable of operating without external power during a power failure at the individual's home for a minimum period of 24 hours and automatically transmit a low battery alert signal to the response center if the back-up battery is low. The emergency response console unit shall also be able to self-disconnect and re-dial the back-up monitoring site without the individual resetting the system in the event it cannot get its signal accepted at the response center.

15. Monitoring agencies shall be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It is the PERS provider's responsibility to ensure that the monitoring agency and the agency's equipment meet the requirements of this subsection. The monitoring agency shall be capable of simultaneously responding to multiple signals for help from multiple individuals' PERS equipment. The monitoring agency's equipment shall include the following:

(a) A primary receiver and a back-up receiver, which shall be independent and interchangeable;

(b) A back-up information retrieval system;

(c) A clock printer, which shall print out the time and date of the emergency signal, the PERS individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;

(d) A back-up power supply;

(e) A separate telephone service;

(f) A toll free number to be used by the PERS equipment in order to contact the primary or back-up response center; and

(g) A telephone line monitor, which shall give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

16. The monitoring agency shall maintain detailed technical and operations manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and recordkeeping and reporting procedures.

17. The PERS provider shall document and furnish within 30 calendar days of the action taken a written report to the support coordinator/case manager for each emergency signal that results in action being taken on behalf of the individual. This excludes test signals or activations made in error.

18. The PERS provider shall be prohibited from performing any type of direct marketing activities.

Q. Shared living administrative providers shall have a signed provider participation agreement with DMAS and shall meet all of the requirements set forth in 12VAC30-120-1034(A)(5) and 12VAC30-120-1069. The provider designated in this agreement shall directly coordinate the services and directly bill DMAS for reimbursement. The administrative provider shall ensure that there is a back-up plan in place in the event that the live-in companion is unable or unavailable to provide supports. The administrative provider shall maintain documentation of the actual rent or mortgage and utilities costs and submit it with the service authorization request. The approvable amount for rent and utilities costs shall be the lesser of the live-in companion's half of the rent cost incurred by the individual receiving waiver services and utilities costs or the maximum allowable amount for the region of the state in which the individual and live-in companion reside. The maximum reimbursable room and board shall be based on the range of fair market rent in the state, using one rate for Northern Virginia and another for the rest of the state (ROS) as established by DMAS. The administrative providers shall submit monthly claims for reimbursement. A DBHDS provider possessing a DBHDS triennial group home and community residential services license, shall manage the administrative aspects of this service, including roommate matching as needed, background checks, training as needed, periodic on-site monitoring, and disbursing funds to the individual. This provider agency shall be reimbursed a flat fee payment for the completion of these duties. DMAS shall audit such provider's records for compliance with these requirements.

R. Transition services. These provider requirements shall be the same as set out in 12 VAC 30-120-2000 and 12 VAC 30-120-2010.

12VAC30-120-1580. Payments for services.

A. All assistive technology, crisis support services, center-based crisis support services, community-based crisis support services, environmental modification, electronic home based

services, community engagement, community coaching, group day services, independent living supports, individual supported employment, group supported employment, PERS, shared living, and transition services provided in this waiver shall be reimbursed consistent with the agency's service limits and payment amounts as set out in the fee schedule, available at www.dmas.virginia.gov

B. Reimbursement rates for individual supported employment shall be the same as set by the Department for Aging and Rehabilitative Services for the same services. Reimbursement rates for group supported employment shall be as set by DMAS.

C. All AT, EM, and EHBS covered procedure codes provided in the BI waiver shall be reimbursed as a service limit of one. The maximum Medicaid funded expenditure per individual for all AT, EM, and EHBS covered procedure codes shall be \$5,000 for AT, EM or EHBS each per calendar year. No additional mark-ups, such as in the durable medical equipment rules, shall be permitted.

D. Duplication of services.

1. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the ADA (42 USC §§ 12131 through 12165), the Rehabilitation Act of 1973, the Virginians with Disabilities Act, or any other applicable statute.

2. Payment for services under the Individual Support Plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

3. Payment for services under the Individual Support Plans shall not be made for services that are duplicative of each other. Expenditures made for services determined in post payment review audits to be duplicative shall be recovered by DMAS.

4. Payments for services shall only be provided as set out in the individuals' Individual Support Plans.